QUEENSLAND COURTS

# CORONERS COURT OF QUEENSLAND

# FINDINGS OF INVESTIGATION

| | |
|---|---|
| CITATION: | **Non-inquest findings into the death of Mr M** |
| TITLE OF COURT: | Coroners Court |
| JURISDICTION: | BRISBANE |
| DATE: | 9 June 2026 |
| FILE NO(s): | 2024/242 |
| FINDINGS OF: | Melinda Zerner, Coroner |
| CATCHWORDS: | CORONERS: Pressure Injuries; Pressure Care Management; Terminal Wounds; Palliative Care; Residential Aged Care Facility. |

# Table of Contents

## Introduction

1. Mr M was born on 20 December 1941, and died on 11 January 2024, at the Redland Hospital, Queensland. He was 82 years old.

2. A doctor from the Redland Hospital reported Mr M's death to the Coroner because his death was identified as a potential healthcare related death within the definition of a reportable death in the *Coroners Act 2003*. The concerns were that he had developed sepsis secondary to chronic pressure injuries on his lumbar/sacral spine.

3. Mr M's wife has expressed concerns about the adequacy of the care provided to Mr M following a 'change of ownership of the rest home'. Specifically, that:

    - Mr M was not being 'moved' and was left to sit for hours; and

    - Mrs M had not been notified of the sacrum pressure wound until a week prior to Mr M hospitalisation (when the wound was being dressed).

4. The role of a Coroner is to investigate reportable deaths to establish, if possible, the cause of death and how the person died. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability. An investigation is about attempting to find the root cause of the incident that precipitated the death and in appropriate circumstances to analyse systemic failures that contributed to the death and to design remedial responses.

5. In making my findings, they are based on proof of relevant facts on the balance of probabilities. I am not able to make adverse findings against, or comments about individuals, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

## Circumstances of the Death

6. Mr M was married to Mrs M. They had three children together.

7. Mr M had been a resident at the residential aged care facility (RACF) since 6 March 2023, initially for respite care. He transitioned to permanent care on 27 March 2023. He was under the care of a General Practitioner (GP) at the RACF.

8. Mr M had several medical comorbidities including:

    - Parkinson's Disease with Dementia;
    - Aortic incompetence (pacemaker implanted in 2015);
    - Arthritis (knees) and Osteoarthritis;
    - Gastroesophageal Reflux Disease;
    - Haemochromatosis;
    - Hypertension; and
    - Peripheral neuropathy.

9. During the evening of 3 January 2024, Mr M was transferred from the RACF to the Redland Hospital. This had been recommended by a GP. The reason for the transfer was recorded as:

    > *Drowsy ++ , Necrotic, malodourous wound on sacrum with yellow greenish exudate, Unable to give oral abs and medication for pain.*

10. Mr M was non-verbal and showed limited responsiveness. His sacral wound was measuring 15cm x 7cm and it was categorised as unstageable. It was necrotic and had an offensive smell. The impression was '*sepsis secondary to severe sacral sore and possible concurrent aspiration*…'.

11. Mr M's family was advised that he had a significant infection in the sacral wound and because of that, he had deteriorated quickly. When told Mr M would require surgery, the family advised they did not wish for any life prolonging treatments. Comfort cares were sought, and palliation commenced.

12. At approximately 6am on 11 January 2024, Mrs M notified staff that Mr M was no longer breathing. At 7:40am he was declared deceased.

## Medical Records

13. According to the records from the RACF, Mr M required assistance with transfers and required some assistance with nutrition. He seemed to be capable of intelligible responses to questions but was prone to confusion. He was incontinent of urine and faeces. It is noted Mr M had suffered several falls in late 2023.

14. Mr M had an Advanced Health Directive in place which stated that he was not for antibiotics or fluids if he had a significant health condition from which he was unlikely to recover.

### *Pressure injuries*

Risk assessment

15. The RACF had assessed Mr M as being at risk 'of developing excoriated/reddened areas' due to pressure. His risk assessment paperwork recorded a requirement that staff '*reposition appropriately to reduce the risk of pressure-related injuries, as per the Allied Health mobility assessment*.'

16. The records provided are essentially silent as to the strategies put in place by the RACF to mitigate this risk prior to mid to late December 2023 (including repositioning schedules and pressure relieving tools).

Left heel wound

17. On 26 October 2023, a registered nurse (RN) completed an incident report after identifying a 'blister' on Mr M's left heel (the heel wound). A RN who was asked to review the heel wound, described it as 'a large darkened blistered area'.

18. The heel wound was photographed, measured (50mm in width x 50mm in length), chartered, dressed, and listed for review the following day. Mrs M was notified, as was the care manager/facility manager.

19. The heel wound was reviewed and dressed on 27, 29, 30, and 31 October 2023. As of 30 October, it was observed to have turned red in colour with a moderate haemoserous (red/yellow) exudate. That same date, the dressing was found to have become dislodged, and the blister had burst.

20. On 1 November 2023, the heel wound was charted as being pink in colour with low serous (yellow) exudate. When the GP reviewed the heel wound later that day, he noted that it had ruptured but was clean. He instructed the nurses to continue regular dressings and to use a heel cushion.

21. On 5 November 2023, the heel wound was measured as being 90mm x 90mm and at repair stage 2. Dressing checks were occurring daily, with dressing changes occurring every four days.

22. The GP reviewed the heel wound again on 8 November 2023. He observed it to be clean and dry, and recommended regular dressings and a GP review in two weeks.

23. On 13 November 2023, a RN charted the wound as being black in colour and at repair stage 1. Dressing change frequency was altered from four days to three days, with dressing checks were to continue daily. The wound had not changed in size.

24. When the GP reviewed the wound on 15 November 2023, he assessed it as healing well, with no signs of infection. He also observed that Mr M had been walking comfortably. A review was scheduled for two weeks' time.

25. On 21 November 2023, a RN recorded the following observations of the heel wound:

    - At 10:03pm: *Wound dressing attended. wound had offensive smell. exudate on dressing was brownish in colour. moderate exudate. wound bed with mixed tissues - black eschar and, yellow slough and some granulating tissue. surrounding edges macerated. wound swab taken. wound dressing plan changed. prn Paracetamol given for pain on the wound. Resident afebrile.*

    - At 10:31pm: *Resident unable to mobilise this shift due to the wound on his leg - reports it was sore. Prn paracetmol given at 2030hrs while attending to the wound . prn paracetamol 500mgx 2 tabs with good effect. wound swab x1 booked for collection - booking number 134618.*

26. A silicone foam dressing (secondary) was applied, and a dressing change was scheduled for the following day.

27. The GP reviewed the heel wound the next day (22 November). He recorded the following notes:

    > *LEFT HEEL BACK PRESSURE INJURY IS CLEAN AND MOIST BUT IT IS TURNING BLACKISH.* ***PLEASE REFER HIM TO A WOUND INNOVATION CLINIC*** *FOR FURTHER MANAGEMENT OF THIS PRESSURE INJURY. Actions: Imaging request printed to Qld Xray: Doppler studies - LEGS, Bilateral, Doppler studies - Peripheral Arteries, Bilateral. (LEFT HEEL CHRONIC NON-HEALING PRESSURE INJURY) REVIEW AFTER RESULT. 2. RESPIRATORY VIRUSES PCR: NAD*

28. On 24 November 2023, a RN observed (in the wound chart) that the heel wound's purulent green/brown exudate observed on that day 'may indicate infection'.

29. On 26 November 2023, a foam dressing (secondary) was applied, and the frequency of dressing changes altered to every three days (with daily reviews to continue). The wound chart noted that the wound (said to be at repair stage 4) was yellow and deteriorating, and it had a serous (yellow) exudate.

30. The GP reviewed Mr M three days later, on 29 November 2023, but made no specific notes regarding the heel wound.

31. The next wound chart entry was on 1 December 2024. The heel wound was black, though with nil odour or exudate. It was said to be at repair stage 4, with dressing changes to occur every five days.

32. On 6 December 2023, Mr M was reviewed by the GP who recorded:

> *PRESSURE INJURY OVER THE BACK OF LEFT HEEL IS CLEAN, DRY BUT IT IS GETTING BLACKISH IN SEVERAL SPOTS. HE STILL TENDS TO WALK BY HIMSELF. STAFF HAS BEEN USING HIS HEELCUSHIONS. HE IS WAITING TO HAVE ARTERIAL DOPPLER FOR THE LEGS. REVIEW IN 2 WEEKS.* [it appears no doppler studies were completed]

33. As of 10 December 2023, the heel wound was still black in colour and considered to be deteriorating. However, the size of the wound had decreased to 40mm x 30mm, but with a depth of 0.5mm. Vaseline[1] was applied as a primary dressing, with silicone foam as the secondary dressing. Dressing changes were to occur every three days.

34. Between 10 December and 20 December 2023, the heel wound remained black in colour and measured 40mm x 35mm. There was nil odour, and, on occasions when exudate was present, it was said to be red/yellow. Dressing changes fluctuated between every two to three days, but the wound was checked daily. The repair stage was assessed as being stage 2.

35. Relevantly, I note the entry from the podiatrist on 13 December 2023:

> *Rt[2] presents for general podiatry care. GNC Consent obtained. Rt does not report any pain to B heels. does not recall last dressing change. (Checked wound chart 10/12/23 due to be reviewed and dressed today 13/12/23). Foam dressing present B heels. R heel dressing coming undone, saturated with clear exudate, strong odour present when removing shoes. Exudate saturated on heels of shoes. Elongated nails BF, OX OM nails. Nil redness or maceration within interdigital spaces. Skin anhidrotic. Pre and post foot prep with chlorhexidine. Trim and file all nails, Reduce required nail thickness. Checked wound chart. Vaseline has been used on the 10/12/23 on macerated wet wound? Reconsider dressing options to allow wound site to dry (e.g liquid iodine) Review 6/52 Sterilisation:12/12/23 #3665*

36. I cannot see any evidence within the wound chart of the podiatrist's dressing suggestions having been adopted.

37. On 20 December 2023, the GP reviewed Mr M. He considered the 'ulcers' (presumably the heel wound and the sacral wound) to be healing slowly and noted that 'No Wound Innovation'[3] was taking care of them. This is the GP's last note about the heel wound.

38. By 26 December 2023, the heel wound had changed to red in colour. It remained so up until the last entry in the wound chart on 2 January 2024. By that stage, the exudate had changed from yellow (serous) to red/yellow (haemoserous), and the dressings had been increased to daily.

[1] The RACF disputes Vaseline used but that it would have been Paraffin (which looks similar to Vaseline)
[2] I understand this to mean Resident.
[3] The GP says 'No' should be 'NOW' but there is no evidence Wound Innovations were involved.

Sacral wound

39. The sacral pressure injury (sacral wound) was first documented on 13 December 2023. There was no incident report for this.

40. The sacral wound measured 5mm (depth) x 15mm (width) x 40mm (length). It was black with haemoseous (red/yellow) exudate. The wound was 'secured with a silicone foam border' and a dressing change was scheduled for the next day. [I have reviewed a photograph of the wound when it was first identified]

41. The status of the wound suggests it was at least a Stage 3 injury (perhaps worse). Therefore, the injury must have developed much earlier than 13 December 2023, but it had gone unnoticed by staff caring for Mr M.

42. By 16 December 2023, the sacral wound had turned pink, and its exudate was clear. The frequency of dressing changes was altered to three days (from daily).

43. Between 17 and 19 December 2023, the wound changed from yellow to red, and transitioned from a yellow exudate to a clear one. It also went from having an offensive smell to no smell at all.

44. On 20 December 2023, the GP reviewed Mr M's sacral wound for the first time. He considered the 'ulcers' (presumably the heel and sacral wounds) to be healing slowly and noted that 'No[4] Wound Innovation' was taking care of them.

45. Between 23 and 25 December 2023, the wound's colour changed from red to pink and the exudate remained clear. Notably though, on 25 December 2023, the RN observed an offensive smell and recorded the following note:

> *The wound look deteriorated, elder is sit-ting in chair most of time, need to be pressure area cared- moved every 2hrly and dressing changed daily.*

46. Then, on 26 December 2023, a RN documented that the 'buttock area and left heel pressure areas' looked infected. Further, that they did not seem to be healing. An email was purportedly sent to the GP seeking a review the following day. A note was also left in the 'GP folder'. [the GP did not review the email or receive the note]

47. The following day, another RN sent the GP an email expressing concerns that the wounds were necrotic and not healing. The GP did review Mr M that day, however his notes do not mention either wound.

48. On 29 December 2023, a RN noted that the sacral wound was deteriorated, and it required a GP review. The RN contacted Mrs Mr and scheduled the GP appointment.

49. On 30 December 2023, a RN contacted CAREPACT[5] out of concern that Mr M's sacral wound was worsening 'day by day'. A photograph of the wound was emailed to CAREPACT and Mrs M consented to having Mr M assessed the following day. I note that by this stage, the length of the wound had increased from 40mm to 100mm.

[4] The GP says 'No' should be 'NOW' but there is no evidence Wound Innovations were involved.
[5] Comprehensive aged residents emergency partners in assessment care and treatment.

50. A CAREPACT nurse reviewed Mr M, as arranged, on 31 December 2023. The progress notes record the following:

> *Reviewed by care pact team today for his all wounds. Wife Beverly was in attendance. WOUND ONHIS FOOT - Carepact team advised for long bed, since he has a short bed, his both legs always pressing the bottom part of the bed, MOISTUE LESION- Form dressing done by carepact team, Asper them, continue doing positioning q2nd hrly, can only be sit in the chair for 2 hrs with pressure relieving cushion, if no pressure reliving cushion, stay in bed and continue positioning him for 2hrs,WOUND SPECILIST TO BE SEEN. Carepact team will send a discharge letter. CC, CM and FM were informed.*

51. A note recorded approximately two hours later indicated that although Mr M had been referred to a wound specialist, any review could not happen until January 2024.

52. On 1 January 2024, the sacral wound was black, with a purulent (green/brown) exudate. It was now measuring 900mm in length (meaning if the measurement is not erroneous that it had grown by 800mm in two days). Next to this entry (in the wound chart) was a note that the exudate 'may indicate infection'. Further, that Mr M was 'awaiting wound specialist review'.

53. Over the next 24 hours, the sacral wound had developed an offensive smell. Again, the chart contained a note about possible infection. The first progress note for this date, stated:

> *Mr M has already been referred to wound innovations for assistance with wound management however nil confirmed date of visit yet. His sacral and heel wounds were previously seen by carepact. On shift RN will follow up with care pact today for further instructions until wound innovation team is able to provide any input. Mr M is on 2nd hrly reposition.*

54. Four hours later, a different RN made the following entries:

> *Contacted care pact team today regarding Mr M's wounds. They said continue all the recommendations from the last visit, ie, clean wound with microdacyn wound care solution and continue to do dressing same as previous. Change position 2nd hrly. They will send discharge summary today. Continue dressing until wound specialist review. Informed to cc.*
>
> *As per care pact protostan solution is same as microdacyn wound care solution, so they happy to use microdacyn solution instead of protostan.*

55. During repositioning that night, Mr M was 'grimacing and rigid', and he reported being in pain. A GP review was requested for the following day, however due to Mr M's complaints of pain, an after-hours GP saw Mr M at 1:10am on 3 January 2024.

56. The after-hours GP prescribed antibiotics and Endone, and a wound swab was taken. Instructions were given to 'nurse resident side to side 2/24 to reduce further wound breakdown of sacral area and feet'.

57. Later that day, at around 12:30pm, the regular GP reviewed Mr M. He recorded this note:

> *HE HAS JUST DEVELOPED EXTENSIVE PRESSURE INJURY OVER THE SACRUM AND COCCYX. THERE ISA BIG BLACK NECROTIC AREA IN THE CENTRE WITH ULCERS EXTENDING IN ALL DIRECTIONS WITHGREENISH EXUDATE. HE SHOULD NOT SIT IN THE SOFA. HE SHOULD LIE IN BED ON HIS SIDE.FUCIDIN OINTMENT DRESSING DAILY FOR ALL THESE ULCERS. REVIEW AFTER SWAB RESULT. Actions: Request printed to Qml Pathology: Swab M/C/S; ULCER OVER SCARAL AREA. YOU MAY PLEASE CONTACT WOUND INNOVATION FOR FURTHER MANAGEMENT OF THESE ULCERS.*

58. Approximately two hours later, the Care Coordinator recorded the following note:

> *RGP has reviewed PI on sacrum region. Swab collected and booked. Fucidin charted by RGP to apply all over affected areas. NOK to be notified, handed over to PM shift for same. GP will review results of swab next week. Mr M remains on keflex 1 g BD as charted by AHGP. Imprest stock taken and given this morning. Pharmacy will supply rest this evening. Mr M to be repositioned strictly every 2 hrs.*

59. A subsequent note made by the Care Manager, recorded that the GP did not intend to review the wounds until 'next week'.

60. During the evening of 3 January 2024, Mr M was transferred to the Redland Hospital.

**ACQSC Information**

61. I posed a series of question to the Aged Care Quality and Safety Commission generally regarding the management of pressure injuries. On 22 July 2024, I was advised,

    a. Approved providers must comply with various legislative responsibilities, including those provided for in the *Aged Care Act 1997* and the various Principles made under the Aged Care Act. They must also comply with the Aged Care Quality Standards.

    b. The aged care legislation does not define 'good clinical governance', Quality Standard 3 requires an approved provider to demonstrate that each aged care recipient receives safe and effective personal care, clinical care, or both personal care and clinical care that is best practice. This includes wound management.

    c. Where wound management is provided, the standard of wound care should be maintained by a clinical governance framework. This should be achieved through the provision of effective leadership behaviours, policies, procedures, responsibilities, relationships, planning, monitoring and improvement mechanisms to support effective would management.

    d. The ACQSC does not have a guideline like the Australian Commission on Safety and Quality in Health for preventing pressure injuries and wound management. It was said to be reviewing its internal policy documents and it not aware of any such guidelines.

62. I note on the ACQSC website as of 12 May 2026, inadequate wound management is one of the most common clinical complaints received by the ACQSC and it states,

> *Failure to implement effective and timely wound care, can lead to poor health outcomes for residents in aged care,* ***in particular preventable wound infections*** *that may then require antimicrobial treatment or hospitalisation* (emphasis added).

63. On the website as of 12 May 2026, the ACQSC outlines several wound management mistakes. They include,

    a. Failure to adequately document the wound assessment process e.g. missing essential information such as wound dimensions, wound bed appearance, amount and type of discharge and signs of infection.

    b. Infrequent wound assessments, including not re-assessing the wound when it deteriorates.

    c. Failure to update treatment plans, including documenting reasons for treatment changes.

    d. Failure to document the goals of treatment e.g. whether the goal is to heal, or to manage the wound if it is assessed as unlikely to heal.

    e. Inadequate pain management e.g. not using an appropriate pain assessment tool, not scheduling dressing changes/treatments around the administration of pain medication and not documenting pain management strategies.

    f. Poor quality photographs which fail to show the condition of the wound.

    g. Not escalating a deteriorating in the wound to the resident's GP in a timely manner.

64. The ACQSC concludes this section by stating,

> *To ensure good wound management, providers and their staff must start with an initial comprehensive assessment of the resident's wound. This assessment should be documented and guided by contemporary wound management guidelines. It should consider all factors that affect wound healing, including the resident's age, health status (e.g. poor circulation, diabetes etc.) and nutritional status.* [the link is to the Wounds Australia website].

65. The ACQSC website as of 12 May 2026 also has a section titled 'Prevention and Treatment of Pressure Ulcers/Injuries: Clinical Practice Guideline and states,

> *This resource provides evidence-based recommendations and best practice statements for the prevention and treatment of pressure ulcers and injuries, including quality indicators and implementation guidance. It serves as a comprehensive clinical guideline to support health professionals in reducing pressure-related injuries. This resource may apply to healthcare contexts outside of aged care. Please consider the applicability of this resource to your care setting.*

*This resource was developed internationally and therefore its applicability and usefulness may be limited.*

***Author***
*External resource*
***External Link***
*https://internationalguideline.com/*
*…*

*This is not a Commission publication. Any views are those of the author. You are responsible for considering this in context and based on your circumstances and the Aged Care Act 2024 (Cth) requirements.*

**Forensic Physician Opinion**

66. I obtained a preliminary opinion from a Forensic Physician, Dr Shaw concerning the care Mr M was provided.

As to the falls Mr M had experienced, Dr Shaw felt they were understandable, 'given the description of Mr M being able to freely mobilise while being impulsive from cognitive impairment'.

67. Dr Shaw considered that despite being capable of ambulating and moving his arms and legs (albeit with restrictions), Mr M was 'incredibly vulnerable' to pressure injuries having regard to his dementia,[6] peripheral neuropathy,[7] and restricted mobility.[8]

68. These conditions, however, may have meant that Mr M was not maintaining repositioning away from his pressure injuries – thereby presenting challenges for the staff.

69. In relation to RACF's care, Dr Shaw opined as follows:

- There was evidence of escalation of concern by the RACF to [the GP]. On one occasion this resulted in the recommendation for a referral to a private wound care service. However, it '*is unclear if the failure for this review to occur was due to a delay in referral or a delay in the ability of the service to review. Regardless,* ***the interim deterioration of the patient required further escalation***.'

- The RACF did further escalate their concerns back to [the GP] in late December for the sacral injury, though he did not document any meaningful response to their concerns. The RACF subsequently enlisted the CAREPACT service, but '*Surprisingly* ***the CAREPACT nurse having reviewed the pressure injury, discharged the patient back to the RACF'***.

- While it is not possible (on a review of the records) to say that the RACF staff adhered to all care recommendations, the records do not indicate there was a failure to adhere to such recommendations. Despite repeated attempts by staff to escalate clinical concerns, it was not until there was a deterioration in Mr M's consciousness that he was ultimately referred for hospital admission.

[6] Which can impair compliance with pressure care and may also reflect a state of poor self-care and potentially inadequate nutrition intake.
[7] Which would impair sensation that otherwise protects from injuries.
[8] Which typically results in increased loading of parts of the body when sitting or lying.

- **There was no obvious missed opportunity to provide life prolonging care**. However, Mr M could have received palliation in his RACF.

70. As for the GP, Dr Shaw's view was that although '**GP decision making' did not reflect a missed opportunity**, Mr M's case presented an opportunity for the GP to 'reflect on the circumstances and identify some opportunities for improved clinical practice in future circumstances.'

71. Dr Shaw was subsequently provided with Mr M's wound and vital observations chart, but these did not change his opinion. In his view, the 'very mild' weight reduction during Mr M's final months may have reflected a decrease in nutrient intake but was otherwise insignificant.

72. Dr Shaw completed the Coronial Certificate as to the cause of Mr M's death. He opined Mr M died from 'sepsis; due to pressure injury – sacrum, heel; due to Parkinson's disease, dementia'.

**Response from the GP**

73. I sought clarification from the GP who had been regularly seeing Mr M. He has advised,

    a. Any pressure injury which does not seem to improve in six weeks despite aggressive management would usually require escalation. In this case the RACF referred Mr M to Wound Innovations at his request on 22 November 2023 [the RACF has admitted this did not occur].

    b. Before any such referral he assesses the vascular status of a patient's lower limb and requests an arterial doppler to assist the wound service manage pressure injuries. This did not occur prior to Mr M's passing.

    c. For referrals to Wound Innovations, it is routine practice for the nursing home to refer itself. He does not generally arrange the referral. He says once that occurs, he does not manage the wounds. Staff though keep him updated on the progress of wound healing.

    d. He recommends transfer to hospital in circumstances where there has been no improvement or there had been a worsening of the ulcers despite active interventions.

    e. He was not notified of any concern regarding Mr M's sacral wound in late December 2023. He tells nursing homes not to email him for any medical issues as he does not have the time to check the 20-30 emails, he receives daily from the different nursing homes he services. He was not aware of Mr M's sacral wound; he would otherwise have assessed it. Nurses can always contact him via phone, the afterhours GP or the CAREPACT team.

    f. When he is consulting at the nursing home, he is there for six to eight hours. During this time a nurse could have notified him about Mr M's pressure injuries.

**Response from CAREPACT**

74. The speciality Emergency Physician who is the Clinical Lead of CAREPACT has advised,

    a. CAREPACT is an Emergency Department Equivalent Care service for Metro South Health. It provides Aged Care Residents an alternative to transport to hospital for Emergency Medicine care.

    b. A resident can be referred to CAREPACT to determine the best location of care. The decision is made by a Physician or Geriatrician. The service operates seven days per week from 7.30am to 4pm. Paramedics attending on residents in a RACF can contact the service 24 hours per day.

    c. At the conclusion of an episode of care, the patient is referred to the continuity of care provider in the same way that an episode of care in the Emergency Department would be concluded. This handover of care is completed verbally and in writing. Copies of the discharge summary is provided to the RACF and the GP. All documentation for the episode of care is submitted to the iEMR. Discharge back to a GP is consistent with best practice after Emergency Medicine care.

    d. The referral for Mr M was received on 30 December 2023 and triaged. He was seen by the Mobile Team on 31 December 2023 at approximately 11am. A thorough clinical assessment was undertaken, and a photograph taken over the sacral pressure injury which was shared by secure communication with the medical consultant. I note that the photograph shows a significant sacral injury with necrosis and black tissue in the base of the wound. An assessment of the heel pressure injury was included and there was no concern of changes related to it. As to the sacral wound, the physician states,

        *The assessment…concluded that while there was deterioration of the sacral wound, and the surrounding pressure areas had increased, there was no signs of infection. The goals of care for Mr M were confirmed with the EPOA over the phone. This phone call included confirmation that the goals of care was most consistent with this patients' preferences*.

        *The governance for wound management was confirmed with RACF staff to be with a private wound provider 'Wound Innovations'. It was noted that there was some small scope to improve pressure offloading when sitting with a 'rojo' cushion, and a longer bed for offloading the heels. Dressings were optimal (mepitel occlusive and adherent dressing) but addition of prontosan cleaning fluid was recommended*.

        *The patient was not transferred to hospital on this day as it was determined after the assessment that all cares being provided in the RACF were the same (or better) than that would be provided in hospital. At the time of review there was no indication for advanced imaging or treatments that required hospital-based care. This decision was confirmed to align to the goals of care.*

75. As to Mr M's deterioration and the progression of his sacral wound, the ED physician states,

> *I note that this patient had a long progression in worsening frailty and a recent infection with COVID. In our experience this causes a significant global deterioration, often related to myalgia, lethargy, and deconditioning. Mobility reduces dramatically while unwell and pressure offloading due to immobility is particularly fraught where an existing pressure injury occurs.* ***When this is combined with reduced caloric intake and severe cognitive impairment, we often see that these wounds are a marker of a global decline or 'pre-terminal'. This has led us since this time to call these wounds 'terminal wounds' as this has been an improved method of communicating the likely trajectory when identified.*** (emphasis added)

**Response from the RACF**

76. The RACF undertook an investigation concerning the circumstances regarding Mr M's death. I have been advised that:

    a. Mr M was assessed as being at high risk of developing pressure injuries. As a result, various interventions, including daily skin inspections, movement and repositioning were implemented. A repositioning chart was commenced on 27 December 2023 and a pressure-relieving mattress put in place on 16 December 2023.

    b. While the GP had recommended referral to Wound Innovations on 22 November 2023, this action was not completed by the Service. It extends its sincere apologies to Mr M's family for this oversight. The RACF has advised,

        > *Clinical notes indicate that it was believed that a referral was made to Wound Innovations around the end of December 2023. Evidence of this referral could not be located but clinical notes have indicated that a secondary referral was escalated to CarePact on 30 December 2023 due to the unavailability of the primary wound care specialist over the holiday period.*

    c. The RACF acknowledges that as part of the review it has been identified that Mr M's sacral pressure injury would meet the criteria for reporting to the Aged Care Quality Safety Commission (ACQSC) under the Serious Incident Response Scheme (SIRS) due to the later identification of the wound. The RACF acknowledges that this wound should have been reported pursuant to the SIRS. They acknowledge that this was not identified at the time of discovery.

    d. Until late November 2023, Mr M retained a degree of independent mobility, which was increasingly impacted by his Parkinson's Disease. From 11 December 2023, he required a full sling hoist lift for transfers. A repositioning chart was implemented on 27 December 2023 to ensure systematic adherence to repositioning schedules.

    e. As is documented in the clinical records, Mrs M was notified of the sacral wound on 13 December 2023. She was aware of the referral to CAREPACT on 30 December 2023, and as I understand, was consulted about the plan for Mr M.

f. The RACF acknowledges the wound was first incorrectly identified as a 'moisture lesion' and as such an incident form was not completed in line with the Incident Management Policy. All pressure injuries are required to be reported as incidents to ensure these are reported on accurately and escalated where required.

g. The RACF has proactively undertaken a significant amount of education and training during 2024 related to wound care and management. It has also implemented a Continuous Improvement Plan to address identified areas for enhancement and to ensure best practices are consistently followed. Some key initiatives include:

    1. Improved Documentation and Photo Quality;

    2. Enhanced Wound Care Practices;

    3. Dressing Trolley Hygiene and Preparation;

    4. Staff Education and Ongoing Monitoring;

    5. Restructure of the clinical governance team.

77. In conclusion the RACF states,

> *It is deeply committed to ongoing best practice in wound care management and ensuring the highest standards of care for our residents. To further strengthen our capabilities in this critical area, we are actively recruiting for a Nurse Practitioner with a specialisation in wound care. This role will provide advanced clinical expertise, support staff education, and contribute to continuous improvement of wound management practices across our service. This initiative underscores our dedication to delivering excellence in resident care and addressing opportunities for enhanced clinical support.*

**Independent Expert Opinion from Aged Care Specialist**

78. I had approached a Geriatrician to provide an expert opinion on the care Mr M had received. Unfortunately, after over nine months I had to ask for the return of the Brief of Evidence and seek the opinion of another expert. This unfortunately delayed my investigation considerably.

79. Eventually, I was able to brief another expert, Dr Bill Lukin. Dr Lukin is an Emergency Physician and a Palliative Care Physician. He is one of the Medical Leads for the Residential Aged Care District Assessment (RADAR) Service at the Royal Brisbane and Women's Hospital (RBWH). RADAR provides outreach services to Residential Aged Care Homes. He is also the Medical Lead for the Specialist Palliative Care in Aged Care Service Community and Oral health. He spends a significant portion of his clinical contact physically in aged care homes.

80. I asked to Lukin to review two other similar cases, in addition to Mr M's.

81. Concerning Mr M, Dr Lukin opined:

    a. Mr M was an extremely frail man at the end of a long journey with Parkinsons disease and dementia. He was at extremely high risk of developing a pressure injury.

b. Mr M developed the pressure injuries as part of the dying process rather than the pressure injuries causing him to die.

c. The care provided by the RACF to Mr M was appropriate and to standard and the pressure injury was likely inevitable and always untreatable. It is unlikely that a more timely review by a wound specialist would have altered Mr M's trajectory or healed the wound.

d. The factors which supported Mr M had entered the dying process were that:

    i. On 18 October 2023, the GP clinical record noted that Mr M was experiencing frequent falls (noting also he was having low blood pressure and that he was not on any antihypertensive medications). New falling is a high-risk indicator a resident is entering the dying phase.

    ii. On 28 October 2023, Mr M started to develop pressure injuries.

    iii. On Mr M's presentation to the Emergency Department, he had an Albumin of 21 g/L which is a high predictor of a dying phase in this setting.

e. The timing of Mr M's death was related to his Parkinsons disease/dementia not the skin breakdown.

f. While Mr M may have had infection or colonization in his pressure wound, there is no evidence it was the cause of his death or indeed that it hastened his death. He states,

> *From the photos taken at the time of his presentation to hospital I am not sure there was any infection. While I cannot categorically state he did or did not have infection I think on the balance he probably did not have infection contributing to his death.*
>
> *On presentation he had a reduced GCS in the presence of a normal blood pressure. I think this is evidence that his reduced conscious state at the hospital was caused by acute neurological deterioration rather than sepsis or septic shock. Septic shock can cause a reduced conscious state but usually does this by causing circulatory failure. From his vital observations recorded in the emergency department he did not have circulatory failure. In addition, his biochemistry on presentation was not consistent with septic shock. His bicarbonate level was normal, and this should have been low if he had presented in septic shock.*
>
> *The description of his dying is in keeping with dying from end stage parkinsonism. In addition, it is not uncommon for very frail patients to die 10 to 20 days after a COVID infection. In my experience multimorbid patients like Mr M will survive the first week of an acute viral infection like COVID only to die in the fashion he did in the weeks after.*
>
> *I do not agree with the statement in the Form 30A that the Parkinsons disease and dementia were unrelated to the underlying cause given in Part 1 (Sepsis-Pressure Injury).*
>
> *I would argue that the cause of death was Parkinsons Disease with associated dementia. Whether the mode of dying was sepsis/Skin failure or neurological*

*failure leading to multi-organ failure is not able to be established with certainty. What is certain in my mind is that this man died because he had Parkinsons disease with associated dementia. A severe relentlessly progressive neurological disorder that has no cure and is a well-recognised cause of death. In addition, the clinical features of his dying are very familiar to me after looking after many people dying from this disease.*

g. Mr M's wishes expressed in his Advance Health Directive that was completed on 8 May 2020 were not followed. The document had become active in that Mr M was in the terminal phase of a 'terminal, incurable or irreversible illness or condition'. If the document held force, which Dr Lukin believed it did, Mr M's wishes expressed in the document were not honoured. The transfer to the hospital would be against Mr M's wishes as expressed in his Advanced Health Directive. He sates,

*I think there was a significant missed opportunity for Mr M to die in his facility comfortably if his dying had been recognised and acted upon by a clinician empowered to diagnose dying and engage the family and facility in planning this process and providing appropriate symptoms relief.*

h. The family's distress was likely intensified by discussions at the hospital about the quality of care provided at the RACF. That is, the impression by the hospital staff that the pressure injury was the result of poor care or some omission at the RACF. He states,

*Often family distress is intensified by beliefs that care at the nursing facility has been substandard despite evidence to the contrary. This distress is often intensified by comments made by the hospital staff about the standard of care at the Nursing Facility without evidence that the care was indeed substandard. This seems to be driven by a misconception by the hospital staff that if a pressure injury has occurred then there must have been substandard care. In my experience this is often not the case.*

82. I asked Dr Lukin what the role of the Residential Aged Care District Assessment and Referral (RADAR) team (or similar such service) is in the management of pressure injuries, taking into account circumstances when other multiple parties may be involved in a resident's care. He responded by advising,

*I can only speak for the RADAR service in which I work, and our model is to support the General Practitioner with Specialist Advice where required. I believe any service in reaching into Aged Care should only do so with the permission of the GP and have a robust mechanism for communicating with the general practitioner the outcome of any visit.*
*The makeup and skillset of the different RASS services in Queensland varies from service to service. They comprise a mix of Adult Emergency Physicians and Geriatricians. To my knowledge I am the only Palliative Care Physician working in a residential Aged Care outreach service.*

*Many of the Hospital and Health Services also have funded Specialist Palliative Care in Aged Care (SPACE) services but the models and staffing vary greatly from service to service. They do not operate in the after hours. These services are well equipped with the skillsets to manage end of life in the three patients presented but the dying needs to be recognised, and the patients need to be referred to such a service.*

*If the GP is uncontactable or refuses to provide end of life care RADAR/RASS or a Specialist Community Palliative Care Service can provide the care by working with the facility staff.*

83. I asked Dr Lukin in what circumstances where there is little to no likelihood a pressure injury will heal, and how that is to be appropriately managed in the residential aged care setting. He responded by stating,

> *In this setting the patient needs to be seen by a clinician who can differentiate if this is a wound as a result of a dying process or a healable wound. On the recognition that the wound is unlikely to heal the family needs to be engaged by a clinician skilled in conducting end of life conversations. When this happens goals of care and end of life planning can occur. It is often in these discussions that the provision of End-of-Life medication is discussed and consent for this being provided by the family. This clinician needs to be able to prescribe these medications at this point as they are often needed suddenly and without warning. This clinician needs to be the General Practitioner, Nurse Practitioner or a Palliative Care Clinician who is familiar with prescribing in end of life in Aged Care.*

84. I asked Dr Lukin what the appropriate standards/clinical guidelines are to be used in the aged care setting, and whether he considered more guidance is required. While saying he would defer this question to an experienced aged care provider, he stated,

> *There is no reference that I can find in the Australian published standards to Skin failure as part of a terminal phase. In the flow chart published by the Australian Commission on Safety and Quality in Healthcare there is no mention that a pressure injury may be the sign of a terminal decline or indeed what action to take when this is recognised. It is difficult to place the blame on the Residential Aged Care industry for not recognizing this clinical scenario when it remains unrecognized by the Australian Commission on Safety and Quality in Healthcare.*

85. Dr Lukin did note that pressure injury management is well recognised in palliative care and nursing literature.

86. In conclusion, Dr Lukin, made some observations regarding these types of cases. He stated,

> *All three of these cases strike a very familiar chord with me as I have been involved in very many similar deaths.*
>
> *I believe all three cases reveal a systematic problem in recognizing and responding to the dying frail and cognitively impaired adult. A significant missed opportunity was the chance for these three men and their families to have some agency in the manner and place of death. While there is no suggestion they were subjected to unnecessary suffering in the hospital or palliative care unit, it is my experience that these families suffer greatly with the uncertainty of the process when dying has started but remains undiscussed. In addition, all three of the men and their families were subjected to the distress and uncertainty of being transferred at such a late stage of dying where it is very likely with the appropriate clinical oversight they could all have died comfortably in their facilities with their families and the clinical staff who know them. I think it likely the families suffering was intensified by discussions at the hospital about substandard care.*
> *I believe the care at the facilities in all three cases was to standard.*
>
> *I do not believe an earlier or more attentive attention by a wound specialist would have altered the outcome. I cannot in my experience remember a pressure injury*

*that was obviously caused by poor care. While there is no doubt poor care can lead to pressure injuries in my experience the industry is so frightened of this outcome that I see extremely diligent care most of the time. Of the pressure injuries I personally see the majority are wounds in dying people that are not going to heal. The remainder are usually in people who are not dying acutely but are refusing to comply with the direction of the nursing staff.*

*These patients are usually competent and able to accept the consequences of their actions. I am usually called to help reinforce the risks to these patients and provide some surety to the facility staff that if the patient died as a result of their pressure injury there will be documentation to the effect that the patient was informed of the risks and was competent to understand and accept the risks.*

*I believe the General Practitioner should be the primary coordinating resource for the patient, the facility and the family.*

*In my experience in facilities where there is well engaged general practice there is very little requirement for in reach of specialist services.*

*My experience leads me to believe that the funding structure for general practitioners falls far short of providing remuneration for the care required. Most general practitioners are capable of the clinical skills required for End-of-Life care in aged care but in my opinion, there is not adequate recompense for the time required. Acute end of life care requires daily input by a senior clinician capable of adjusting drug doses including adjusting continuous infusion doses seven days a week. The general practitioners who are willing to be on call twenty-four hours a day seven days a week are few in number. As a result, there is a great unmet need in the end-of-life space in residential aged care.*

*Another major barrier to end of life care by General Practitioners is reluctance to prescribe opioids. In June of 2018 the federal government sent a letter to the top 20% of opioid prescribers in Australia. This letter discussed the opioid prescribing habit of the GP compared to their peers. A proportion of these general practitioners were providers of care into Aged Care. General Practitioners who provide care into residential aged care do tend to be in the higher opioid prescribing group because of the high rate of End-of-Life care in aged care. An unintended consequence of this letter was a dramatic decrease in the numbers of general practitioners who were willing to prescribe the opioids required for End-of-Life care. This has had a major detrimental effect on the provision of End-of-Life care in Aged Care and in Community Palliative Care. This may have contributed to the decision made by the after-hours GP to prescribe oral antibiotics rather than the opioids required by Mr M on the night before he was sent to hospital.*

*RACGP - Government to warn almost 5000 GPs over high rates of opioid prescribing*

*In this article by the RACP it was predicted that this may happen by the Royal Australasian College of General Practice, and it has indeed come to pass. This has made this difficult time for residents and their families even harder to navigate.*

**Response from the GP**

87. As to what occurred with Mr M, the GP says,

*In my experience, many patients at an RACF experience rapid deterioration due to acute infective process which are usually treatable. Most of these patients will stabilise after proper antibiotic treatment. As most of these patients stop eating and drinking due to these conditions, they are referred to hospital for intravenous treatment following which they often return to the RACF, generally in a stable state. This was the expected pathway for Mr M.*

88. Mr M's GP was asked to respond to Dr Lukin's report. He says he was not aware of the Advanced Healthcare Directive (AHD) and states,

    *The usual practice for being informed about the existence of an AHD is to be informed verbally by the RACF at the time of a deterioration of a patient's condition. Had I been aware the Mr M had an AHD in place, it would not have altered my management of the wound and I still would have consulted the family as to whether they would like Mr M transferred to hospital. This is because, at that stage, I did not have the clinical expertise to determine whether Mr M's condition was a 'terminal, incurable or irreversible illness or condition' and referral to hospital would have enabled specialist assessment.*

89. The GP noted palliative care had not been raised for Mr M, because prior to his rapid deterioration he had generally been stable and comfortable, eating and drinking reasonably well. As he only became aware of the sacral pressure injury on 3 January 2024, he had insufficient clinical information to know whether the pressure injury was likely to heal. He says if any pressure injury does not heal within six weeks, advice is typically sought from the wound clinic, CARE-PACT team, or Wound Innovations. The healable or non-healable nature of wounds is not determined without specialist input from one of these sources.

90. As to Dr Lukin's comments about Mr M's falls, he states,

    *It is not possible for a GP to determine that any particular fall necessarily represents a beginning of the dying process. Only specialists can make this determination. Following falls, many patients are managed conservatively with many stabilizing.*

    *Before deciding about whether a patient should be treated palliatively, I try to rule out all treatable or curable conditions before providing a definitive reason for commencing palliative care by managing the patient in accordance with clinical standards in the first instance.*

    *If, for example, a patient was having frequent falls, I would refer the patient to he CARE-PACT team or a geriatrician for management.*

    *Following geriatrician, CARE-PACT team and/or hospital advice, I discuss palliative care with the family if the condition is proven to be untreatable or incurable, as this involves significant responsibilities and is an irreversible process. Therefore, such a decision is not made independently.*

## Conclusion

91. After considering the material obtained during the coronial investigation, I consider I have sufficient information to make the necessary findings required by s 45(2) *Coroners Act 2003* in relation to Mr M's death.

92. Pressure injuries are caused by prolonged pressure combined with shear and/or friction forces on the skin and underlying tissues, restricting blood flow. Most pressure injuries are preventable. In a frail and elderly person, once a pressure injury develops it can rapidly deteriorate leading to a catastrophic outcome. This is because of the difficulty in healing a pressure injury in a compromised patient once a pressure injury had developed.

93. There are nursing interventions to actively manage the risk of a pressure injury developing. These include risk assessments; the use of a pressure relieving mattresses; active change of position of a patient; and monitoring of nutrition.

94. Pressure injuries have four stages, from least severe to the most severe:

    a. Stage 1: Redness, warmth, or discoloration of the skin that does not fade after pressure is relieved.

    b. Stage 2: Partial loss of skin that may appear as an open sore, blister, or abrasion.

    c. Stage 3: Full loss of skin that may appear as a crater.

    d. Stage 4: Full loss of skin tissue that may affect muscles, tendons, bones, or joints.[9]

95. Based on the evidence of Dr Lukin, it appears that the issue in these types of cases is for clinicians to be able to make an informed clinical decision as to whether the pressure injury is retrievable/treatable or that active treatment will be futile. The ED physician from CAREPACT has advised when mobility is reduced dramatically while the resident is unwell, pressure offloading due to immobility is particularly fraught where there is an existing pressure injury. He states,

> *When this is combined with reduced caloric intake and severe cognitive impairment, we often see that these wounds are a marker of a global decline or 'pre-terminal'.* ***This has led us since this time to call these wounds 'terminal wounds' as this has been an improved method of communicating the likely trajectory when identified.*** (emphasis added)

96. Notwithstanding Dr Lukin's opinion, I am of the view there were some deficits in the care Mr M was provided. When Mr M's sacral wound was identified it was already at least a Stage 3 wound. The photograph of the sacral wound at the time is troubling. When it was discovered, it was significant, and it was too late to attempt to heal the wound given his frailty and deteriorating condition. This indicated to me there was likely a lapse in the monitoring of Mr M's skin integrity over the relevant period.

97. While Mr M was still mobile until late November 2023, by 11 December 2023 he was requiring a full sling hoist lift transfer. He was not placed on a pressure relieving mattress until 16 December 2023 and a repositing chart was not commenced until 27 December 2023. A nurse noted on 25 December 2023, that Mr M was sitting in the chair most of the time. Second hourly documented repositioning with some sort of pressure relieving cushion could have been implemented from at least 13 December 2023 when the sacral pressure injury was first identified, even if this was only a comfort measure.

---

https://www.hopkinsmedicine.org/health/conditions-and-diseases/pressure-injuries#:~:text=Stages%20of%20pressure%20injuries,of%20the%20blood%20called%20sepsis.

98. There was also a failure to escalate the review of Mr M's sacral wound when first identified on 13 December 2023. The GP reviewed the heel wound on 20 December 2023 and was under the impression a referral had been made to Wound Innovations. It had not. While emails were sent to the GP on 26 and 27 December 2023, he did not review those, having previously advised the RACF if they required clinical advice on a patient, he was to be contacted by phone. I also note, 26 December 2023 was a public holiday. Appropriately, CAREPACT was involved on 30 December 2023.

99. I accept it was appropriate for Mr M to remain at the RACF on 31 December 2023 as there were no signs of infection, and the cares he required at that time could be provided at the RACF. I also accept the first time the GP was made aware of the sacral wound was on 3 January 2024. Adopting the CAREPACT ED physician's terminology, by this time the pressure injury would be classified as a 'terminal wound'. This is seemingly a relatively new term in the aged care space. I find that care and comfort were really all that could be provided to Mr M by the time he developed this wound.

100. On balance, I accept Dr Lukin's opinion as to the cause of Mr M's death, over that of the Forensic Physician. That is, that Mr M died from multiorgan failure due to neurological failure due to Parkinsons disease associated with dementia.

101. I acknowledge the difficult situation the GP was in. Mr M had suddenly deteriorated, and he was not sure of the cause of the deterioration and whether it was reversible (it was initially thought it could have been a UTI or a progression of his Parkinson's disease). As Mr M's family were not contactable, the GP and the RACF proceeded to err on the side of caution and arranged his transfer to hospital. Despite Dr Lukin's opinion, I consider this was reasonable in the circumstances.

102. I am not satisfied that it is in the public interest to hold an Inquest (formal court hearing), but I am of the view, it would be helpful to publish these findings (de-identified) to the Coroners Court of Queensland website so that others can reflect on and learn from them.

103. As to the comments made by Dr Lukin, I have provided a copy of my findings in these three cases and I have written to the Royal Australian College of General Practitioners, the Aged Care Quality and Safety Commission (ACQSC), and the Australian Commission on Safety and Quality in Health Care, encouraging these agencies to consider the development of a clinical pathway/guideline for the management of pressure injuries in residential aged care facilities which importantly differentiates between a retrievable/treatable wound as distinct from a wound that becomes irretrievable or 'terminal', and the care of the resident in each scenario. This could include appropriate communication with families and quality palliative care for residents with wounds which are established as no longer treatable. That is, the wound has become irretrievable or 'terminal'.

104. I have also provided a copy of these findings to Clinical Excellence Queensland and to the Office of the Health Ombudsman. It is possible there can be some collaboration between the public health sector, in particular the aged care services with the Aged Care Quality and Safety Commission to improve the management of residents with irretrievable pressure injuries, with the objective being that an aged care resident can die with comfort, dignity, and respect at the facility they have resided in.

105. I have also provided a copy of these findings to Wound Australia and the National Pressure Injury Advisory Panel (an international organisation).

106. I have annexed a copy of the letter which has been sent to the various organisations to these findings.

107. I extend my condolences to Mr M's family and friends for their loss and acknowledge this has been a protracted process.

**Findings required by s.45**

| | |
|---|---|
| **Identity of the deceased** – | Mr M |
| **How he died** – | 1(a) Multiorgan failure<br><br>ANTECEDENT<br><br>1(b) due to neurological failure<br>1(c) due to Parkinson's disease with associated dementia |
| **Place of death** – | Redland Hospital REDLAND BAY QLD 4165 AUSTRALIA |
| **Date of death**– | 11/01/2024 |

I close the investigations.

Melinda Zerner
Coroner
CORONERS COURT OF QUEENSLAND - BRISBANE OFFICE
9 June 2026

QUEENSLAND COURTS

8 June 2026

Dear The Proper Officer,

I have recently completed my investigation into the deaths of Mr H, Mr M and Mr B. The deceased were all residents of aged care facilities (**RACF**) who had developed significant pressure injuries leading up to their deaths.

After considering the expert opinion of Dr Bill Lukin, I determined not to hold an inquest into these deaths. However, I am writing to you to bring to your attention the issues I have identified in relation to processes relevant to your agency in the conduct of my investigation.

Dr Lukin is an Emergency and Palliative Care Physician, and one of the Medical Leads for the Residential Aged Care District and Assessment (RADAR) Service, as well as the Clinical Director of the Metro North Community Palliative Care Service and the Medical Lead for the Specialist Palliative Care in Aged Care Service Community and Oral Health.

In providing his expert opinion to the Court in relation to these deaths, Dr Lukin has illustrated what I consider to be service delivery gaps in the recognition of skin failure as part of a terminal decline in cognitive and neurological diseases (in particular, dementia and Alzheimer's disease).

Dr Lukin has articulated the academic position in this field of medicine that skin breakdown, pressure injuries and associated sepsis and/or clinical decline is (at times) an inevitable part of the dying process in persons with end stage dementia or Alzheimer's disease. This process, as demonstrated in these cases, is not always related to inappropriate care, and should not necessarily initiate a highly clinical process where a person is subjected to unnecessary interventional medical treatment in hospital for a process which is inevitable and untreatable.

Dr Lukin's opinion was that these deaths:

> *…reveal a systematic problem in recognizing and responding to the dying frail and cognitively impaired adult. A significant missed opportunity was the chance for these three men and their families to have some agency in the manner and place of death. While there is no suggestion they were subjected to unnecessary suffering in the hospital or palliative care unit, it is my experience that these families suffer greatly with the uncertainty of the process when dying has started but remains undiscussed. In addition, all three of the men and their families were subjected to the distress and uncertainty of being transferred at such a late stage of dying where it is very likely with the appropriate clinical oversight they could all have died comfortably in their facilities with their families and the clinical staff who know them. I think it likely the families suffering was intensified by discussions at the hospital about substandard care.*

In circumstances where a person has a valid advanced health directive, it is likely that their wishes are not being honoured by being transferred to hospital for treatment when their skin failure (pressure injury) represents the terminal phase of a "terminal, incurable or irreversible illness or condition" including dementia or Alzheimer's.

Treatment in hospital may then, as has been demonstrated in these cases, lead to a traumatic and distressing experience by the resident and their family, and possibly

misconceived opinions about whether care leading to the pressure injury has been substandard.

It is apparent to me that with appropriate support and education provided to the RACF providers, including the development of a clinical pathway/guideline, an opportunity exists for residents with end-stage dementia to experience a comfortable and dignified death at their RACF, avoiding distress to them and their families, but also avoiding the need for a hospital transfer (and subsequent death in hospital).

Notably, it has been emphasised that while the general practitioner should be the primary coordinating resource for the patient receiving end of life care in a RACF, there are not adequate resources or recompense to facilitate this. Dr Lukin noted that:

> *Acute end of life care requires daily input by a senior clinician capable of adjusting drug doses including adjusting continuous infusion doses seven days a week. The general practitioners who are willing to be on call twenty-four hours a day seven days a week are few in number. As a result, there is a great unmet need in the end-of-life space in residential aged care.*

In my view, investment in this approach and resourcing would not only meet this need for services but also reduce pressure on the public hospital system which is providing end-of-life care to aged care residents, in circumstances where it seems that is not necessary.

The issue of under prescribing of opioids by GPs in end-of-life care, as a consequence of messaging by the Commonwealth Department of Health in 2018,[10] was also brought to my attention in this investigation. It is of concern that this messaging may have the unintended, but detrimental effect on the provision of end-of-life care in Aged Care and in Community Palliative Care in relation to a GPs reluctance to prescribe opioids in this setting, when it is otherwise appropriate to do so. This anecdotal evidence is of concern to me in the broader context of constraints on GPs providing sound care to residents in the aged-care setting, as has been detailed above.

I hope that you will take these matters under consideration as to what can be done to address these gaps in service delivery with the intention of improving the end-of-life care residents deserve in these circumstances.

Please find **enclosed** a copy of my findings and comments.

Please be advised I have also sent this correspondence to the Australian Commission on Safety and Quality in Health Care, the Aged Care Quality and Safety Commission, Royal Australian College of General Practitioners, Clinical Excellence QLD, the Commonwealth Department of Health and Wounds Australia and the National Pressure Injury Advisory Panel.

I would be grateful if you could advise me of any action taken in relation to these matters.

Yours sincerely,

Melinda Zerner
Coroner

[10] RACGP - Government to warn almost 5000 GPs over high rates of opioid prescribing

Melinda Zerner, Coroner
[redacted]
Email: coronerbrisbane4@justice.qld.gov.au

15 June 2026

## LETTER DATED 8 JUNE 2026

Dear Melinda,

Thank you for the letter outlining the investigation.

Wounds Australia is a Not-for-Profit charity and the nation's peak body for wounds prevention, treatment, management and healing. We represent the clinicians, professionals, patients and partners working together to end the silent epidemic of chronic wounds in Australia.

Wounds Australia uses evidence-based education, advocacy and collaboration to empower clinicians and consumers to achieve better outcomes. Around the world, Wounds Australia unites international wound care organisations in an approach that puts Australia, its researchers, care professionals and consumers at the heart of global innovation. Through strategic partnerships with government, industry and community stakeholders we are building a future where chronic wounds are no longer a barrier to quality of life.

Wounds Australia is engaged in the research and development of evidence-based Guidelines, Best Practice and Consensus in open access documentation. The Wound Practice and Research Journal is an open access internationally recognised publication that is issued 4 times a year. WPR Journal link Wounds Australia.

The standards and Guidelines is "open access" with significant and relevant documents: Wounds Australia. This section includes:

**International Pressure Injury Guidelines:**

Wounds Australia is part of a collaboration of 34 Nations in the Pressure Injury International Guideline. The 4th edition is available on our website as an open access document with the 5th Edition due in 2026. The Guideline update was launched internationally in Sydney Australia on March 1, 2025, By Professor Zena Moore, Chair of the European Pressure Ulcer Advisory Pannel and Professor Keryln Carville, Chair of the Pan Pacific Pressure Injury Alliance Committee.

**Australian Standard for Wound Prevention and Management 4th Edition.**

The fourth edition provides an evidence-based framework for best practice in wound prevention and management, guiding clinical practice, policies and education.

Level 44, 600 Bourke St
Melbourne VIC 3000
1800 870 855
admin@woundsaustralia.org
ABN 69 104 482 963

**Pressure Injury Recurrence Toolkit**

An online, user-friendly, evidence-based toolkit for healthcare professionals, and for patients and carers, providing best practice for preventing recurrent pressure injuries in people with spinal cord injuries.

The project was developed in collaboration with the European Wound Management Association, EWMA, and launched in Australia in April 2026.

**Palliative Wound Care**

This document responds to the WHO's call for clinician resources in palliative care, reviewing wound-related symptoms and providing up-to-date practice recommendations.

Its objective is to provide a synthesis of current evidence on management of core symptoms in palliative wounds, supporting health care professionals in selecting the best strategies for management of palliative wounds, and to enhance patient outcomes, research and education in this field

**Managing Wounds as a Team**

Healing chronic wounds requires a multidisciplinary approach, which can be complex for both patients and healthcare professionals. This position document, developed with EWMA and AAWC-USA, presents a patient-centred model to guide team-based wound care.

Wounds Australia is supportive of investigating funded research with National and International peak bodies, institutions and qualified individuals.

I seek your approval to share the information provided with the Wounds Australia representative to the Pan Pacific Pressure Injury Alliance Committee to assist in their ongoing research and leadership in this field.

Yours sincerely,

Jeff Antcliff

Chief Executive Officer, Wounds Australia

[redacted]

Level 44, 600 Bourke Street, Melbourne VIC 3000