MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Leigh Mackey, Coroner, have investigated the death of Maureen June McDonald.

During her life Mrs McDonald liked to be known as Kitty, a nickname given to her by her husband and I will refer to her as Kitty in these findings. Kitty was born on 13 February 1935 and was 87 years of age at the time of her death on 20 February 2022. Kitty was one of four children. She attended Ogilvie High School until leaving at the age of 15 years to work for the Transport Commission where she remained for four years until marrying her husband, William McDonald. They had three children, Wendy, Gregory and Craig, before William died in 1993 from emphysema.

Kitty lived independently in her own home until 2020 with the assistance of her children, her partner, Peter Attrill, and neighbours. Over the years Kitty experienced issues with her health including atrial fibrillation, a left knee replacement in 2016, gout, osteoarthritis, dementia, asthma and chronic obstructive pulmonary disease (COPD).

On 2 July 2017, Kitty suffered a degloving injury to her legs when a friend reversing a motor vehicle accidentally struck and ran over her as she stood near it. As a result Kitty required split skin grafting, was left with ongoing weakness of her legs and became vulnerable to falling.

Kitty underwent an assessment by geriatrician, Dr Jane Tolman, on 30 July 2020 and was considered by Dr Tolman at that time to no longer have the cognitive capacity to make decisions including as to where she should live.

On 2 August 2020, Kitty fell at home suffering a fracture to her left femur. She was treated at Calvary Hospital where the fracture was fixed by the insertion of a steel rod. The injury exacerbated Kitty's decline. She experienced ongoing difficulties with transfers and mobility and had limited strength in her legs causing reduced standing tolerance and poor balance. She required assistance with many aspects of her self-care including meal preparation, shopping, laundry and transport. The fracture of the femur and consequent immobility also caused Kitty to develop a recalcitrant pressure sore to her sacral region and because of her dementia, she had reduced insight into her care needs.

On 28 August 2020, the Guardianship and Administration Board (now the Tasmanian Civil and Administrative Tribunal (TASCAT)) appointed the Public Guardian as limited Guardian of Kitty with the power to:

i. Decide where she is to live whether permanently or temporarily;
ii. Determine which services she should access and provide consent to such as required;
iii. Make healthcare decisions for her; and
iv. Restrict visits to her to such extent as may be necessary in her best interests and to prohibit visits by any person if the Guardian reasonably believes they would have an adverse effect on her.

On 6 October 2020, considering her declining health and dependence on others for her daily care needs, Kitty was admitted to the Fairway Rise Residential Aged Care Facility (RACF). At the time of her admission to the RACF she continued to suffer the sacral pressure sore secondary to the femur fracture and was experiencing weight loss which was considered reflective of the general decline in her condition.

The RACF completed a mobility and transfer assessment of Kitty's needs. It was noted that her mobility was impacted by the fracture of the femur suffered in 2020 as well as bilateral oedema of the ankles. Kitty was assessed as requiring physical assistance and the use of a four wheeled walker (4WW) for sit to stand transfers and, with one person stand by assistance, for mobilisation over short distances. For mobilisation beyond 50 metres or over uneven ground she required the use of a wheelchair. It was noted that Kitty was a significant risk of falls given her preference to self-transfer and mobilise without the 4WW and her lack of insight.

The sacral wound

The sacral wound resulted from Kitty's extended immobilisation which in turn had been caused by the fracture of her femur and its surgical repair. The wound predated her entry to the RACF. The RACF documented it and the necessary protocol to be applied to monitor and treat it from the commencement of Kitty's stay at the facility.

To assess the sacral wound, I have inferred that the RACF utilised the classification system adopted by the National and European Pressure Ulcer Advisory Panels as the references made to the wound in Kitty's notes by the RACF accords with the language used by that system. In accordance with that classification tool at stage one a pressure injury has intact skin, at stage two there is a partial thickness loss of dermis which presents as a shallow open wound without slough or eschar, at stage three there is full thickness tissue loss with possible exposure of

subcutaneous fat, at stage four bone, tendon or muscle is exposed with slough or eschar possibly present and when unstageable the base of the wound is covered by slough or eschar.[1]

At the time Kitty entered the RACF the sacral wound was assessed at stage two. The RACF through the protocols it had in place, specifically wound management plans and wound monitoring charts, was cognisant of the importance of monitoring and treating the wound to avoid infection and deterioration.

Kitty's wound management plan required close monitoring of the wound. The risk of the wound deteriorating emerged in April 2021 when from then until January 2022 the wound fluctuated in its assessments between stages one and two. The wound management plan in this period required the application of moisturiser daily to the area and the repositioning of Kitty two hourly. In January 2022 the RACF's system of monitoring and care of the wound lapsed and the wound became unmonitored and untreated between 19 and 26 January 2022. Over this time the wound deteriorated and on 26 January 2022 was assessed at stage three and at stage four on 27 January 2022. Kitty's wound was reviewed by a general practitioner on 4 February 2022 and given the deterioration and presence of infection she was prescribed and provided with antibiotics.

Based on the notes of the RACF another period of lapse when the wound does not appear to have been monitored or dressings changed occurred between 29 January 2022 and 6 February 2022. There is further no reference in the notes over this period of specific interventions being made to ensure Kitty was not sitting or lying in a way that was placing pressure on the sacral wound beyond her being repositioned twice per day, as per the recommendation of the General Practitioner at his review of Kitty on 4 February 2022 that suitable sitting conditions needed to be arranged for her to take pressure off the sacral area.

When assessing the sacral wound on 26 January 2022 nursing staff at the RACF noted that Kitty was showing signs of confusion and in the period leading up to this time Kitty had lost weight despite nutritional interventions undertaken at the RACF. The confusion and weight loss ought to have been identified by the staff of the RACF as indicators that Kitty's condition was deteriorating, and steps ought to have been taken to investigate the cause of and respond to the deterioration at that time.

On 1 February 2022, staff at the RACF were alerted by Kitty's bed sensor alarm and immediately attended to her at her room where she was found sitting on the edge of her bed

[1] Pressure injury classification system based on National Pressure Ulcer Advisory Panel (NPUAP), European Pressure Ulcer Advisory Panel (EPUAP). Prevention and Treatment of Pressure Ulcers: Clinical Practice Guideline. 2009, Washington DC: NPUAP cited in Australian Wound Management Association. Pan Pacific Clinical Practice Guideline for the Prevention and Management of Pressure Injury. Abridged Version, AWMA; March 2012. Published by Cambridge Publishing, Osborne Park, WA.

with a skin tear on the left-hand upper side of her arm and small multiple bruises. Kitty stated at that time she was looking for biscuits and her bed side tabletop revealed that the plywood surface had lifted and was broken, most likely being the cause of her skin tear. On 6 February 2022, Kitty had an unwitnessed fall in her room. She was found on the floor under the base of a table conscious but confused. Ambulance Tasmania (AT) attended and conveyed Kitty to the Royal Hobart Hospital (RHH). AT assessed Kitty as having a Glasgow Coma Scale ranging from between 5 to 13 during the period she was in their care. She was admitted to the RHH for observation and commenced on intravenous antibiotics for the sacral wound. Radiological investigations revealed no bony injury, and she was transitioned to oral antibiotics and discharged back to the RACF on 8 February 2022.

The RACF identified the failure to have implemented the wound management plan during 19 to 26 January 2022 after an audit was undertaken but made no reference to the later period of lapse from 29 January 2022 to 6 February 2022. As a result of its audit and on the 12 February 2022 the RACF entered an incident report documenting the failure to have undertaken monitoring and treatment of the sacral wound in accordance with the wound management plan over the period 19 to 26 January 2022. Also on that day, by email, the RACF advised Kitty's guardian of the worsening of the sacral wound, the presence of infection and its omission in checking or changing the dressing to the wound over a couple of days contrary to the wound management plan which was likely causative of the deterioration in the wound.[2]

There is, however, no specific explanation as to why or how the observations, input and care as directed by the wound management plan and by the attending general practitioner, did not occur over the two identified periods. There is no assertion that there were any specific demands on the staff of the RACF that gave rise to the omissions.

I have received the assistance of the Coronial Nurse, Ms Newman, who has considered the records of the RACF and identified disparities between the records for Kitty prior to 25 December 2021 and those entries from that time and over the January 2022 period. Whilst the absence of entries in the care records does not necessarily mean a care intervention did not occur, there is a significant reduction in the record of interventions undertaken for Kitty's care when comparing the pre and post 25 December 2021 periods. This may reflect an issue in staffing levels, an escalated demand on staff or a change in staff that resulted in a reduction in the care provided to Kitty at that time. Following her review of the records Ms Newman reached an "*impression*" that processes or procedures had failed in the care of Kitty, subsequent steps taken to provide staff training and education by the RACF were appropriate but there remained no clear reason evident as to why the lapses occurred.[3]

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[2] Email from Jolene Perry to the Public Guardian dated 12 February 2022.
[3] Report Ms Libbie Newman, Coronial Nurse page 14.

The RACF at the time of these events undertook a Root Cause Analysis. That they did so appears clear from references made to that assessment in the RACF's incident report and email to the Public Guardian.[4] However, the RACF has been unable to provide a copy of that analysis. In its stead they have undertaken another Root Cause Analysis. That analysis was undertaken by Ms Tanya Roberts and completed in November 2024. As a result of her review, Ms Roberts identified system causes as contributory to the failures in Kitty's care including:

- Inattention/distraction;
- Inadequate risk assessment/response;
- Literacy/comprehension;
- Improper use of equipment/tools;
- Inadequate training; and
- Inadequate induction.

Specifically, she noted that whilst Kitty received care including regular repositioning there was a "*lack of timely and comprehensive interventions, particularly in managing her chronic conditions and pressure injury. As her condition progressed, the care plan did not adapt appropriately leading to a deterioration in her wound and her overall health".*[5] There remains, however, no explanation as to why these omissions occurred.

The cause of Kitty's death

On the 16 February 2022 a video meeting was held between Dr Fong (Kitty's treating general practitioner), Ms Samantha Wall (Clinical Care Manager of the RACF), Kitty's daughter Wendy, and Kitty's guardian. Kitty's medical condition and her treatment needs were discussed. As a result of that meeting it was agreed that the priority was Kitty's comfort, she would not be returned to the RHH but proceed to palliation at the RACF. This decision was reasonable given Kitty's condition.[6] Kitty died at the RACF on 20 February 2022.

In considering the cause of Kitty's death I have been assisted by the examination undertaken by Staff Specialist-Forensic Pathologist, Dr Andrew Reid. Dr Reid conducted an autopsy examination of Kitty and found the cause of her death to be the terminal exacerbation of her chronic obstructive pulmonary disease and an antecedent cause as the sacral wound.[7] I accept his opinion and find accordingly.

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[4] Incident report completed by Jolene Perry dated 12 February 2022 and email from Jolene Perry to the Public Guardian dated 12 February 2022.
[5] Ms Tanya Roberts Roots Cause Analysis page 7.
[6] I have had the benefit of the opinion of Dr Anthony Bell, medical advisor to the Coronial Division who in a report dated 29 June 2022, concluded, after having considered all the records that "*the decision to palliate was sound*".
[7] Short final report of death to the coroner dated 21 February 2022.

The failure to manage the sacral wound.

Noting the apparent omissions in the RACF's care of Kitty and specifically the management of her sacral wound, a draft of these findings was provided to the RACF for its comment. A response was received by letter dated 31 March 2025. In its response the RACF provided a copy of the Serious Incident Response Scheme (SIRS) tool it completed relevant to the care of Kitty's sacral wound on 20 February 2022. The SIRS identified neglect by the RACF of Kitty's sacral wound.

The RACF failed to comply with the wound management plan it had developed in response to Kitty's sacral wound. It did not recognise Kitty's deteriorating condition or adapt to her evolving care needs. It further failed in a timely manner to execute the recommendation of the general practitioner for measures to be put in place to avoid pressure being placed on the sacral wound.

The RACF's omissions in treating Kitty, at least to the extent of the period 19 to 26 January 2022, have been recognised by the facility. The Root Cause Analysis identified changes that have been undertaken by the RACF to improve its service delivery because of and since the omissions occurring in Kitty's care. Those improvements include:

1. Introduction of targeted education and training programs for registered nurses and extended care assistants through Health Generation Australia focusing on recognising and responding to the needs of deteriorating residents;
2. The skin management policy was updated and reinforced through practical training;
3. Reviewed the wound dressing product range and a new range of Mölnlycke wound care products were introduced across all facilities operated by the RACF with training;
4. Incontinence Acquired Dermatitis and Pressure Injury management education was provided to ensure that staff were equipped to differentiate between the two conditions and apply the appropriate interventions; and
5. Development of new roles with a focus on quality including the Quality Education Coordinator and the Incident Review Coordinator.[8]

I am further now advised by the RACF that following their notification to the Aged Care Quality and Safety Commission the RACF entered a Voluntary Enforceable Undertaking (VEU) in December 2023. Because of the VEU the RACF have strengthened the Incident Management Policy and Process to include ensuring that their electronic risk management system is being

[8] Ms Tanya Roberts Roots Cause Analysis dated pages 6-7.

used as a central repository for documentation ensuring that incident investigation outcomes are securely stored within the system.

As an explanation for the omissions that occurred in their care of Kitty the RACF have identified that there was an identified omission by their nursing staff to create a new wound chart for Kitty. As a result, a "task" was not created in their system and, consequently, no automatic alert was generated by the failure to have recorded an inspection or other management activity concerning the sacral wound from that time.

Ordinarily the RACF operate an electronic documentation system that creates a task each time a wound care chart is completed, and the date of the next review is entered. If the task is not completed by the due date an alert is triggered in the system. This provides an automated reminder system for individual client care however, as observed, it is dependent on the data having been entered into the system for the alert to be generated.

The RACF further notes that at the time there had been some disruption to their senior staffing with the Clinical Care Coordinator having recently returned from maternity leave and relocated to a new facility, and a vacancy in the Facility Manager Role at the RACF. These factors are identified by the RACF in their response to the draft findings as resulting in a reduced level of oversight in the clinical care at the RACF at the relevant time including the failure to undertake additional checking of wound charts outside of the alert system.

I find, pursuant to Section 28(1) of the *Coroners Act* 1995, that

a) The identity of the deceased is Maureen June McDonald (Kitty);

b) Kitty died as a result of terminal exacerbation chronic obstructive pulmonary disease and sacral tissue pressure area injury (treated with antibiotics);

c) Kitty's cause of death was terminal exacerbation chronic obstructive pulmonary disease; and

d) Kitty died on 20 February 2022 at Lindisfarne, Tasmania.

In making the above findings, I have had regard to the evidence gained in the comprehensive investigation into Kitty's death. The evidence includes:

- The Police Report of Death for the Coroner;
- Affidavits confirming identity;
- An opinion of the forensic pathologist;
- Affidavits of Wendy Dickson, Senior Next of Kin;

- Medical records of Kitty;
- Report of Dr Anthony Bell MD FRACP FCICM dated 29 June 2022 including addendum;
- Report of Ms Libbie Newman, Coronial Nurse;
- The response of the RACF to the draft findings by letter dated 31 March 2025
- Root Cause Analysis of Tanya Roberts; and
- Records of Fairway Rise Residential Aged Care Facility (RACF).

Comments and Recommendations

The circumstances of Kitty's death are such as to cause me to make **recommendations** pursuant to Section 28 of the *Coroners Act* 1995. The **recommendations** I make adopt to some extent those identified in the RACF's Root Cause Analysis and are that:

1. All registered nursing staff be regularly assessed for competency including in the areas of:

    a. Wound classification;
    b. Wound management; and
    c. Recognising and responding to a deteriorating resident.

    Any area of skill development identified as lacking be addressed including by the provision of suitable education programs.

2. Residents are assessed for their care needs at the time of their entry into a RACF, at regular intervals during their residency at a RACF and at times of change in their condition noting the planning for a resident's care needs to be dynamic and responsive to changes in a resident's condition. The assessments are to utilise any industry accepted and standardised tools such as the Waterlow tool[9] in the context of pressure wounds.

3. A workflow system be considered and if feasible implemented to provide clarity to staff as to the specific care needs of each of the residents in their care and which requires the attendance to those needs to be recorded and the creation of an alert if the care need is not attended to.

4. Care managers undertake a weekly review of all wound charts of RACF residents to ensure:

[9] The Waterlow Pressure Ulcer Scale is a tool used to assess the risk for the development of pressure injuries by reference to several indicia including weight, mobility, continence, age and skin type.

a. Wound management is appropriate and meeting the needs of the individual;
b. No wound management tasks have been missed or overlooked; and
c. Any education or training needs for nursing staff are identified and actioned.

I thank the RACF for their response to this investigation and acknowledge the steps they have undertaken to prevent omissions in care such as occurred here from occurring again. I convey my sincere condolences to the family and loved ones of Kitty.

Dated: 16 June 2025 at Hobart Coroners Court in the State of Tasmania.

Leigh Mackey
Coroner