MAGISTRATES COURT TASMANIA

MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

(These findings have been de-identified in relation to the name of the deceased and family by the direction of the Coroner pursuant to s 57(1)(c) of the Coroners Act 1995)

I, Leigh Mackey, Coroner, having investigated the death of BE

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

a) The identity of the deceased is BE (date of birth 4 November 1937).

b) BE was born in New Zealand, migrated to Australia and settled in Cammeray, Sydney. He has three daughters; RV resides in Tasmania, DM resides in Victoria and AI resides in Spain. BE held a masters degree in economics, a degree in town planning and enjoyed working as a town planner until he was 82 years of age. His health and independence significantly declined after he suffered a stroke in 2021 and became unable to live independently. In light of the decline in his health he moved to Tasmania to live with RV on her acreage in Channel Region. BE's medical history also included dementia causing cognitive decline, chronic small vessel ischaemia, heart disease, benign prostatic hypertrophy, parkinsonism, deep vein thrombosis, cervical radiculopathy and acute renal failure.

BE lived with and was cared for by RV from 27 May 2021 until his admission to Snug Village Residential Care, a registered residential age care facility (RACF), initially for respite, on 19 September 2022 and then as a permanent resident from 1 October 2022. During the time he resided with RV, she, and a care worker, funded through a Level 4 Care Package, supported him with his daily care needs. BE required full assistance in respect of all activities of daily living including his nutrition, hygiene, toileting, dressing and mobility.[1] RV provided for his emotional and social

[1] Tasmanian Health Service medical records page 101.

needs by ensuring he engaged with friends through skype, had daily time in the fresh air and listened to music and podcasts.

BE moved to the RACF for respite following a decline in his condition. His stay was initially intended to be for a week to provide RV respite but was extended and then became permanent. At the time of his admission RV provided detailed information and strategies to assist the RACF in their care of BE including procedures relevant to his nutrition, toileting and skin care. RV became an advocate for her father and her expectations as to his care whilst he was at the RACF. She regularly raised issues regarding his toileting, showering, fluid and dietary intake, dentures, flies in his room, dressing changes and seating. She took photographs documenting her issues of concern. The advocacy role assumed by RV, informed by her deep understanding of her father's needs having cared for him at her home, caused tension in her relationship with the staff and management of the RACF.

Prior to his admission to the RACF, BE developed a pressure sore near his sacrum. He received medical treatment and the sore improved. RV describes the pressure sore at the time of BE's admission to the RACF as healed. RACF care notes record the registered nurse's assessment of the sacral pressure sore on admission as "*almost resolved*".[2] Whether the pressure sore was or wasn't present on admission is not a factual issue that is necessary to resolve. If it had or had not resolved at the time of BE's admission to the RACF his recent experience of a pressure sore in the sacral region, his age and immobility, were all factors that put him at risk of developing pressure sores or of them worsening, and appropriate protective and treatment strategies to mitigate against pressure sores were required to be put in place and followed in his circumstances.

BE was immobile and effectively non vocal. Shortly prior to his admission to the RACF, he walked with the assistance of a pelican belt and with a slow, unsteady and shuffling gait.[3] The RACF physiotherapist assessed him shortly after his arrival on 23 September 2022 as having no active participation in rolling.[4] He relied on the assistance of others to reposition whilst in bed and when sitting.

[2] RACF Nursing Care notes 19 September 2022.
[3] Home Care Package Care Plan dated 1 June 2022.
[4] RACF Physical mobility scale assessment dated 23 September 2022.

AI travelled from Spain to Tasmania and spent time with her father at the RACF during October 2022 to 10 November 2022. Her observations of Mr BE's care at the RACF at that time were that he was not being supported to drink sufficient water and that dressing changes to his sacral pressure sore were not occurring whilst she was present.[5]

The family organised an occupational assessment of BE's seating needs whilst resident at the RACF. Based on that assessment his family supplied an Aspire Cover Pressure relief chair and Roho cushions for BE's use whilst at the RACF.[6] These measures were intended to mitigate the risk of pressure sores occurring or worsening. RV was present at the RACF most afternoons and became concerned that BE was not being repositioned by the RACF staff whilst sitting in the chair whilst she was present.

Within weeks of his admission to the RACF BE developed a pressure sore, or his preexisting sacral pressure sore worsened. By November 2022 the sore was assessed as unstageable.[7] The sore became infected, and BE developed a fever. He was taken by ambulance to the Royal Hobart Hospital (RHH) on 28 November 2022. At the RHH BE was diagnosed with sepsis, his condition deteriorated, and his care transitioned to palliative. BE died on 7 December 2022.

c) BE's cause of death was systemic sepsis due to infected right perineal ulcer and associated perianal abscess extending to the base of the right lobe of the prostate gland.

d) BE died on 7 December 2022 at Hobart, Tasmania.

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

- The Police Report of Death for the Coroner;
- Affidavit confirming identity;
- Opinion of the forensic pathologist regarding cause of death;
- Report from Kevin Egan, Forensic Nurse, dated 3 March 2023;
- RACF records and responses to Coronial Division queries regarding BE's care and treatment at the RACF;

[5] Statement of AI.
[6] Affidavit of RV page 4.
[7] Royal Hobart Hospital (RHH) Outpatient Consultation Records 23 November 2022.

- Tasmanian Health Service medical records;
- Affidavit of RV sworn 21 February 2023 and material provided by her including USB and annotated documents relevant to BE's care at the RACF;
- Complaint to the Aged Care and Quality Commission dated 4 April 2023;
- Statement of AI;
- Statement of DM; and
- Statement of the RACF in response to Mr Egan's report and draft findings dated 30 March 2026.

The RACF

The RACF aims to provide a high quality of individualised care for its residents. They advise that they adopt a:

> "... *structured, person-centred approach to care planning that ensures residents and their families or representatives are actively involved in the development, implementation, and ongoing review of care plans, including wound management and skin integrity strategies. This process is underpinned by comprehensive assessment, multidisciplinary collaboration, and clear communication pathways*".[8]

To achieve this, multidisciplinary assessment and consultation is undertaken for residents on admission to the facility. Such an assessment was undertaken upon BE's admission.

Care needs of residents are subject to regular review at the RACF and include an engagement with and consent of the resident and their family. The care needs of residents at the RACF are supported by and recorded in an Electronic Care Management System (ECMS). The ECMS prompts and records care interventions for staff at the RACF. It has the capability for providing pre-populated text entries and for free text to be used for "*exception reporting*"[9] enabling reporting of activities, observations or variations by staff that fall outside the norm.

Pressure sores

[8] Statement of the RACF in response to Mr Egan's report and draft findings dated 30 March 2026 p4.
[9] Statement of the RACF in response to Mr Egan's report and draft findings dated 30 March 2026 p6.

Pressure sores are soft tissue injuries which occur due to the application of pressure or friction to the skin. Persons with reduced mobility through age, infirmity, disability or injury are at risk for developing pressure sores. In hospital, aged and disability care settings the evaluation of pressure sores is undertaken by using an evidence based assessment scale. The Waterlow assessment scale is used by the RACF and is a widely accepted assessment tool for the assessment of the susceptibility to and the severity of pressure sores.

Mitigation strategies to prevent pressure sores include the provision of good skincare, hydration/nutrition and the use of aids and tools to provide relief from pressure to the skin including pressure dispersion cushions, mattresses and chairs, frequent resident/patient rotation and skin care. Once a pressure sore has formed it requires ongoing and regular assessment, wound care, investigation for the presence of any infection and implementation of appropriate treatment responses, including the redistribution of pressure through active patient repositioning and the use of special dressings.

A pressure sore can become subject to urinary and faecal contamination depending on where it is sited. As BE's pressure sore was in the sacral region it was vulnerable to contamination. Strategies to treat the pressure sore needed to consider his toileting needs as contamination not only presents a risk of infection but gives rise to increased frequency of dressing changes which disrupt and interfere with wound healing.

The progression of BE's pressure sore

After his admission to the RACF as outlined earlier in these findings, the first reference to BE's sacral pressure sore was in late September 2022. Photographic documentation of the wound appears in the RACF notes on 24 September 2022 and at that time it was assessed as stage 1 on the Waterlow scale.[10] On 28 September 2022. care notes refer to the sacral wound as at stage 1 and requiring ongoing and strict twice daily repositioning. On 13 October 2022 BE was seen by the facility nurse who noted the wound was deteriorating.[11] At medical review on 17 October 2022 bacterial infection of the wound (MRSA) was detected and further wound deterioration identified. The observation was made at this time that BE didn't look to be in pain.[12]

[10] RACF Wound Care notes 24 September 2022.
[11] RACF Nursing Care notes 13 October 2022.
[12] RACF Nursing Care notes 17 October 2022.

BE developed a fever and on the 28 November 2022 was taken by ambulance to emergency department of the Royal Hobart Hospital (RHH). On arrival at the RHH BE was assessed as having a large grade 3 pressure wound with yellow discharge. It was noted that his dressing had fallen off and had been in contact with faeces. The pressure sore was assessed at the RHH as unstageable indicating that there was full thickness tissue loss and the base of the sore could not be seen as it was covered with slough or dead tissue.

RACF's treatment and care of BE

Whilst resident at the RACF BE was regularly reviewed by a General Practitioner, and registered nurse. He was subject of assessments on arrival by the physiotherapist regarding his mobility capacity and needs, a nutritionist and speech pathologist. He was assessed as requiring full care for mobility, hygiene, and personal care needs.

The RACF responded to BE's admission with a stage 1 or newly healed sacral pressure sore by putting in place a regime of regular repositioning, skin care and use of barrier creams as prevention measures. The prevention and management of pressure sores required BE to be regularly repositioned whilst in his chair and in bed. RV asserts that the staff at the RACF appeared disinterested in repositioning BE whilst she was present on most afternoons at the RACF.[13] The records of the RACF reflect that regular repositioning occurred.

BE's pressure sore deteriorated. The RACF did not refer him to a wound care nurse for review until 28 October 2022. The review did not occur until 23 November 2022. Once undertaken, detailed recommendations were made for the management of the sacral sore including by dressing the sore with thick application of Medihoney with absorbent pads be changed every 2-3 days or when compromised by faecal contamination.[14] An analgesic plan was recommended noting that BE was not on analgesia and recognising it was "*unlikely that this wound is not painful*".[15] The use of pressure relieving aids including a dynamic mattress and Roho cushions were recommended to be continued. Faecal management was noted as requiring improvement recognising that wound dressing changes due to faecal contamination were not conducive to wound healing.

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[13] See Affidavit of RV page 4.
[14] Waterlow assessment dated 24 November 2022 in RACF records; see RHH Outpatient Consultation Records 23 November 2022.
[15] Waterlow assessment dated 24 November 2022 in RACF records; see RHH Outpatient Consultation Records 23 November 2022.

To investigate the standard of BE's care at the RACF particularly in the context of his worsening sacral pressure sore, records of the RACF were reviewed by Mr Kevin Egan, THS Forensic Medicine Coronial Nurse. He identified concerns regarding the management of the sacral wound, and incontinence strategy.[16] He considered that whilst the demand for the services of a wound specialist may cause delays in obtaining an assessment the notes reflect a delay in requesting a review and a lack of any urgency in facilitating it to occur.

Over the period 13 October 2022 to 25 November 2022 each daily or second daily wound care note reflects that the sacral sore was deteriorating and had likely progressed to stage 3 in that period.[17] Urinary and faecal contamination resulted in dressing changes several times a day, a circumstance not conducive to healing. Escalation of care to specialist review and the implementation of more aggressive preventative and management strategies were warranted but did not occur. Whilst the RACF's notes are comprehensive and extensive the ECMS is in a pre-filled text format and Mr Egan considered that it may not represent an accurate picture of the care provided to BE.[18]

The RACF considered Mr Egan's report and reviewed the records of their care of BE and identified that whilst care was delivered in accordance with his assessed needs, the ECMS records were not consistently completed on every occasion his care needs were attended to. There were occasions when positional changes were undertaken but not recorded in the ECMS. The RACF accept that there are gaps in the recording of their care of BE.[19] They note that continence management was provided to BE in accordance with his identified needs and care plan. At times and where applicable the RACF sought to accede to the expressed wishes of BE's family and responded to unplanned or increased care needs.[20] They recognised that bowel management was important to prevent wound contamination and reduce the frequency of dressing disruption and to ensure optimal incontinence management plans were prepared in consultation with the treating general practitioner.

The lines of communication between the RACF and RV were strained as referred to earlier in these findings, and this may have detracted from open and constructive communication regarding BE's care and needs. The RACF identified a disjunct

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[16] Report of Kevin Egan dated 3 March 2023.
[17] Report of Kevin Egan dated 3 March 2023.
[18] Report of Kevin Egan dated 3 March 2023.
[19] Statement of the RACF in response to Mr Egan's report and draft findings dated 30 March 2026 p6.
[20] Statement of the RACF in response to Mr Egan's report and draft findings dated 30 March 2026 p7.

between RV's understanding of BE's health and needs and the reality of his frailty and decline which caused a difficult transition from BE's home environment with RV in Channel Region to the RACF for his family. The RACF acknowledge that the difficulty of the transition and tension between the family of BE and the staff at the RACF, whilst staff-maintained professionalism and aimed to communicate appropriately and respectfully, "...*added complexity to the delivery of care"*.[21]

The RACF may not have anticipated the level of care required by BE and were at times impacted by resourcing and staffing issues. In considering this aspect Mr Egan notes staff shortages are a chronic problem at many aged care and health services.[22] The RACF confirm that staff shortages, when they occur, are actively managed to ensure continuity of care for residents.

Comments and Recommendations

On admission to the RACF BE was entirely dependent on his caregivers for his daily needs including his movements and pressure relief both in and out of bed. The extent of his needs may not have been completely understood by his family and their concern regarding his pressure management may have been justified noting their actions to provide an occupational therapist assessment and suitable aids (cushions and chair) and the subsequent development and unarrested deterioration of the sacral pressure sore.

The demands placed on the RACF regarding the care of BE by his family at times were contrary to expert opinion and risked frustrating the capacity of the RACF to manage BE's needs, including his rotation, wound management and incontinency management optimally.

The RACF provided thorough assessments of BE and his care needs on arrival into the facility which was regularly reviewed and supported by oversight from a General Practitioner during his stay there. Management of the sacral wound was complicated by recurrent faecal soiling of dressings despite incontinence management undertaken by the RACF. However delay accessing specialist wound management assessment ought to have been anticipated and the referral of BE for review requested earlier than it was given the wound's deterioration. The provision of pain relief also ought to have been given earlier noting the nature of his wound.

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[21] Statement of the RACF in response to Mr Egan's report and draft findings dated 30 March 2026 p7.
[22] Report of Kevin Egan dated 3 March 2023.

I make the following **recommendations** pursuant to Section 28 of the *Coroners Act* 1995:

1. All staff be provided education and assessed for competency in

    a. Wound classification;

    b. Wound management;

    c. Recognising and responding to a deteriorating wound; and

    d. Timing of specialist intervention.

2. Policy and processes directed toward the prevention of pressure sores in residents be developed and instituted including

    a. Repositioning;

    b. Use of pressure relief aids; and

    c. Use of barrier cream/skin care creams.

3. Training concerning appropriate documentation for routine interventions be developed.

4. Training regarding the provision of pain relief medication to include the importance of considering the nature of the injury in the assessment of need for pain relief.

5. The development of education and expectations regarding communication with the family of residents, the impact it may have on care and mechanisms and pathways for escalation and resolution of family concerns.

I convey my sincere condolences to the family and loved ones of BE.

Dated: 19 May 2026 at Hobart, in the State of Tasmania.

Leigh Mackey
Coroner