CORONERS ACT, 2003

SOUTH *AUSTRALIA*

FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 2nd, 3rd, 4th, 5th, 6th, 9th and 19th days of July 2018 and the 7th day of September 2018, by the Coroner's Court of the said State, constituted of Mark Frederick Johns, State Coroner, into the death of Peter James McBride.

The said Court finds that Peter James McBride aged 86 years, late of 99 Grey Terrace, Port Pirie, South Australia died at the Royal Adelaide Hospital, North Terrace, Adelaide, South Australia on the 11th day of April 2015 as a result of multi-organ failure due to sepsis on a background of sacral pressure ulcer. The said Court finds that the circumstances of his death were as follows:

1. Introduction and cause of death

1.1. Peter James McBride died on 11 April 2015. He was 86 years old at the time of his death. He died in the Royal Adelaide Hospital where he had been a patient for two days having been transferred to that hospital from the Port Pirie Regional Health Service (Port Pirie Hospital) where he had been a patient for 61 days. He had been admitted to the Port Pirie Hospital on 7 February 2015 and during his time there he developed a sacral pressure ulcer. His death at the Royal Adelaide Hospital was reported to the State Coroner by a resident medical officer and the stated reason for the death being reportable under the Coroners Act 2003 (the Act) was that the death was unexpected[1]. The reporting doctor also gave as another reason for the report 'concern re medical neglect' and expressed as the doctor's opinion of the cause of the death 'overwhelming sepsis secondary to sacral pressure wound infection'[2]. An opinion was sought from Dr McIntyre of Forensic Science South Australia who, together with forensic

[1] See paragraph (a) definition of 'Reportable Death', section 3(1) of the Act
[2] Exhibit C4, page 20

pathologist Dr Wills, reviewed the medical records from the Port Pirie Hospital and the Royal Adelaide Hospital. They gave as their opinion for the cause of death 'multi-organ failure due to sepsis in an individual with a sacral pressure ulcer'[3], and I so find.

2. Pressure injuries

2.1. According to the Policy, Clinical Guideline, Pressure Injury Prevention and Management Guideline[4], promulgated by the SA Health Safety & Quality Strategic Governance Committee in 2012:

> 'Pressure injuries are highly preventable, and it is recognised that their potentially long healing time has consequences for quality of life, susceptibility to infection, pain, sleep and mood, and the provision of services.'

The guideline describes clinical practice that is based on the Pan Pacific Clinical Practice Guideline for the Prevention and Management of Pressure Injury, 2012, Australian Wound Management Association[5].

2.2. Ms Godleman is the Chair of the Country Health South Australia Local Health Network Committee on Pressure Injuries and she made an affidavit in these proceedings[6]. According to Ms Godleman, a pressure injury or ulcer occurs where there is localised injury to the skin and/or tissue. It usually occurs over bony prominences. The injury can be caused as a result of pressure, shearing, friction, moisture or a combination of these things. Ms Godleman said that pressure injury management is the prevention of these causes by identifying patients at risk. Patients are rated as nil, low, medium or high risk and strategies are assigned to reduce, manage or eliminate the risk. She said that in 2012 Country Health South Australia Local Health Network participated in a move to standardise the implementation of preventing and managing pressure injuries across country South Australia. She set out the process by which this was achieved and it is clear enough that the efforts by Country Health South Australia Local Health Network at that time were integrated with the more general work of SA Health as set out in the Pressure Injury Prevention and Management Guideline I have referred to above[7]. Ms Godleman said that all Country Health South Australia Local Health Network health services adopted a standardised approach to skin assessment in 2013

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[3] Exhibit C1a
[4] Exhibit C10
[5] Exhibit C7, Annexure SG3 and the National Safety & Quality Health Service Standard 8, 2012, Australian Commission for Safety and Quality in Health Care
[6] Exhibit C7
[7] Exhibit C10

by the adoption of the Braden Scale. She said that in the context of an admission to hospital, the skin assessment should be made within eight hours of admission. She said that in 2013 posters were placed on the walls of most facilities within the network setting out the Braden Scale and that the Braden Scale document was automatically included in the medical record in most facilities. Certainly, the Braden Scale appeared in the medical records of Mr McBride for his admission at Port Pirie Hospital in 2015[8].

2.3. Ms Godleman said that in 2014 a five step model for pressure ulcer prevention called SSKIN was adopted. It was developed from a UK regional healthcare service and is as follows:

(a)	**S**urface:	Make sure your patients have the right support.
(b)	**S**kin Inspection:	Early inspection means early detection. Show patients and carers what to look for.
(c)	**K**eep:	Your patients moving.
(d)	**I**ncontinence/Moisture:	Patients need to be clean and dry.
(e)	**N**utrition/Hydration:	Help patients to have the right diet and plenty of fluids.

According to annexure SG2 to Ms Godleman's affidavit[9] the UK SSKIN model was introduced with the goal of eliminating avoidable grade 2, 3 and 4 pressure ulcers by December 2012. According to the annexure 95% of pressure ulcers are preventable. They cause patients long term pain and distress and can mean longer stays in hospital. Within the UK the treatment of pressure ulcers costs the National Health Service more than £3.8 million every day.

2.4. Ms Godleman also referred to the Country Health South Australia Local Health Network procedure for Preventing & Managing Pressure Injuries[10]. The purpose of the policy was to ensure the application of pressure injury prevention and management in country health services. In particular it introduced risk assessment and planning 'tools' being:

> '1 Pressure injury and risk assessment (MR95) form incorporating the Braden risk assessment scale and skin assessment.
>
> 2 Pressure injury prevention plan form (MR95A).'

[8] Exhibit C3
[9] Exhibit C7
[10] Exhibit C7, Annexure SG6

3. Mr McBride's medical notes

3.1. Mr McBride's medical notes include examples of the documents just referred to, namely the MR95 and MR95A. Unfortunately, the forms do not greatly assist me to assess the level of pressure area care that was provided to Mr McBride throughout his stay. It is quite clear however that during his stay he developed a sacral pressure injury of the most serious severity. On his admission the skin of his sacral area was unbroken and at most there may have been a red mark present. It is notable that the nursing history and assessment form and admission checklist for Mr McBride[11] includes the following information. Under the heading 'skin integrity' the 'yes' box has been ticked to the prompt 'wound/pressure injury identified'. It is notable that immediately under this the form states 'if yes complete wound assessment form' and then boxes to be completed recording whether the wound assessment form has been completed or not. The wound assessment form is the MR95. It is the wound assessment form which contains the necessary table for the Braden Scale to be applied. In Mr McBride's case the wound assessment form or the pressure injury risk assessment form MR95 was not completed until 14 February 2015, a week after Mr McBride's admission. Thus, contrary to the Country Health South Australia Local Health Network guidelines referred to above, the full assessment and application of the Braden Scale in Mr McBride's case was not carried out within the mandatory eight hours after admission.

3.2. Mr McBride's patient care plan, another document prescribed to be completed as part of his records, does not contain a relevant note under the heading of 'skin integrity' until 16 February 2015[12]. The patient care plan for Mr McBride was not punctiliously completed in that entries are meant to be made for each shift and this did not occur. When the entry was made on 16 February 2015 in relation to Mr McBride's skin integrity, the entry was '4/24 PAC' which means that he should have pressure area care every four hours, 24 hours per day.

3.3. When a new patient care plan was commenced for Mr McBride on 22 February 2015[13] the ongoing need for pressure area care every four hours was not carried over to the new chart as it should have been. Indeed it did not reappear until 14 days later when

[11] Exhibit C3, page 216
[12] Exhibit C3, page 234
[13] Exhibit C3, page 238

the third patient care plan chart was commenced on 8 March 2015. On that day the relevant entry was '2-4/24 PAC' and it was noted that a pressure injury risk assessment had been completed[14]. Thereafter this note remained in the patient care plan chart for Mr McBride.

3.4. When the pressure injury risk assessment form, the MR95, was completed on 14 February 2015[15] the box that was ticked was for an existing pressure injury. The form prescribed as key actions in that circumstance the following:

- Offload affected area. Eliminate pressure, friction, shear and moisture as much as practicable.
- Arrange active (dynamic) pressure mattress and chair cushion.
- 1-2/24 position changes with careful manual handling.
- Reassess Braden and pain scores and inspect skin each shift.
- Commence Pressure Injury Prevention Plan. MR95A can be used.
- Commence wound chart and management.
- Notify medical officer and refer to dietitian. Consider other referrals.'

3.5. Thus it should have been the case that the Pressure Injury Prevention Plan chart MR95A should have been commenced on 14 February 2015. The records show that the chart was not commenced until 16 February 2015[16].

3.6. The acknowledgment in the pressure injury risk assessment form MR95[17] that there was an existing pressure injury on 14 February 2015 should, as I have mentioned above, have necessitated the commencement of the wound chart and management thereafter, but this was not done. It should also have precipitated the introduction of an active (dynamic) pressure mattress and chair cushion. That was not done either. The patient care plan should have been updated to record the need for one to two hourly position changes with careful manual handling. This was not done either and, as I have said, it was not until two days later on 16 February 2015 that the belated requirement for four hourly position changes was included[18] only to be dropped from the next two charts of that category before belatedly being reinstated on 8 March 2015[19].

[14] Exhibit C3, page 246
[15] Exhibit C3, page 287
[16] Exhibit C3, page 292
[17] Exhibit C3, page 287
[18] Exhibit C3, page 234
[19] Exhibit C3, page 246

3.7. The evidence showed that the member of the nursing staff who completed the MR95 on 14 February 2015 did not have time to complete the MR95A or the other key actions I have referred to above.

3.8. In fact the pressure mattress was not instituted until 17 March 2015 and the wound chart not started until 7 March 2015. No dietician was arranged until 18 March 2015 and the physiotherapist had stopped without any explanation on 13 February 2015 after seeing Mr McBride on four occasions.

3.9. There are scattered entries of pressure area care having been attended to in the progress notes. However, the Braden Scale MR95 was not completed on every day. The progress notes are subjective and inconsistent. For example, as I have said the pressure injury risk assessment form MR95A completed on 14 February 2015 records the existence of an actual pressure injury. Yet a nursing note in the progress notes on 4 March 2015[20] states:

> 'Skin Integrity: intact.'

These notes are difficult to reconcile. On 7 March 2015 the note is made that the pressure wound on the sacrum is stage 4, sloughy with offensive odour[21]. On 27 February 2015 there is a nursing note recording 'patient has wound on buttock/sacrum. Wound appears dry and clean due to toileting in the toilet'[22]. The lack of attention to the keeping of proper records in the charts referred to above makes it difficult to assess the true state of Mr McBride's sacral region during the course of the early part of his hospitalisation.

3.10. This lack of certainty is exemplified by the evidence of the witness Heather Matthews, the Assistant Nurse Unit Manager at Port Pirie Hospital:

> 'A. I suppose maybe nurses have different interpretation of what a pressure injury is. Like to me, any reddened skin, you know, any discoloured skin, to me, is a pressure injury.
>
> Q. Well that's not what you said before. You said before that the pressure injury - existing pressure injury should be taken to indicate broken skin.
>
> A. Yeah and also broken skin, so -
>
> Q. So that is suggestive, isn't it, that almost certainly - almost certainly the nursing note of 4 March is - and I'm not saying it's deliberately so - but it's got to be wrong, hasn't

[20] Exhibit C3, page 159
[21] Exhibit C3, page 161
[22] Exhibit C3, page 154

it, when it talks about the skin being intact if we've seen - as Mr Kalali has already pointed out - on 12 February you've got very red, blackened and bruised and then you've got - we know, on 7 March you've got stage 4 injury and we know that on 14 February you've got somebody recording an injury.

A. Yes.

Q. So all around it you've got records of an injury of some level of severity, on 12 March it's red, blackened and bruising, on 4 March there's no way that the skin's intact.

A. It could remain intact. Like, the skin can become very thin in that where the injury is, but not actually what we would term breakdown as in, you know, there'd be a tear in the skin or like an obvious wound.

Q. Well yet we've got 'existing pressure injury' having been recorded on 14 March.

A. Yes.

Q. 14 February.

A. So to me that's the registered nurse's interpretation of -

Q. Well how do we know that that interpretation is the correct one and that the note of 4 March is just wrong.

A. Well we don't; we don't know.

Q. That's a possibility too, isn't it.

A. Yes.

Q. In fact, it's a more likely possibility having regard to the severity of the observations that were made on 12 February -

A. Yes.' [23]

3.11. As I say this passage of evidence highlights the subjectivity of observations written in progress notes. In that context I merely record the following progress note entries:

Date	**Progress Note Entry**
8 February 2015	Patient complains of pain in/on right buttocks, small red mark present.[24]
9 February 2015	Patient states pain to his tail bone, PAC attended.[25]
12 February 2015	Patient complained of a sore bottom.[26]
12 February 2015	Buttocks & per anal area very red, blackened with bruising, sore to touch.[27]
15 February 2015	Broken area noticed to sacral region, with darkened area on coccyx.[28]

[23] Transcript, pages 123-124
[24] Exhibit C3, page 122
[25] Exhibit C3, page 123
[26] Exhibit C3, page 131
[27] Exhibit C3, page 132
[28] Exhibit C3, page 137

Date	Progress Note Entry
16 February 2015	Skin integrity: Frail, pressure area to sacrum. PAC attended 4/24.[29]
18 February 2015	Dressing on coccyx intact.[30]
21 February 2015	Skin integrity: Patient dressing remains intact on sacrum.[31]
23 February 2015	Skin integrity: Pressure area sore, mepilex border insitu, lower sacrum.[32]
24 February 2015	Skin integrity: Dressing on lower sacrum remains intact.[33] A similar note is made on 25 February 2015
26 February 2015	Sacrum border applied to skin breakdown on sacral region.[34]
27 February 2015	Patient has wound on buttock / sacrum. Wound appears dry and clean due to toileting in the toilet.[35]
2 March 2015	Patients skin intact.[36]
3 March 2015	There is a progress note that skin is intact, but another progress note that day referring to the patient complaining of pain in sacral area.
4 March 2015	This is the reference I have already referred to of skin integrity intact, sacral area red.
7 March 2015	Skin: Mepilex replaced on pressure wound on sacrum. Stage 4. Sloughy with offensive odour.[37]
10 March 2015	Sacral dressing still remains insitu; not changed this shift.[38]
11 March 2015	Unable to assess/check for pressure sores and skin integrity as patient lying on left hip, refusing to straighten legs out as it 'hurts'.[39]
11 March 2015	Skin Integrity: Unable to perform PAC due to patients discomfort. Tried to use pillow to keep patient off sacral, insitu and working.[40]
12 March 2015	Skin: Dressing on sacrum due to be changed today. Can it please be done this PM? [41] **I note that there is no record as to whether that instruction was complied with.**
13 March 2015	Skin: Unable to assess sacral wound and dressing due to patients resistiveness.[42]
14 March 2015	Dressing to sacrum remains intact.[43]
14 March 2015	Skin integrity: Nursed 2/24 from side to side. Dressing intact sacrum.[44]

[29] Exhibit C3, page 138
[30] Exhibit C3, page 141
[31] Exhibit C3, page 146
[32] Exhibit C3, page 149
[33] Exhibit C3, page 149
[34] Exhibit C3, page 152
[35] Exhibit C3, page 154
[36] Exhibit C3, page 157
[37] Exhibit C3, page 161
[38] Exhibit C3, page 163
[39] Exhibit C3, page 165
[40] Exhibit C3, page 166
[41] Exhibit C3, page 168
[42] Exhibit C3, page 170
[43] Exhibit C3, page 170
[44] Exhibit C3, page 171

Date	Progress Note Entry
16 March 2015	Skin integrity: Wound on sacrum reviewed. Wound appears necrotic, sloughy. Wound is smelly+++. Purulent exudate +++. Surrounding skin appears macerated and reddened. Wound swab to be attended. Wound to be attended daily. Cleansed with n/saline, dressed solosite and mepilex lite.[45]
16 March 2015	Patients sacral wound has a very offensive smell. When changing pad dressing was falling off. Secured with x2 mepilex borders.[46]

On 17 March 2015 the progress notes contain a pressure injury notification label which appears to have been stuck in the notes, recording that the site of the pressure injury is the sacrum and that it is at stage 4 and that it was hospital/care acquired. That same day another progress note refers to the pressure area on the sacral area and that verbal permission had been given (presumably by Mrs McBride) for staff to take a photo of the pressure area for the notes and the need to complete an SLS[47].

3.12. I will not continue this overview of the progress notes because by 17 March 2015 at least the pressure wound was unequivocally established to exist. Over the period from 8 February 2015 to 17 March 2015 the progress notes contain many nursing entries with no reference to Mr McBride's sacrum, no reference to his skin integrity and no reference to pressure area care. It is not possible to determine from the progress notes whether any attention was paid to his sacral area on those many other occasions. It is clear however that on a number of occasions as reflected in the narrative above, that the sacral area was not inspected at all, because the note merely records the dressing was noted to be 'intact' which presumably means that the area underneath it was not inspected.

3.13. It is beyond doubt, and I find, that Mr McBride developed a sacral pressure injury which by 17 March 2015 was assessed as stage 4. Finally, on that day also, action was taken to remove Mr McBride's old mattress and replace it with an air mattress which, according to policy and the MR95 form[48], was mandatory as at 14 February 2015, more than a month before. Finally, the Director of Nursing at Port Pirie Hospital gave evidence. He acknowledged that pressure area management is a nursing responsibility and that Mr McBride ended up with a catastrophic sacral ulcer for which the nursing

[45] Exhibit C3, page 174
[46] Exhibit C3, page 175
[47] Exhibit C3, page 177
[48] Exhibit C3, page 287

staff at Port Pirie Hospital must bear responsibility[49]. He was asked if he was able to ascertain who was responsible for that failure of nursing and his reply was as follows:

> 'No, we certainly did a review at the time but when you look at the record, we provide three shifts over a number of days so it was a multiple range of people involved in the provision of care and at any one of those points in time, as has been highlighted, it could have been acted on and then appropriate assessments implemented. So to define that it was a person or one or two individuals, it appears to be more of our system of care that should have - that did fail.' [50]

3.14. I should also record that evidence was given by the nursing staff who gave evidence at the Inquest that because Mr McBride was brought in following a fall, it was a mandatory policy within the Port Pirie Hospital that he had to be kept in bed until he could be reviewed by a physiotherapist. As a result of this initially Mr McBride was not mobilised in the first couple of days of his hospital stay, a matter which was the subject of concern expressed by the expert overviewer in this case, Professor Whitehead. The Director of Nursing gave evidence that there was no such policy. He had been Director of Nursing since 2009. This is another matter of considerable concern and a failure of nursing practice at Port Pirie Hospital[51].

4. Mr McBride's background and pre-admission health

4.1. The Court heard from Mr McBride's son who provided background information as to Mr McBride's pre-admission circumstances. Mr McBride had lived in Port Pirie all of his life. He was a driver who retired at the age of 62. All of his life he had been interested in harness racing and had been a trainer. He had given up his participation in harness racing training five years before his death. Until two months before his admission to hospital he would walk the family dog for half an hour every day. After that he complained of weakness in his legs and did not do the walk, but during that period of two months he was still mobile around the house. He had a walking stick but did not use it around the house. He had also been given a walking frame but did not ever use it. Mr McBride's son said that approximately a fortnight before his admission to hospital Mr McBride had occasional hallucinations. There was a tree across the road from Mr McBride's house and he imagined that a horse was tied to the tree when this was not so. Mr McBride's son said that he visited his father twice in hospital because he (the son) lived in Adelaide. He said his father seemed quite depressed about his stay

[49] Transcript, page 494
[50] Transcript, page 494
[51] See generally transcript, pages 487-489

in hospital and expressed the concern that he did not think he would come out of hospital. Mr McBride's son said that his father's short-term memory had been bad before his admission and remained so in hospital. He said that while in hospital he had another hallucination which centred on a print on the wall of his room. He was convinced that there was a cow in the picture when there was not. Mr McBride's son said that his father had been a lucid conversationalist prior to his hospitalisation and would read the newspaper every day and complete the crossword with Mrs McBride. As I have already mentioned however, his short-term memory was poor and he might for example forget that he had had lunch half an hour previously.

4.2. Further information as to Mr McBride's general wellbeing prior to his admission to hospital came from his general practitioner, Dr Seemanpillai. Dr Seemanpillai said that he had been Mr McBride's general practitioner for 30 years and knew him very well. He gave a comprehensive list of Mr McBride's comorbidities in his statement[52] which I will not set out in detail. The main features included a total left knee replacement in 1983, a coronary artery bypass in that year, diagnosis of hypercholesterolaemia in 1998 together with hypertension in that year. Chronic atrial fibrillation was diagnosed in 1999, gout, osteoarthritis and spondylosis in 2000. He had a bilateral cataract implant in 2001 and significantly, was diagnosed with diabetes mellitus type 2 in 2002. A pacemaker was inserted in 2005 and in that year he was diagnosed with renal impairment and, significantly, nephropathy secondary to diabetes. In 2011 he had a left subdural haemorrhage as a result of anticoagulation and in 2012 transitional cell carcinoma of the bladder. In 2013 transurethral resection of the prostate and in 2014 he had a transient ischaemic attack.

5. Medical care while in Port Pirie Hospital

5.1. I have previously dealt with Mr McBride's nursing treatment. Unfortunately his medical care was the responsibility of three different general practitioners from the same general practice in Port Pirie. The primary responsibility fell on Dr Seemanpillai under whose bed card Mr McBride was admitted. However, other crucial elements of his medical care were attended to by two other doctors, Dr DeSilva and, to a lesser extent, Dr Jayasinga. Unfortunately there was a lack of communication between the treating doctors which led to a number of problems in and of itself.

[52] Exhibit C14

5.2. I heard from Dr DeSilva and Dr Seemanpillai, but not from Dr Jayasinga whose role was less significant. I start with the evidence of Dr DeSilva.

5.3. It was Dr Jayasinga who saw Mr McBride immediately after his admission on 8 March 2015. On that day he noted that Mr McBride's blood tests revealed pancytopenia. More significantly, it was Dr Jayasinga who placed a urinary catheter in Mr McBride for reasons that are not clear from the records. This urinary catheter was a significant development and was the subject of comment by Professor Whitehead in his review. Dr Seemanpillai saw Mr McBride the following day and directed that there be a trial void. His evidence was that he was attempting to eliminate the need for catheterisation. The catheter was reinstated by Dr DeSilva on 10 February 2015.

5.4. Dr DeSilva

Dr DeSilva was subject to limited registration from AHPRA in 2015 and was subject to general supervision by doctors from the general practice in that period. At the time of giving evidence he was nearing the end of his period of supervision in this country. He said that Dr Seemanpillai was experiencing his own health problems in February 2015 and required time off for treatment. Dr DeSilva therefore had to fill in for Dr Seemanpillai in connection with Mr McBride's treatment to accommodate Dr Seemanpillai's need for treatment, but also in the course of Dr DeSilva's weekend roster from time to time at the Port Pirie Hospital. It was in those two capacities that he encountered Mr McBride. He had never seen Mr McBride before the his admission to the Port Pirie Hospital.

5.5. Dr DeSilva prescribed an antibiotic for a urinary tract infection. On 13 February 2015 he prescribed a single dose of olanzapine because Mr McBride had pulled out his IV cannula[53]. Dr DeSilva said that the next prescription of olanzapine which was a PRN phone order was made by Dr Jayasinga. Dr Seemanpillai introduced risperidone at 0.5mg at night from 14 February 2015. All in all, Mr McBride received 30mg of olanzapine between 13 and 18 February 2015 when it was stopped. Approximately 15mg to 20mg were administered between 13 and 15 February 2015. This was described by Professor Whitehead as a high dose, not recommended for behavioural disturbance in older people. I will return to that later. Dr DeSilva said that his first contact with Mr McBride was on 10 February 2015 when he replaced the catheter that

[53] Exhibit C3, page 135

had been removed for a trial void at the direction of Dr Seemanpillai. He said that he was reinserting it at the direction of 'the treating doctor'. That cannot be correct because Dr Seemanpillai's evidence, which I accept, was that he was trying to wean Mr McBride off the catheter. It may be that Dr DeSilva was acting on the instructions of Dr Jayasinga, but that is not clear. In any event, when asked about whether he had looked at the preceding notes during that consultation, he responded by saying:

> 'Well I was given a direct order by the treating doctor, so as a junior doctor I just carried out my order.' [54]

At that point in his evidence it was noted by the Court that a significant amount of interaction was taking place between Dr DeSilva and a woman who was sitting in the body of the Court. As a result the woman was asked to leave the Court. I was informed that she works as a consultant looking after international medical graduates who run into trouble with AHPRA or their registration[55]. Dr DeSilva said that his practice was not to look at preceding notes, if he was requested to do something he would merely attend to that thing[56]. Dr DeSilva said that he prescribed the risperidone on 13 February 2015 because of Mr McBride's agitation[57]. He also said that Mr McBride had '*a little bit of dementia*' and that risperidone was indicated for the treatment of dementia[58].

5.6. Dr DeSilva said he did not have an awareness at an early stage of Mr McBride's potential pressure injury.

5.7. It was conceded by counsel for Dr DeSilva that there were occasions on which Dr DeSilva was attending Mr McBride for the purposes of review, and for the purpose of considering current management requirements and that, without going back to read previous notes, he could not possibly have a proper appreciation of the circumstances that he was presented with. Dr DeSilva admitted[59] that if he had read the previous notes he would have become aware of a potential evolving pressure injury. He admitted that if he had looked at Mr McBride's buttocks in response to a report of buttock tenderness on 12 March 2015 he would have clearly seen the ulcer[60].

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[54] Transcript, page 282
[55] Transcript, page 282
[56] Transcript, page 283
[57] Transcript, page 246
[58] Transcript, page 246
[59] Transcript, page 285
[60] Transcript, page 295

5.8. Given that the ulcer had been clearly recognised on 17 March 2015 it is not particularly useful to consider Dr DeSilva's involvement from that time until 4 April 2015. At this point I should interpolate that on 23 March 2015 Dr Seemanpillai ceased to attend at the Port Pirie Hospital. It was Dr Seemanpillai's evidence that he handed over his management of Mr McBride to Dr DeSilva. Dr DeSilva had a different recollection of that matter and I will return to it later.

5.9. On 4 April 2015 Dr DeSilva formed the view that it was necessary for a surgical opinion to be obtained in respect of the ulcer because it needed debridement. Dr DeSilva said that he was told by the nursing staff that the ulcer was longstanding and had been managed conservatively thus far. He said that the first time he became aware of the pressure ulcer was 3 April 2015. He said that there was a surgeon on call in Port Pirie by the name of Dr Ali and he informed the nurses to contact that surgeon. He said that he did not regard it as something that was urgent because Mr McBride had been managed conservatively to that point and Dr DeSilva was happy to wait. On 5 April 2015 he inspected the ulcer again. On 6 April 2015 he examined the ulcer again and noted that it was awaiting wound debridement. On 7 April 2015 he did not inspect the ulcer. On 8 April 2015 Dr DeSilva found that Mr McBride's condition had changed. He was confused, he was in pain, was pale and it was Dr DeSilva's impression that he may have sepsis from the sacral wound. He obtained blood for testing and his review of the results confirmed the existence of an infection. He believed that it was sepsis from the sacral wound. He discussed Mr McBride's case with the on call surgeon at Port Augusta and sent him photographs of the wound and that surgeon advised that Mr McBride needed plastic surgical review. As a result of this Dr DeSilva contacted the Royal Adelaide Hospital and arranged for Mr McBride's transfer to that hospital. He was advised by the Plastics Registrar, Dr Mila, to commence Mr McBride on vancomycin and flagyl and he did so.

5.10. In summary Dr DeSilva was not an impressive witness. He had a number of interactions with Mr McBride between 10 February and 8 April 2015. He never bothered to obtain a clear understanding of the patient. His view was that he was merely attending to specific issues as needed and that primary responsibility for Mr McBride fell upon Dr Seemanpillai. I accept Dr Seemanpillai's evidence that he handed over responsibility for Mr McBride to Dr DeSilva around 23 March 2015. I found Dr Seemanpillai to be a frank and reliable witness and prefer his evidence to that of

Dr DeSilva. In any event, Dr DeSilva's lack of action in relation to the pressure wound between 23 March 2015 and 4 April 2015 probably made no difference to the outcome in this case.

5.11. Dr Seemanpillai

Dr Seemanpillai made appropriate concessions and admitted his shortfalls. His evidence was forthright. He made it clear that it was his aim for Mr McBride to get him out of hospital and back at home and his action in taking the catheter out and reducing the dosage of risperidone was directed to that end. Dr Seemanpillai was aware that Mr McBride had, in 2014, been assessed as requiring knee surgery but this had been refused because of an anaesthetic opinion to the effect that Mr McBride was not a suitable candidate for anaesthesia. This influenced Dr Seemanpillai not to refer Mr McBride for surgical opinion in mid-March 2015 when the sacral wound was fully established because it was Dr Seemanpillai's view that an anaesthetic assessment would result in the same outcome as previously. Dr Seemanpillai frankly admitted that this was not a correct approach and that he ought to have consulted fully with Mr McBride's family. I do bear in mind that during this period Dr Seemanpillai was suffering from his own medical conditions that were affecting his ability to function and that was the reason why he decided on 23 March 2015 no longer to attend at Port Pirie Hospital and handover the care of Mr McBride to Dr DeSilva. Dr Seemanpillai was not a young man in 2015 and his illnesses provide an explanation for his errors in this case. He freely acknowledged his errors and I have no hesitation in accepting his evidence in its entirety, including his evidence that he did indeed handover the care of Mr McBride to Dr DeSilva on or about 23 March 2015.

6. Expert Overview – Professor Whitehead

6.1. Professor Whitehead provided a report dated 21 April 2016[61]. Professor Whitehead wrote in his report that although it is an unusual cause of mortality in an older person, he believed Mr McBride did die from the direct consequences of his pressure area. Professor Whitehead said this is almost certainly a preventable death. He summarised his views of what he think happened to Mr McBride during his stay in Port Pirie Hospital. He said that Mr McBride had probably had pre-existing mild cognitive impairment, possible early dementia. He then developed a hospital acquired delirium.

[61] Exhibit C16

Professor Whitehead said he may have already had an incident of delirium before he entered hospital which caused his admission, but either way his confusion seemed to worsen over the first few days. Professor Whitehead said the risk factors for this would have been the insertion of an indwelling catheter which is a recognised risk factor as well as the possibility that Mr McBride had an underlying viral illness which may have caused the pancytopenia which in itself could have precipitated the delirium. He said that unfortunately the quality of the assessment done when he came into Port Pirie Hospital did not enable him to determine from the notes whether Mr McBride was delirious on his arrival in the Port Pirie Hospital. He said though that the reference in the notes to Mr McBride being somnolent by 12 February 2015 suggested to Professor Whitehead that he had indeed developed delirium by that process.

6.2. Professor Whitehead opined that Mr McBride's delirium was perpetuated by a range of factors. Firstly, he had quite high doses of antipsychotics between 13 and 18 February 2015 including the olanzapine at what Professor Whitehead said was a high dose of this drug in a person this age. Professor Whitehead said olanzapine has anticholinergic properties and this would have contributed to Mr McBride's worsening cognition at that stage. Professor Whitehead noted that Mr McBride continued to have relatively high doses of risperidone throughout his admission, again at doses greater than he would normally recommend for a man of this age. Professor Whitehead said that recent randomised control trials in palliative care settings show that antipsychotic medications do not improve delirium symptoms. Professor Whitehead said that Mr McBride became progressively dehydrated over his hospital stay. His urea had risen from 29 to 52 by the time he was discharged and he had a high urea/creatinine ratio. This could well reflect dehydration. It also could possibly reflect significant metabolism of his body tissues related to the large pressure area wound. Professor Whitehead suspected that his oral intake was poor and certainly a very high urea with mildly increased creatinine would suggest that he was dehydrated biochemically. Lastly, his delirium was perpetuated by the increasing septic and inflammatory burden of the pressure care area that he developed during his hospital stay.

6.3. Professor Whitehead said that the other major feature in this case was the rapidly declining mobility. He noted that there was very limited physio involvement and that Mr McBride was largely managed resting in bed during his hospital stay. Professor Whitehead said this process of resting someone in bed leads to rapid loss of muscle

function and rapid loss of mobility. The mobility impairment was further exacerbated by the use of antipsychotics which induce both sedation and Parkinsonism and reduced mobility activity.

6.4. On the question of pressure area care Professor Whitehead said that the mainstay of management is preventing the development of severe pressure areas in the first place. He said that pressure areas need to be prevented and once one sees visible ulceration or skin breakdown it is 'already too late'[62].

6.5. Professor Whitehead remarked that he found it difficult to know whether Mr McBride really needed the indwelling catheter or not. He thought that the catheter was introduced because of palpable bladder but then noted that there was no documentation of a significant volume of urine being released when the catheter was inserted. His view was that the urine output initially, as recorded in the catheter bag, was consistent with low urinary output and not urinary retention. Professor Whitehead expressed an opinion about antibiotics. He said that these have no role in the healing of a pressure ulcer and they are only indicated once septicaemia had set in.

6.6. Professor Whitehead summarised his opinion as follows:

> 'In summary Mr McBride has died of a number of complications of excessive bed rest and poor nursing care. This has been manifested by the acceleration and development of his pressure area. There are a number of failures of good nursing care when related to pressure area management in particular the non-use of preventive strategies but rather a reactive strategy once the ulcer had developed, the excessive use of antipsychotics and the poor mobilisation of the patient. ' [63]

6.7. Professor Whitehead elaborated upon his opinion in his oral evidence. He remarked that the main indication for using an indwelling catheter in a male is inability to pass urine and that if urinary retention was a problem he would expect a big flush of urine of the order of 400ml to 500ml to be discharged upon the introduction of the catheter. He thought that the amounts which were noted in the hours following the introduction of the catheter were indicative of normal urine output, but certainly not acute urinary retention. He said that the use of a catheter to measure urine output would most certainly be inappropriate[64].

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[62] Exhibit C16, page 5
[63] Exhibit C16, page 7
[64] Transcript, page 405

6.8. Professor Whitehead conceded that indwelling catheters are often perceived as a relatively benign intervention but that what is not widely understood is that in an older adult it increases the risk of delirium and it was his belief that the indwelling catheter did contribute to the development of delirium in Mr McBride[65]. He referred to research that the use of an indwelling catheter increases the risk of delirium in and of itself by a factor of two. He noted that this knowledge would not be expected of a general practitioner in a country town[66]. He suggested as a different option for testing the issue of urinary retention the strategy of an '*in/out catheter*' whereby one would introduce the catheter, drain the bladder and then remove the catheter immediately to assess what happened[67]. Professor Whitehead said that no formal diagnosis or recognition of delirium was made in this admission. He said that the change of environment by virtue of hospitalisation, the indwelling catheter and the possibility of a viral illness may all have been precipitating factors for delirium[68].

6.9. Professor Whitehead was asked about the introduction of antibiotics to treat the urinary infection that was noted after some days of catheterisation. He said that as a general rule one does not treat infections that are associated with catheters unless there is good evidence of generalised sepsis. He said that in the case of an infection of a native urinary tract without a catheter systemic sepsis is much more common and it is customary to treat with antibiotics in that situation. Professor Whitehead noted that in the reports which came back from the laboratory in the Flinders Medical Centre there is a standard note to the effect that if this is a catheter associated specimen, do not treat[69]. Professor Whitehead said that he would expect that the average general practitioner would know that catheter associated urinary infections do not need treatment[70].

6.10. Professor Whitehead referred to the introduction by the Australian Safety and Quality Commission of a clinical care standard which will be compulsory at a national level to measure for the screening and recognition of delirium. He said that this standard was not in operation in 2015[71].

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[65] Transcript, page 406
[66] Transcript, page 409
[67] Transcript, pages 408-409
[68] Transcript, page 411
[69] Transcript, page 414
[70] Transcript, page 415
[71] Transcript, pages 416 and 473

6.11. Professor Whitehead noted that the introduction of the indwelling catheter had a further disadvantage in that it compounded Mr McBride's mobility issues by depriving him of further opportunities to mobilise when going to the toilet. He said that the indwelling catheter amounted to bed-centred care. He emphasised that decisions around the catheterisation and lack of mobilisation at the very early stage of Mr McBride's admission affected his outcome and that the things that were done in the very first days of the hospitalisation led to a vicious circle of progressive dependency[72]. He remarked that Mr McBride prior to admission was reasonably mobile, but was at high risk for all complications including delirium, pressure wounds and falls in hospital[73]. He said that rest in bed for an 86 year old man for three days is harmful because at that age muscles are weak. After three days one could be bed-bound permanently. He said that it is important to empower nursing staff to make judgments about whether it is safe for a patient to walk as part of the nursing skill set without the necessity for a physiotherapist to make that judgment, at least initially[74].

6.12. Professor Whitehead noted Dr DeSilva's prescription of olanzapine for Mr McBride's agitation and confusion when he pulled out a cannula. Professor Whitehead remarked that confusion is not an accurate label. He said it is necessary to distinguish between behavioural disturbance in the context of established dementia or an acute delirium that is hospital acquired and may potentially be reversible with a background of mild dementia[75]. He said that in either event whether it be delirium or dementia the routine use of antipsychotics cannot make cognition better[76]. He remarked that the introduction of antipsychotics may be necessary if the patient's behaviour is extreme, for example, hitting the nursing staff. Professor Whitehead said that if it is merely a case of the patient getting in and out of bed frequently causing difficulty for nurses, but not actual harm, the situation is different[77]. He remarked that he would not have started Mr McBride at 0.5mg of risperidone per day as did Dr DeSilva, but rather at half that dose in an older person such as Mr McBride[78].

6.13. In summary, Professor Whitehead thought that the olanzapine and risperidone would have perpetuated Mr McBride's delirium and worsened his immobility. He noted that

[72] Transcript, page 418
[73] Transcript, page 420
[74] Transcript, pages 421-422
[75] Transcript, page 427
[76] Transcript, page 427
[77] Transcript, page 428
[78] Transcript, page 429

the trunk muscles are affected by these drugs which affect the ability of the patient to roll over in bed and to reposition himself.

6.14. Professor Whitehead noted that it would have been more constructive to have treated Mr McBride more effectively for his pain, which in itself is an avenue for dealing with his behavioural issues[79].

6.15. Professor Whitehead said that once the sacral ulcer reached stage 4 it was too late to do anything effective. He said one could only obtain healing with surgical debridement at that stage and then there would be a sizeable hole which would require grafting and intensive side-to-side nursing on a strictly one to two hour basis which is a very big undertaking in a frail and cognitively impaired man[80]. However, he said that the decision about whether Mr McBride required transfer for surgery and the consideration of anaesthesia was one which required family engagement in order to enable the family to make an informed decision after an open disclosure process about what had happened noting that Mr McBride himself was unable to consent to anything at that point. He accepted that the judgment of Dr Seemanpillai that Mr McBride would not be a suitable candidate for anaesthesia was not unreasonable as a medical judgment, but the process of engaging with the family and obtaining proper informed consent should have been undertaken[81].

6.16. On the subject of cause of death Professor Whitehead noted that to get septicaemia and have a septic shower as a result of a sacral ulcer wound is unusual and that he could not find anything recorded in the scientific literature as to incidents of septicaemia from sacral pressure wounds. He said that it is more common to see patients in this condition waste away rather than die from septicaemia. However, he said he thought it was the most likely cause of death and he was prepared to commit to the opinion that by far the most likely cause of the septicaemia was the sacral wound[82].

6.17. Professor Whitehead said that failure to recognise the comorbid delirium, even in the presence of pre-existing mild dementia, was a diagnostic error[83]. He repeated his view that the delirium was hospital induced[84] and said that prevention of delirium is the best

[79] Transcript, page 435
[80] Transcript, page 444
[81] Transcript, page 447
[82] Transcript, page 449
[83] Transcript, page 452
[84] Transcript, page 453

treatment because it is not always reversible[85]. Nevertheless it is potentially reversible and the patient should be managed accordingly.

6.18. Professor Whitehead repeated his view that a person who has significant behavioural issues in the context of pain can be much easier to manage by managing the pain to help to control the behavioural symptoms[86].

6.19. It was put to Professor Whitehead that nursing staff may have been reluctant to force Mr McBride to get out of bed and mobilise against his will given that he did not like to be touched and there were multiple references in the progress notes to this effect[87]. Professor Whitehead said that nursing staff and doctors have a responsibility when dealing with a cognitively impaired adult to respect their choices and to respect their autonomy, but that when they cannot monitor their own safety the clinician has a responsibility as a healthcare professional to actually try and give them the intervention that is in their best interests because they are not in a position to make an informed choice[88].

6.20. It was Professor Whitehead's view that appropriately skilled geriatric nursing would not have been hard to do when Mr McBride first came in when he was mobile, and that was when it needed to happen, but in the later stages of his admission because of the deterioration he would have been a very big nursing challenge[89].

6.21. It was Professor Whitehead's view that with best practice nursing care Mr McBride would not have ended up with the pressure injury[90]. He said that the pressure area was clearly not well managed and that proper management of pressure injuries is something that ought to be able to be achieved in small country hospitals. He said that the primary user of small country hospitals is the older patient and that in many respects these hospitals exist to service such people[91]. He noted that Mr McBride's cooperation was not necessary in order to place him on a pressure relieving mattress and that as elderly people such as Mr McBride are the predominant consumer in the setting of an acute

[85] Transcript, page 454
[86] Transcript, page 455
[87] Exhibit C3
[88] Transcript, page 456
[89] Transcript, page 457
[90] Transcript, page 458
[91] Transcript, page 459

ward in the country, there should be systems in place to care for such people. He made the following forceful remark:

> 'Prevention is standard nursing care that should have been available from the moment he arrived. It is unacceptable in my view in the 21st Century when you look at the consumers of a hospital that you cannot provide those basics of geriatric care because they are the people who are using the hospitals.' [92]

6.22. Professor Whitehead remarked that a person such as Mr McBride can lose 10% of his muscle power per day of bed rest and that bed rest after a fall is absolutely not the right thing for such a person[93]. He noted that there are differences between a person's ability to climb out of bed and then to mobilise once having done so[94].

6.23. In my opinion Professor Whitehead's exposition of the circumstances surrounding Mr McBride's admission are extremely compelling and I have no hesitation in accepting his evidence in its entirety.

7. Conclusion

7.1. It was clear from Professor Whitehead's evidence that pressure area care is a nursing responsibility. There were three other factors which contributed to Mr McBride's pressure wound:

1) The decision to rest him in bed pending physiotherapy review in conformity with what was wrongly thought to be a policy to that effect. There was no such policy. The result was to condemn Mr McBride to muscle weakness that would see him likely bedridden for the rest of his life. This was quite unnecessary and produced the immobility that, together with poor basic pressure area care management, resulted in the sacral ulcer.

2) The decision to insert a urinary catheter. Professor Whitehead could find no proper basis for this decision. Certainly it was not a reflection of the view of the principal medical officer, Dr Seemanpillai, who made an attempt to reverse the situation and would not have catheterised Mr McBride in the first place. The catheter facilitated Mr McBride's immobility as it was no longer necessary for him to get up to empty his bladder.

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[92] Transcript, page 466
[93] Transcript, page 464
[94] Transcript, page 464

3) The introduction of antipsychotics, principally the olanzapine, but also the risperidone. These drugs served to exacerbate Mr McBride's immobility as referred to above.

Those three factors made it crucial that Mr McBride receive the very best possible pressure area care from the nursing staff. Unfortunately the pressure area care was quite inadequate.

7.2. The evidence in this case demonstrated that the demographic exemplified by Mr McBride - the frail and elderly population - are the most common patient in regional hospitals such as Port Pirie Hospital. As Professor Whitehead said, if they cannot manage pressure area care well, it is difficult to see why not. It should be their bread and butter. Clearly much work has been put into the development of policy and procedure in this area - there is no point in recommending further work in that category. Competent execution of the task by nursing staff is all that is required.

7.3. The evidence in this case showed that there were only four active (dynamic) pressure mattresses in Port Pirie Hospital, of which two were in the palliative care suite. Out of a total of 52 beds, that left only two active pressure mattresses for the rest of the hospital. We know that Mr McBride did not get the benefit of such a mattress for weeks, long after he clearly needed one. Presumably the existing active pressure mattresses were already being used by patients in greater need than Mr McBride, difficult as it is to imagine a need greater than his. Clearly there is a need for a substantial increase in the number of active pressure mattresses at Port Pirie Hospital, to reflect the demographics of the Hospital's patient profile, and I intend to so recommend.

7.4. It would be valuable for the general practitioner community to be reminded that indwelling catheters double the risk of delirium and promote bed-centred care and that catheter associated urinary tract infections do not require antibiotic treatment when there is no evidence of a more generalised infection, and I intend to recommend that the SA Health take steps to ensure that reminders to that effect are issued.

8. Recommendations

8.1. Pursuant to section 25(2) of the Coroner's Act 2003 I am empowered to make recommendations that in the opinion of the Court might prevent, or reduce the likelihood of, a recurrence of an event similar to the event that was the subject of the Inquest.

8.2. I recommend that the Port Pirie Hospital substantially increase the number of active pressure mattresses to reflect the demographics of their patient profile.

8.3. I recommend that SA Health promulgate to the general practitioner community a reminder that indwelling catheters double the risk of delirium and promote bed-centred care and that catheter associated urinary tract infections do not require antibiotic treatment when there is no evidence of a more generalised infection. I also draw this recommendation to the attention of the Royal Australian College of General Practitioners and the Australian College of Rural and Remote Medicine.

Key Words: Hospital Treatment; Country Area Medical Services

In witness whereof the said Coroner has hereunto set and subscribed his hand and Seal the 7th day of September, 2018.

State Coroner