CORONERS COURT OF QUEENSLAND

FINDINGS OF INVESTIGATION

CITATION:	**Non-inquest findings into the death of Mr B**
TITLE OF COURT:	Coroners Court
JURISDICTION:	SOUTH EAST QUEENSLAND
DATE:	9 June 2026
FILE NO(s):	2025/4332
FINDINGS OF:	Melinda Zerner, Coroner
CATCHWORDS:	CORONERS: Pressure Injuries; Pressure Care Management; Terminal Wounds; Palliative Care; Residential Aged Care Facility.

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Introduction

1. Mr B was born on 22 June 1939 and died on 6 September 2025, at the Toowoomba Base Hospital, South Toowoomba, Qld, 4350. He was 86 years old.

2. A doctor from the Toowoomba Base Hospital reported Mr B'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*. That is, concerns were raised about the sacral pressure injury Mr B had which was alleged to have caused his death. Mr B's son is a Registered Nurse and has questioned the quality of care his father was provided by the Residential Aged Care Facility (RACF), where his father was residing.

3. 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.

4. 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

5. Mr B lived in a RACF. He was doubly incontinent and wore incontinence pads. He was bed/chair bound and required physical assistance in all aspects of his cares and transfers. He required regular repositioning every two hours.

6. Mr B's medical history included:

    a. Alzheimer's dementia with severe cognitive impairment
    b. Benign prostatic hyperplasia (BPH)
    c. Congestive cardiac failure (CCF)
    d. Double incontinence
    e. Falls. Currently not mobile, full hoist transfer
    f. Hyperlipidaemia
    g. Hypertension
    h. Osteoarthritis
    i. Parkinson's disease
    j. Severely frail.

7. On 7 February 2025, Mr B was assessed by a Dietician. He was noted to be malnourished and that he had been losing weight. It was thought this was due to his suboptimal oral intake. He was seen again on 22 August 2025 because of ongoing weight loss (6.2kg over three months). He remained malnourished despite attempts by staff to encourage nourishing food intake.

8. On 10 August 2025, there was a reference for the first time to a left buttock pressure injury made by the nursing staff. There is a photograph. The wound at this time is described as, 'PI [pressure injury] Stage 1'. It was cleaned and painted with betadine. The wound was dressed with Inadine and foam lite, and staff were to continue to monitor the wound. A wound management plan was also commenced.

9. On 13 August 2025, Mr B's General Practitioner made a clinical note, 'Stable but has pressure sores over anal region'. This is the extent of the GP's entry.

10. On 14 August 2025, staff found Mr B also had a Stage 1 pressure injury on his left heel. A wound management chart was commenced.

11. On 17 August 2025, staff found a Stage 1 pressure injury on Mr B's right heel. The contributing factor was noted to be a 'change in condition/clinical deterioration'.

12. At or around this time, Mr B had little oral intake, and was refusing his medications. Mr B was on a repositioning chart and had been placed on an air mattress.

13. There then was a dramatic deterioration in Mr B's sacral wound over a two week period. By 1 September 2025, it was a Stage 4 wound, and the photograph showed a significant crater on Mr B's left buttock area close to his sacrum. It was described as looking infected, sloughy and that it had a very strong odour. Mr B's GP was consulted, and a wound swab was ordered. Staff were to continue dressing the wound. It appears this is the first time Mr B's son had been informed about the sacral pressure injury and the interventions which were in place to try and manage it.

14. On 3 September 2025, the staff noted Mr B was drowsy, and 'not fully conscious'. His observations recorded a blood pressure of 85/61; Heart rate 116; Oxygen saturations 90% on room air; temperature of 37.1; and a respiratory rate of 28. He was coughing when he was offered fluids and noted to be gurgling and pale. Mr B's son was contacted, and he requested Mr B be transferred to hospital for further investigation.

15. On 4 September 2025, Mr B presented to the Toowoomba Base Hospital (the Hospital) with signs and symptoms of septic shock. He had had an episode of aspiration in the morning at the RACF. On assessment, Mr B was hypotensive (low blood pressure), but responded to the administration of intravenous fluids.

16. Mr B had low oxygen saturations of 90% on 4 litres of oxygen, was tachycardic (high pulse rate) with a blood pressure of 86/46. He was not responsive to voice.

17. On examination, staff observed a large pressure injury on Mr B's sacrum with green discharge. The depth of the pressure injury was unclear. He also had bilateral pressure injuries to both of his heels. A clinical diagnosis of septic shock was made due to the suspected severe pressure injury on Mr B's sacrum.

18. Following consultation with Mr B's son it was agreed to move Mr B to comfort measures. His son did not want Mr B to return to the RACF due to the pressure injuries which he blamed the RACF for.

19. Mr B was admitted to the Hospital and commenced on the Care of the Dying Pathway. He was administered regular analgesia and provided comfort measures. He passed on 6 September 2025, and was formally declared deceased at 10.35pm.

Forensic Pathologist Examination

20. An external examination with whole body CT scan and urine and blood samples, was undertaken by the forensic pathologist.

21. The post-mortem CT results revealed Mr B had soft tissue thickening and ulceration over the sacrum. There was also permeation/ill-definition of the sacrum deep to the ulcerated region which was supportive of osteomyelitis. It also showed Mr B had severe coronary artery calcification.

22. Pressure injuries were identified on the sacrum and both heels. The sacral injury was classed as a Stage 4 injury. That is, full-thickness skin loss extending through the fascia with considerable tissue loss. There was also associated muscle/soft tissue loss. It was 9.7cm wide, 12cm long, and 4cm deep. The right heel measured 5.5cm wide and 3cm long. There were two injuries on the left heel, one of the medial side which was 2cm wide and 2.5cm long. The other, was on the lateral side and measured 3.1cm wide and 1.5cm long.

23. Microbiology swabs of the sacral pressure injury revealed mixed enteric bacterial and skin flora. The pathologist has advised the absence of a positive blood culture suggests that the bacterial cultured were not causing a systemic invasive infection. The bacteria detected was suggestive of colonisation.

24. As to the cause of death, the forensic pathologist states,

> *Considering the circumstances of death, review of the medical information, postmortem imaging findings, and external examination the cause of death is recommended as septic shock due to severe pressure injuries Alzheimer's dementia with severe cognitive impairment, probable aspiration, congestive cardiac failure, immoblisation, hyperlipidaemia, hypertension, Parkinson's disease, severe frailty are considered significant contributing factors.*

ACQSC Information

25. 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 that:

    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.

26. I note on the ACQSC website as of 12 May 2026, <u>inadequate wound management is one of the most common clinical complaints received by the ACQSC</u> 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).

27. 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.

28. 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 <u>contemporary wound management guidelines</u>. 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].

29. 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.

Independent Expert Opinion from Aged Care Specialist

30. I had approached a Geriatrician to provide an expert opinion on the care two other elderly residents residing in RACFs with significant pressure injuries, 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 in those matters considerably.

31. 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.

32. I requested Dr Lukin review the care of the two other residents from different RACFs, in addition to the care Mr B had received.

33. Concerning Mr B, Dr Lukin opined that:

    a. Mr B's death was inevitable, and a result of his dementia. The timing of his death was related to his dementia and not the skin breakdown.

    b. The mode of dying was multiorgan failure due to neurological failure with the underlying cause being dementia. The skin failure was part of the clinical picture of multi-organ failure.

    c. The condition causing Mr B's death was Alzheimer's Dementia.

    d. The care provided by the RACF was appropriate and to standard as the pressure injury was likely inevitable and always untreatable.

    e. The wound was not able to be healed by the intervention of a wound specialist team.

    f. The progress notes do not indicate the nursing staff recognised Mr B was dying, however, there were many red flags to suggest the dying process had commenced.

g. With the appropriate support, Mr B would have been able to die at his RACF comfortably without the family distress but very likely with his large pressure wound.

h. The family were likely distressed by the mode of Mr B's dying and their perception of the quality of care Mr B received at the RACF. He states,

   It is likely that Mr B's sons' grief was complicated by an implicit assumption that a pressure area equals poor care. These concerns were real but, in my opinion, they could have been considerably eased by an appropriately skilled individual recognising the dying phase, identifying that the pressure injuries were inevitable and not the result of poor care and involving the family in discussions at this point. These discussions explore the nature of the dying process in dementia.

   It is my experience in exactly this type of situation that the family are often greatly relieved by an open discussion of this sort.

34. 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.

35. 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. His response was that:

> *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.*

36. I asked Dr Lukin what the appropriate standards/clinical guidelines are to be used in the aged care setting, and did he consider 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.*

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

38. 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.

Further Information from the RACF

39. Despite Dr Lukin's opinion, I had some concerns regarding the management of Mr B's pressure injury. The RACF did not report the pressure injury to the ACQSC because they have advised they are not required to. They did complete a Continuous Improvement Plan following Mr B's death. The identified issues were wound management gaps. Refresher training was provided and a four hour training session by Wound Innovation were organised for Registered Nurses.

40. The RACF says as per the clinical records Mr B's son was informed of the pressure injury on 10 August 2025. Further, they have advised he was regularly updated but was often unavailable. Messages were left on his phone.

41. As to the events of 1 September 2025, the GP was consulted and provided instructions to obtain a wound swab. The RN followed the doctor's instructions until there was a clear indication that Mr B required palliative care. The facility manager states, '*Mr B's condition deteriorated gradually, and both the GP and Mr B's son were kept informed of his condition'*.

Response from the GP

42. The GP was provided with a copy of Dr Lukin's report and was asked to respond. He says the last time he saw Mr B was on 13 August 2025, at that time the pressure injury was at Stage 1. At this time, he believed Mr B's condition would continue to deteriorate, given his Alzheimer's Dementia, reduced mobility – bed bound, and diminished nutritional intake. Due to these combined factors pressure injury may be inevitable, even with appropriate nursing and medical care.

43. The GP says he may have received a phone call from the RACF on the day Mr B was transferred to the hospital and he would have recommended anticipatory medication to keep Mr B comfortable at the nursing home. It was his son who wished for Mr B to be transferred to hospital.

44. The GP has no recollection of any consult of 1 September 2025 and says at no time was he made aware of the extent of the pressure injury. The RACF clinical note refers to the GP being advised of the Stage 4 pressure injury and that a wound swab was recommended. Given this contemporaneous note was made at 9.14pm, the instruction seems likely to have come from an afterhours GP.

45. As to Dr Lukin's report, the GP states,

> *Thank you for including Dr Lukin's report. I totally agree with his findings that Mr B's pressure injury was inevitable and untreatable apart from comfort measures. Due to his poor nutritional intake, decreased circulation, neurological failure causing dementia, successful wound healing of this type is unlikely. In Mr B's case his pressure area developed rapidly from stage 1 to stage 4, within a matter of weeks. Mr B was taking oral medication at the time of my last review. He was taking opioid at this time. To the best of my ability I recommend anticipatory – comfort measures when I was informed of his deterioration on the 4th of September 2025 prior to his transfer to hospital.*

I never had the chance to speak with Mr B's son, although I had requested a face to face meeting on several occasions. I have left messages with the nursing staff to pass onto Mr B's son to contact me as they had his contact details. I would have discussed Mr B's decline and placing him on comfort measures, de prescribing, and the inevitable progression to end of life pathway. Unfortunately this did not take place.

Conclusion

46. 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) of the *Coroners Act 2003* in relation to Mr B's death.

47. 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.

48. 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.

49. 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.[1]

50. Based on the evidence of Dr Lukin, in these types of cases the issue appears to be 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. In one of the other cases I asked Dr Lukin to review, a different 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 stated:

    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)

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

51. Mr B required full nursing care. His condition was deteriorating in the months leading up to his death. He was losing weight, and he was malnourished due to refusing nourishing foods and fluids. He had several medical co-morbidities which made him extremely susceptible to a pressure injury and sometimes despite best efforts, a resident can develop a pressure injury.

52. As demonstrated in the photographs, the decline in Mr B's sacral wound was dramatic and over a relatively short period. This despite him being on an air mattress, having strict second hourly turning, and daily dressing attendances. It is not possible to establish if the second hourly pressure cares or the standard of the wound dressing was appropriate. The contemporaneous records support the cares were provided.

53. In cases where the wound is retrievable, early, and close intervention is required to prevent rapid deterioration of the wound. It may be that there is a period of active treatment in the initial phase of the pressure injury. However, when there is no improvement or worsening of the wound despite all interventions, there should be a clear pathway for how to manage the 'terminal wound' and the resident to ensure they have the necessary respect, dignity, and comfort they need. Further, there needs to be clear and appropriate communication with the resident's family to manage expectations and to prepare them for the inevitable situation where the wound will not heal, and that the resident has commenced the dying process.

54. These are always difficult cases. I accept that when Mr B developed his pressure injuries, his condition had been deteriorating and that it is very unlikely that the injuries were retrievable due to, as opined by Dr Lukin, the commencement of the dying process. Mr B was in the end stage of his Alzheimer's. Unfortunately, the Stage 4 pressure injury and the rapid deterioration in Mr B likely came as a shock to Mr B's son. There is no clinical pathway/guideline for this type of scenario and the reference to 'terminal wounds' and what is associated with that is seemingly a relatively new term in the aged care space. On the evidence before me, I find there was no amount of wound care or interventions that would have changed the outcome for Mr B.

55. On balance, I accept Dr Lukin's opinion as to the cause of Mr B's death over that of the Forensic Pathologist. That is, that Mr B died from multiorgan failure due to neurological failure due to Alzheimer's dementia.

56. 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 this case.

57. 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'.

58. 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.

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

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

61. I extend my condolences to Mr B's family and friends for their loss.

Findings required by s.45

Identity of the deceased –	Mr B
How he died –	1(a) Multiorgan failure ANTECEDENT 1(b) due to neurological failure 1(c) due to his underlying Alzheimer's dementia
Place of death –	Toowoomba Base Hospital Pechey Street TOOWOOMBA QLD 4350 AUSTRALIA
Date of death–	06/09/2025

I close the investigations.

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

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,[2] 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

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

Melinda Zerner, Coroner
███ ██ ███
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.

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

Level 44, 600 Bourke Street, Melbourne VIC 3000