



CORONERS COURT OF QUEENSLAND

FINDINGS OF INVESTIGATION

CITATION: **Non-inquest findings into the death of Mr H**

TITLE OF COURT: Coroners Court

JURISDICTION: BRISBANE

DATE: 9 June 2026

FILE NO(s): 2024/189

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 H was born on 17 April 1936, and died on 6 January 2024, at the Redcliffe Hospital. He was 87 years old.
2. A doctor from the Redcliffe Hospital reported Mr H'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*.
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 H was a long-term resident in a Residential Aged Care Facility (RACF). He had previously suffered a stroke with paralysis (quadriplegia). His medical history also included: vascular dementia; chronic kidney disease; hypertension; hypercholesterolaemia; and type 2 diabetes. He was bed-bound and fully dependent.
6. On 3 December 2023, the RACF staff observed two red areas on Mr H's bottom. Cream was applied, and he was repositioned every two hours.
7. On 4 December 2023, the RACF staff identified a pressure injury on Mr H's left buttock. The injury was given a 'very high' risk rating and two-hourly repositioning schedules and a skin care regime was implemented. Existing strategies (regular repositioning, a pressure relieving mattress, pillows, and heel wedges) were also in use.
8. On 5 December 2023, a physiotherapist reviewed Mr H and provided bed mobility instructions (utilising two staff and a slide sheet).
9. On 6 December 2023, a Nurse Practitioner (NP)¹ who was retained by Mr H's GP, reviewed Mr H's left buttock pressure injury with the GP. She observed a Stage 1 pressure injury on the right buttock, and a stage 2 pressure injury on the left (the wound).² She recommended a change in the dressings every four to five days (unless soiled or oversaturated).

¹ The NP is an experienced registered nurse with Master degree qualifications in nursing. She was employed on a part time basis, three days per week with the GP and one day per week with the Princess Alexandra Hospital Comprehensive Aged Residents Emergency Partners in Assessment and Treatment (CAREPACT) Unit.

² The grading of pressure areas is (1) non-blanching redness, skin remains intact to (4) loss of tissue, muscles, tendons and bones can be visible.

10. On 9 December 2023, the wound areas were noted to be soiled with faeces. The dressing was replaced, and it was noted his dressings were to be checked daily. There is a document titled 'Wound Report' where it appears the wound (or possibly the dressing) was examined on 9, 10, 12 and 13 December 2023.
11. On 13 December 2023, the NP has advised she was approached by the Clinical Manager (CM) and asked if she consented to having the wound specialist review Mr H's pressure injury. She consented because to make a referral to the wound specialist, the CM required consent of either a GP or NP. It does not appear the NP was asked to review the wound or had seen the wound since 6 December 2023.
12. There is no note of the conversation between the NP and CM in the RACF progress notes or in the NP notes, so I have no confirmation as to whether this conversation occurred on 13 or 15 December 2023.
13. On 15 December 2023, there is a detailed entry regarding Mr H's sacral wound in the RACF progress note. The RN records,

PI breaking down, area expanded to 10x5cm with blistering, an area of broken skin and non-blanching redness, and dark colour. Wound bed granulating, Surrounding skin fragile and dry. Area cleansed with prontosan gel, inadine applied to wound base with allevyan dx. For strict 2 hourly side to side repositioning. CM notified.
14. The CM requested an urgent wound care specialist intervention, and a referral was sent.
15. On 19 December 2023, advice was received from a private independent Nurse Practitioner - Wound Care Specialist (Wound Care Specialist). She had been briefed with Mr H's health and medication summaries, along with photographs of the injury, but did not assess him in person. Regarding a description of the wound, the Wound Care Specialist recorded,

On examination of the photo provided from the 15 December, there is an area of diffuse tissue damage located on the sacrum extending across to the ischium bilaterally. The wound edges are poorly defined with the tissue having a dark marron discolouration that is starting to necrose in the area of tissue damage. There is evidence of serum and blood-filled blister centrally consistent with shear and/or unrelieved pressure. There is a ruptured blister on the left side of the affected area revealing a sloughy wound base. There is likely to be a low level of serous exudate. The affected area is likely to be painful.
16. The Wound Care Specialist diagnosed a 'suspected deep tissue injury' and created a suggested wound care plan (cleansing, creams, primary and secondary dressings, and daily dressing changes). Under the heading Evaluation Plan, she states,

Mr H has been placed on a wait list for an appointment if any telehealth appointments become available this week. If there is any deterioration, then review by his GP and/or RASS Team is recommended. Otherwise, a telehealth appointment is recommended in six weeks' time to review progress and response to recommended wound care plan.

17. On 20 December 2023, Mr H was reviewed by the NP and his GP. It is recorded, 'Notes Wound specialist review with thanks'. The NP records, '*D/W NOK informed re: above findings and changes. Discussed goals of care – to focus on comfort cares and pain free environment*'.
18. The Wound Care Specialist's suggested plan appears to have been followed by the RACF, however on 24 December 2023, a further 'breakdown' of the wound was identified. It was also described as malodorous which can be a sign of infection. On 25 December 2023, the wound again was noted to be malodorous.
19. By 28 December 2023, the wound was noted to be discoloured and to have a bad odour. The plan was to 'continue to monitor' and have the management plan reviewed by the NP. The NP was on leave at the time but consulted with staff in any event.
20. Following her review of a photograph of the wound and the RN's clinical notes, on 29 December 2023, the NP instructed the RN to follow the Wound Care Specialists recommendations. If the wound deteriorated further, the Wound Care Specialist was to be contacted for advice. The NP also notified the RN that she had increased pain relief and advised that two hourly repositioning was to occur.
21. On 31 December 2023, the wound was observed to be further deteriorating.
22. By 3 January 2024, it had reached Stage 4 (though with 'nil' signs of infection). Notwithstanding the apparent deterioration, the NP's advice was to 'continue dressing plan as per the wound specialist'.
23. On 5 January 2024, Mr H was taken to hospital (due to symptoms including shivering, fever, and 10/10 pain). He had been experiencing those symptoms the previous night and was prescribed antibiotics by the NP.
24. When the Queensland Ambulance Service (QAS) paramedics attended the RACF to transport Mr H to hospital on 5 January 2024, they observed a strong odorous smell from the wound and noted that he was hot to touch, pale, clammy, and non-verbal. He was diagnosed as suffering from septic shock and was taken to the Redcliffe Hospital.
25. On arrival at the hospital, Mr H's level of consciousness had deteriorated. The attending doctor recorded a discussion she held with Mr H's daughter, during which she *advised that given patients co-morbidities it would be reasonable to not treat the infection and keep patient comfortable as antibiotics would only be a temporary measure*. Further, that there was a high likelihood that Mr H could die of sepsis in *hours-days*. The family were happy not to take any 'active measures' and palliative care was decided upon. Mr H died the following day.
26. Mr H's ultimate diagnosis was 'severe septic shock secondary to severe sacral pressure injury'.

Forensic Pathologist

27. The forensic pathologist undertook a review of Mr H's clinical records. She states,

On arrival at hospital his level of consciousness had deteriorated to a GCS of 5. Assessment noted him to be febrile, and hypotensive with an approximately 12cm Stage 4 pressure sore on the sacrum. His abdomen was reportedly soft and non-tender and his oxygen saturations were 98% on 2L of nasal prong oxygen.

*Hospital assessment included blood tests which showed a markedly elevated white cell count with high neutrophils (a marker of infection) and blood cultures subsequently grew *Proteus mirabilis*, and a *Staphylococcus* species.*

The impression was that of overwhelming sepsis. Following discussion with family he was treated palliatively and died on 06/01/2024 at 23:12.

28. The forensic pathologist's description of the sacral wound is stated as,

Sacrum: 130 x 110mm pressure ulcer with peripheral purple to red discolouration. There was a 90 x 50 x 10mm central defect with exposed sacrococcygeal bones, showing grey green discolouration and slough within the wound. The skin margins were gaping with up to 30mm of undermining (extension of the wound beneath the overlying skin). The tip of the coccyx was present but dislocated, displaced anteriorly.

29. The CT scan showed a large sacral wound with exposure of sacrococcygeal region with associated fracture. Some destruction of the exposed bone, raising the possibility of osteomyelitis.

30. In conclusion she states,

*In my opinion the cause of death is **complications of sacral pressure injury**. These complications include sepsis and probable osteomyelitis (infection of the bone) along with aspiration in the setting of reduced level of consciousness and palliation.*

Pressure injuries are injuries to the skin and soft tissue at sites of prolonged pressure and friction. Compression of the skin and soft tissue impairs circulation resulting in tissue damage that can progressively lead to skin breakdown, development of ulcers and eventual involvement of deeper tissues including muscle and bone. They tend to occur over bony prominences, with the sacrum being a common site.

Elderly and bed-bound individuals are at increased risk. Other conditions such as diabetes, poor nutrition and some medications such as steroids may impair wound healing and increase the risk of complications such as infection.

In this man his immobility due to previous stroke, along with vascular dementia, diabetes, chronic kidney disease, hypertension and dyslipidaemia are all significant risk factors that would have played a role in the development of a pressure injury and/or impaired wound healing and its complications.

Family Concerns

31. Mr H's daughter raised several concerns regarding poor communication from the RACF regarding her father's pressure area and his deteriorating condition. She advised:

- *Mr H was a long term resident of the care facility for approx. 11 years. During this time, there were no other issues of concerns.*
- *On the 12 December 2023 Tanya was contacted regarding a bedsore that the facility was treating and this was the last correspondence regarding the bedsore prior to Mr H being admitted to Redcliffe Hospital.*
- *On the 19 December 2023 Tanya received a call from the care facility enquiring about the end of life care plan for Mr H. Tanya reported that antibiotics was fine if required however, DNR if his health was to deteriorate at any point. At no point in this discussion was the bedsore talked about and therefore Tanya thought it must have been under control. Tanya did think at the time that the call was quite strange.*
- *On the 5 January 2024 Tanya received a phone call from the facility to advise that Mr H had a temperature and if Tanya would like Mr H to be sent to the hospital for further assessment. Tanya advised that she would like Mr H to be transferred to hospital however, had no idea about the ongoing issues with the bedsore and presumed because she had not heard any more about it, that it was treated and there were no issues.*
- *It wasn't until Mr H was admitted to Redcliffe Hospital that she became aware that her father was extremely unwell and was being treated for sepsis.*
- *The treating team spoke to Tanya noting that her father did not have long to live and was shown a picture of the bedsore on Mr H's body. When the staff were dressing the wound in hospital, she noted that the smell was horrendous and the treating Dr has not seen anything like it in his time.*
- *Tanya reported that the communication was non existent regarding the bedsore and does not wish for any other family to experience what she has and the pain her father would have been in.*

Response from the RACP and the NP

Wound management

32. According to the NP, she coordinated care with the General Practitioner (GP). However, as nurses are more experienced with wound treatment, she was the person who ordered Mr H's wound management interventions. When wounds need to be escalated, they are escalated to a wound specialist rather than a GP.
33. The Clinical Manager of the RACF has advised that wound care specialist referrals occur *if a pressure injury is not showing signs of healing within an expected timeframe, or is increasing in size, depth, or in exudate and/or signs of infection, or if current dressing regimes are not working*. The referral process involves escalation to the Clinical Management Team who, in consultation with the resident's GP, refer to a specialist.
34. Contrary to the Clinical Manager's explanation of the referral process, Mr H's GP was not involved or consulted. The GP's NP was though. Consent was obtained to refer Mr H to a wound specialist on 13 or 15 December 2023 (it remains uncertain when this conversation took place). A referral for an urgent remote review was made on 15 December 2023. The review was done remotely on 19 December 2023 due to the urgency.
35. When the wound was noted to be infected on 28 December 2023, the NP was on leave. Nonetheless, she reviewed the photograph and RN's notes, opining that although there was slough around the wound, there were no other signs of infection.
36. On 29 December 2023, the NP instructed the RN to follow the Wound Care Specialist's recommendations. If the wound deteriorated further, the Wound Care Specialist was to be contacted for advice. The NP also notified the RN that she had increased pain relief, and she advised that two hourly repositioning was to occur.
37. Before commencing leave on 23 December 2023, the NP did not consider that the wound had deteriorated to the point that a hospital transfer was needed.
38. The Residential Aged Care District Assessment and Referral (RADAR) was not contacted by the NP because she *knew they would not have gotten involved due to my ongoing involvement together with the wound specialist*. (the NP worked for a similar organisation CAREPACT one day per week)
39. The Clinical Manager considers that staff followed incident management policies in identifying and reporting the wound on 4 December 2023, and that the escalation process was followed on 15 December 2023 (when the wound specialist referral was sought).

Family communications

40. The Clinical Manager says that the NOK was contacted about the wound on 4 December 2023 (to advise of the wound and proposed care) and again on 19 December 2023 (regarding the wound specialist review). It is understood that she was also contacted on 20 December 2023 by Mr H's GP (about pain relief). On 4 January

2024, a case conference was held with Mr H's wife (Mr H's daughter does not seem to have been present).

41. The NP says she spoke to the NOK once the Wound Care Specialist's review had occurred. She told them that the wounds were unlikely to heal – especially because Mr H was bed-bound. She also has advised the NOK consented to transferring Mr H to hospital to receive intravenous (IV) antibiotics and fluids if his pressure injuries further deteriorated. I note this is not documented in her clinical entry of 20 December 2023.
42. The RACF has an 'open disclosure policy' which requires the nurses on duty to report every event to the family as soon as practically possible.

RACF Investigation

43. The Clinical Manager was involved in a review of Mr H's wound care, and a RACF document titled 'Comprehensive Analysis' has been provided.
44. Notably, the investigation identified that:
 - i. There were no photographs of the wound in the wound chart between 4 and 18 December 2023.
 - ii. Between 9 and 14 December 2023, the wound chart contained 'nil' photographs and 'limited information' – *Looking at these charts it would be very difficult to determine any deterioration.*
 - iii. A photograph of the wound on 19 December 2023 should have been attached to the wound chart *to ensure any team member reviewing wound chart would be able to visualise the wound making it easier to identify deterioration.*
 - iv. The NP notes on 20 December 2023 caused RNs to determine that *Mr H was for comfort cares and pain management, not active treatment and transfer to hospital.*
 - v. Between 21 and 26 December 2023, no photos were attached to the wound chart.
 - vi. Despite further deterioration on 24 and 27 December 2023, escalation did not occur.
 - vii. The NOK should have been updated on 28 December 2023 about Mr H's escalating pain and medication change.
 - viii. On 31 December 2023, the deteriorating wound should have been escalated.
45. Factors found to have contributed to the above failings included confusion by RNs about photographing a chronic wound, time constraints, pressures concerning the amount of documentation required of RNs, confusion about the NP's notes, and workload difficulties.

46. To address the failings and contributing factors, in January and February 2024, the RACF arranged staff education and training (including by Wound Specialist Services and Alpha Care) about pressure injuries – including strategy, prevention, charting and documentation, communication, and roles and responsibilities. Three iPhones were also supplied to staff, with a view to improving documentation processes.

47. The RACF has confirmed that all six recommendations arising from the Comprehensive Analysis have been implemented, specifically:

- *Wound care education including identifying infection, actions and escalation process completed with Registered Nurses on 18/01/2024 and 05/02/2024. This was provided by Wound Specialist Services.*
- *New phones have been purchased and are in use for wound photographs to ensure clear pictures are attended on dressing change and uploaded to wound management charts. This was completed by 31/01/24.*
- *Education on Registered Nurse and /Enrolled Nurse roles and responsibilities completed with our Service staff on 23/01/2024, and 24/01/2024. This was provided by RACF's clinical educator.*
- *Air mattresses education including use, functionality and settings completed with Registered Nurses on 05/02/2024. This was provided by Alpha Care, the supplier of air mattresses. In addition, a full review of mattresses was conducted by Work Health Safety and completed on 07/02/24. Improvements were made from that audit.*
- *Ongoing, a preventative maintenance schedule and mattress replacement program is in place to ensure availability and effectiveness of pressure injury prevention equipment.*
- *Pressure Injury Prevention toolbox talks conducted by our Service's clinical management staff on 01 /02/24 to 05/02/24.*
- *Documentation for safety education including wound charts and photos, using ruler for measurement and capturing deterioration completed with Registered Nurses on 02/02/24, 13/02/42, 14/02/24 and 19/02/2024. This was provided by RACF's clinical educator.*
- *Documented discussions and reflective practice tools for RN's involved in Mr. H's wound care from 10/01/24 to 15/01/24 conducted and completed on 15/01/24. This was provided by the Residential Service Manager.*

48. In addition to the above, the RACF has advised that as of 18 January 2024, a wound chart audit process has been implemented. An example has been provided.

49. The audit process involves a member of the clinical management team *personally observing the wound when deterioration is noted, or wound not healing within the expected timeframe*. It is attended to by the Care Manager and/or Care Coordinator and Quality Support Officer *as an extra check to ensure all wounds are reviewed weekly so as early detection and escalation process is followed*.

ACQSC Information

50. 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.

51. 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).*

52. 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.

53. 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].

54. 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 Medicine Physician Opinion and response from RACF

55. A preliminary expert opinion was obtained from a Forensic Medical Officer, Dr Hall. He formed the opinion:
- a. The wound care management was poor.
 - b. He did not find it surprising the wound broke down after 9 December 2023 when it had been contaminated with faeces.
 - c. He would have expected Mr H to have been transferred to hospital well before he was.
 - d. When Mr H became febrile on 5 January 2023, oral antibiotics were insufficient and that it would have been more reasonable to have treated him for sepsis.
56. The RACF respectfully disagrees with the opinion expressed by Dr Hall. Dressings were initiated, reviews and escalations were undertaken, and care was aligned with best practice guidelines. That is, escalation to the NP and a wound specialist occurred when there were no signs of healing progression within the expected timeframe (14 days), despite the treatment plan being followed.
57. The RACF have though advised there is no formalised process for referring residents to an external wound specialist. Clinical practice is guided by a Wound Care Pathway and a Pressure Injury Care Pathway. Referral should be considered if a wound 'does not improve in a timely manner'. The decision to make a referral is made in consultation between the clinical leadership and the medical team.
58. The NP was engaged by the GP who attended consultations independently of the GP for some reviews. Mr H was referred to his GP and his skin was reviewed by the NP from the GP clinic on 6 December 2023. As the wound was noted to be deteriorating on 15 December 2023, despite treatment a referral was sent to a wound specialist. The request was marked 'urgent wound referral' for worsening pressure injuries with a photograph of the wound. It included a request to review the wound of another resident. There had been a discussion between the Clinical Manager at the RACF and the NP which had resulted in the referral being made. The decision was based on the deterioration of the wound despite the current dressing regime and attempts to minimise any additional pressure by repositioning and the ongoing use of a pressure relieving mattress.
59. The wound specialist was only available for a virtual appointment after there was a cancellation on 19 December 2023. An interim care plan was sent on 18 December 2023. A new wound care plan was developed on 19 December 2023 and was reviewed by the NP on 20 December 2023. RACF have acknowledged due to unplanned leave of the Clinical Manager there was a less coordinated approach to monitoring during this time. The wound continued to be dressed and was reviewed by the NP on 3 January 2024. Mr H began to deteriorate on 4 January 2024 prior to his transfer to hospital.

60. The RACF have advised Mr H was a longstanding resident of the service having been admitted on 22 August 2012. He was at very high risk of a pressure injury due to his immobility and co-morbidities. Previous pressure injuries had been identified and treated effectively by the service.

61. Regarding the RACF's wound care specialist referral process, the RACF have advised:

Our Service's wound care specialist referral process has been enhanced to include a referral to the Residential Aged Care District Assessment and Referral Service initiated by CM/CC in consultation with the treating GP in the event a wound specialist is required and cannot attend in a timely way when the situation is acute. The Wound Care Pathway and Pressure Injury Care Pathways are being reviewed by the Clinical Governance Team with the intent to include clearer guidance on when you would consider a specialist review.

Report to the ACQSC

62. A person had reported Mr H's death to the Aged Care Quality and Safety Commission (ACQSC). The allegations were of neglect and breaches to the Code of Conduct.

63. A review of the care Mr H had received, and the investigation and subsequent actions taken by the RACF were considered. The matter was referred to the Regulatory Action Team. It was ultimately decided that no further action was required.

Independent Expert Opinion from Aged Care Specialist

64. I had approached a Geriatrician to provide an expert opinion on the care Mr H 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.

65. Eventually, I was able to brief, Dr 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.

66. I asked to Dr Lukin to review two other similar cases, in addition to Mr H's.

67. Concerning Mr H, Dr Lukin has opined,

a. Mr H was at the end stage of dementia and that his condition had changed in the months leading up to his death. It was noted by nursing staff, 'M H is settled but has had a gradual decline'.

b. Mr H had previously had other pressure areas which had healed.

c. By 20 December 2023, Mr H's goal of care had changed to comfort measures and not for life prolonging interventions.

- d. Mr H's treating team had reached the conclusion there was little further that could be done to restore Mr H's function. That is, by 20 December 2023, Mr H had commenced the dying process and there was nothing that could be done to delay that process.
 - e. Mr H's death was inevitable as a result of dementia and the timing of his death was related to his dementia rather than the skin breakdown. The skin breakdown was likely unavoidable and was very unlikely to heal despite appropriate care being taken by the facility staff.
 - f. Mr H's death was most likely due to multiorgan failure due to sepsis due to skin failure with the underlying cause being vascular dementia. He notes though that it is possible the sepsis was a urinary or respiratory sepsis, and not sepsis from the pressure area.
 - g. Mr H's dementia was the biggest risk factor for the development of the pressure area and the underlying cause of death.
 - h. The care provided by the aged care facility to Mr H was appropriate and to standard. The pressure injury was likely inevitable and was very unlikely to heal despite appropriate care being taken by the facility staff.
 - i. There was a missed opportunity to improve the care experience by Mr H and his family by responding to recognition that Mr H had commenced the dying process and facilitating better end-of-life planning, communication, and comfort care within the facility.
 - j. With the appropriate support Mr H would have been able to die at his facility, comfortably without the family distress but very likely with his large pressure wound.
68. 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.

69. 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.

70. 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.

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

72. 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.

The GP

73. I provided Dr Lukin's report to Mr H's GP. He has advised Mr H was being reviewed by the NP who is an independent practitioner who has the clinical authority to prescribe and chart palliative care medications as required. He says therefore there was no necessity for his direct intervention.
74. Further, the GP says he was not aware of Mr H's deterioration during the relevant period and that he agreed with the opinions expressed by Dr Lukin.

Conclusion

75. After considering the material obtained during the coronial investigation, I consider I have sufficient information to make the necessary findings required by s45(2) of the *Coroner's Act 2003* in relation Mr H's death.
76. 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.
77. 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.
78. 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.³
79. Based on the evidence of Dr Lukin, the issue appears in these types of cases 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 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'

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

wounds' as this has been an improved method of communicating the likely trajectory when identified. (emphasis added)

80. Mr H was a long-time resident at the RACP. His family had had no previous issues with the care he had been provided, and previous pressure areas he had developed had healed. He had several medical co-morbidities which made him extremely susceptible to a pressure injury and sometimes despite best efforts and appropriate care, a resident can develop a pressure injury.
81. 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.
82. In this case, I find that the pressure injury was identified early at Stage 1 and 2 and advice was provided by the NP regarding the management of the wound on 5 December 2023. I accept the NP's evidence that it is common practice for wound management to be delegated to an experienced nurse or wound care specialist rather than a GP, and that it is common for a GP to rely on the advice of an experienced Registered Nurse regarding wound care management.
83. During the six-day period from 9 December 2023 to 15 December 2023, the wound deteriorated significantly and while an urgent wound care review was requested, that did not occur until 19 December 2023. Whether any further intervention was required during this period is not clear. The wound though was not noted to be infected on 19 December 2023 and the NP commenced leave on 23 December 2023. When she last saw Mr H on 20 December there was no requirement for him to be transferred to hospital.
84. Notwithstanding Dr Lukin's opinion, I find there was potentially a failure by the RACF to closely monitor Mr H's wound after 9 December 2023 through to 15 December 2023. Mr H's wound deteriorated further on 24 December 2023, and it was noted to be malodorous which can be associated with infection. The wound continued to deteriorate.
85. These are always difficult cases. While I have found there were potentially some deficits in the wound care provided to Mr H, these did not cause the wound to be infected by 19 December 2023. I find by this time the pressure injury was not retrievable due to the dying process Mr H was undergoing because of his end stage vascular dementia. There is no clinical pathway 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.
86. As to the overall management of Mr H I accept the opinions expressed by Dr Lukin over those of Dr Hall. Noting Dr Hall does not have the specialist experience in aged care that Dr Lukin has.
87. What was required in this case was a well communicated plan for palliative care to ensure Mr H was kept comfortable. I find there was no amount of wound care or interventions that would have changed the outcome for Mr H. I acknowledge there was

communication with Mr H's family, and it seems there was a case conference with Mr H's wife on 4 January 2024. It may be that more direct information needed to be provided to prepare the family for what seemed inevitable at the time.

88. On balance, I accept Dr Lukin's cause of Mr H's death over that of the Forensic Pathologist, that is, that Mr H died from multiorgan failure due to sepsis due to skin failure due to his underlying condition of vascular dementia.
89. 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.
90. 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'.
91. 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.
92. I have also provided a copy of these findings to Wound Australia and the National Pressure Injury Advisory Panel (an international organisation).
93. I have annexed a copy of the letter which has been sent to the various organisations to these findings.
94. I extend my condolences to Mr H'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 H

How he died – 1(a) Multiorgan failure

ANTECEDENT

1(b) due to sepsis due to skin failure

1(c) due to his underlying condition of vascular dementia

Place of death – Redcliffe Hospital REDCLIFFE QLD 4020 AUSTRALIA

Date of death– 06/01/2024

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 2018,⁴ 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

⁴ [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 Panel 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

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Level 44, 600 Bourke Street, Melbourne VIC 3000