QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INVESTIGATION

CITATION:	**Non-inquest findings into the death of Charlotte Paluszak**
TITLE OF COURT:	Coroners Court
JURISDICTION:	CAIRNS
DATE:	10/10/2024
FILE NO(s):	2017/5320
FINDINGS OF:	Melinda Zerner, Coroner
CATCHWORDS:	CORONERS: Palliative Care in Residential Aged Care Facilities; End of Life Practices in Aged Care; Use of End of Life Medications and Doses.

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Introduction

1. Mrs Charlotte Paluszak (Mrs Paluszak) was born on 8 March 1933 and died on 11 November 2017 at 33 Kokoda Street, Idalia. She was 84 years old.

2. In or around November 2017, concerns had been raised regarding the method of commencing End of Life medications for residents at a Residential Aged Care Facility (RACF), and the lack of examination by the treating general practitioner (GP). The allegations were that:

    (a) there was an identifiable pattern concerning the deaths which involved the GP and a Clinical Nurse Consultant (the CNC) making entries in the residents' records to justify the commencement of End of Life medication; and

    (b) there was a lack of communication to the families of the intention to end the life of the residents.

3. Queensland Police Service (Police) reported the deaths of the aged care residents to the Coroner because their deaths were identified as potentially unnatural or otherwise violent within the definition of a reportable death in the *Coroners Act 2003*.

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

5. On 2 December 2017, the matter concerning Mrs Paluszak was referred under s48(4) of the *Coroners Act 2003* by the then Coroner to the Regulatory Authority, the Office of the Health Ombudsman (OHO) to investigate the practice of the GP. Referrals from other entities had also been made to the OHO.

6. The finalisation of the coronial investigation has been delayed by the OHO investigation, and the subsequent referral of three health practitioners (the GP, the CNC, and a Registered Nurse) for disciplinary proceedings, in or around November/December 2021, to the Queensland Civil and Administrative Tribunal (QCAT).

7. The proceedings in QCAT against the GP and the Registered Nurse (the RN) were eventually discontinued by the OHO. On 30 May 2024, I was advised the proceedings against the CNC had been finalised and that Judicial Member Rinaudo AM had handed down his written decision in QCAT.

8. I have now had the opportunity to consider the voluminous material. In making my findings, they are based on proof of relevant facts on the balance of probabilities. I am guided by the principles outlined in *Briginshaw* v *Briginshaw* (1938) 60 CLR 336. That is, 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.

The RACF

9. The RACF had opened in or around July 2016. The building had three levels. The ground floor was divided into two areas, the secure dementia ward at one end and a low risk unlocked dementia unit at the other end. The second floor was divided into north and south wards. The third floor was also divided into two wards. There were 32 beds on each floor.

10. Following the opening of the RACF there were some issues in retaining a permanent manager and there was a high turnover of staff. A Regional Manager stood in while attempts were made to find a permanent manager. The CNC had been appointed. The facility had two regular visiting GPs.

11. The medications and clinical information were recorded on a computer using the platform called iCare.

Circumstances of the Death

12. It is not possible to summarise or refer to all the material which has been gathered during the investigation. I set out below a summary of the events as I understand them.

13. Mrs Paluszak had commenced residing at the RACF in August 2016. She was affectionately known as 'Lotte' and was of German origin having immigrated to Australia in or around 1962. She had a significant hearing impairment despite a hearing aid. Among other medical conditions, Mrs Paluszak suffered dementia and type 2 diabetes.

14. In or around 2004, Mrs Paluszak was diagnosed with breast cancer. She was successfully treated with no recurrence of disease. It appears from the clinical records Mrs Paluszak was investigated in 2012 for mild to moderate cognitive impairment. By 2015, she was noted to have had gradual declining cognition over a 15 year period.

15. In 2014, Mrs Paluszak moved up from Sydney to live with her daughter, Mrs Petra Andersen, an assistant in nursing. Mrs Andersen was Mrs Paluszak's primary carer.

16. As reported by her daughter, Mrs Paluszak was very stubborn and had some challenging behaviours due to her dementia. She had been prone to urinary tract infections due to self-replacement of a prolapse. The prolapse was effectively treated in or around April 2016 with a pessary. She had also reverted essentially only to speaking her native tongue of German (Mrs Paluszak was used to speaking German as she had spoken German in her own home her whole life). When Mrs Paluszak's care requirements increased it was agreed by her family that she would be placed into care.

17. On 19 January 2015, Mrs Paluszak was reviewed by the Gerontology Services of the Townsville Hospital & Health Service (THHS).

18. On 14 March 2016, Mrs Paluszak was placed in a RACF for respite care. She had a fall and dislocated her acromioclavicular joint and lacerated her scalp. At the time her blood sugar level was 25.7 (very high), and among other treatment she was administered 6 units of Novorapid (insulin). She was discharged back to the RACF on two hourly blood sugar monitoring.

19. Later that day the staff contacted Mrs Paluszak's GP at that time, as they were concerned about her elevated blood sugars levels. They had been taking them every two hours and they had not improved. The GP visited the RACF and ordered a stat dose of 5 units of Novorapid (insulin). He added Diamicron (oral medication to help control blood sugar) to her other diabetic medications and staff were to monitor her blood sugar levels. He visited again the following day, and noted her condition remained stable.

20. On 21 April 2016, the GP noted Mrs Paluszak's 'sugars' were mostly okay being less than 20. He increased her Diamicron to twice daily. On 12 July 2016, the GP recorded "*sugars are ok 10-12*".

21. On 20 July 2016, a check electrolyte liver function test showed Mrs Paluszak had a random glucose level of 24.9. In her previous blood test of 22 March 2016, her random glucose was 21.2.

22. On 4 August 2016, Mrs Paluszak scored 5 on a mini mental state examination which indicated severe cognitive impairment. On the same day, her GP completed a 'Medical Information' form for permanent placement in a RACF. Her medications at that time were Circadin 2mg (sleeping medication), Coversyl 5mg (anti-hypertensive), Diamicron 60mg (to control blood sugar) and Neo-Mercazole 5mg (to treat an overactive thyroid). Mrs Paluszak's weight was around 63kg at this time.

23. Mrs Paluszak was subsequently placed in the RACF where she eventually died. As her regular GP did not visit RACFs, it was necessary to engage one of the two GPs who regularly consulted at the RACF.

24. On 30 August 2016, the new GP reviewed Mrs Paluszak at the RACF for the first time. Under the heading 'Management' he states,

> *Drugs Midazolam, hyoscine (Buscopan) and Morphine which are given Subcutaneously are to be used as End of Life drugs. If the patient is still in pain after oral stepwise pain ladder has been used and failed to relieve pain symptoms then Morphine s/c may be used at the RN's discretion.*
>
> *Places themselves at risk because of wandering behaviour and has no insight into risks so as a consequence requires environmental restraint with regular three monthly review or earlier if deemed clinically appropriate. Review every three months or sooner if indicated.*

25. There is a Medication Profile which has numerous dates with a signature next to it. I understand this to be the GP's signature. The Order was for various 'PRN' medications. It included Midazolam, 5mg by subcutaneous injection three times a day when required. The initiating order was 1 August 2016, the subsequent dates which I understand are 'review dates' are 28 March 2017, 13 June 2017, and 22 August 2017. This was the order which staff used to administer the End of Life medications to Mrs Paluszak.

26. On or around 6 September 2016, Mrs Paluszak's daughter was advised the GP wanted to trial Risperidone in an endeavour to modify some of Mrs Paluszak's behaviours.

27. On 27 September 2016, the GP commenced Mrs Paluszak on Risperidone 0.5mg 1 nocte (night). The dose did not appear to change after it was prescribed.

28. In or around December 2016, Mrs Paluszak's daughter had checked Mrs Paluszak's blood sugar level at home, and it was too high. She requested the GP review her mother for her diabetes and to prescribe some ear ointment that Mrs Paluszak required.

29. On or around 30 December 2016, there is a record wherein Mrs Paluszak's daughter reported her mother's blood sugar level was 32.9. A Registered Nurse (RN) records, "[the GP] *notified as she was also showing signs of increased thirst. [The GP] requested Charlottes BGL be taken tDS before meals for the next 4 days and will review on Tuesday*". Mrs Paluszak was very resistant to having her blood sugar level checked. Prior to 1 January 2017, the last time Mrs Paluszak had had her blood sugar level checked was 25 September 2016.

30. On or around 10 January 2017, Mrs Paluszak was commenced on insulin at night. This was due to her pathology results and consistently high blood sugar levels.

31. On 20, 22 and 25 January 2017, Mrs Paluszak refused to have her blood sugar level tested due to a 'fear of needles'. The behaviour management plan on 22 January 2020 suggested to "*divert the resident's attention by asking her to walk with the staff in the garden and show her how to water the plants*". The records reflect at times Mrs Paluszak would not have her blood sugar level tested or have her insulin, and at other times there was no resistance.

32. Despite the commencement of insulin, Mrs Paluszak's blood sugar levels remained high. Her GP contacted Mrs Paluszak's daughter to discuss the refusal of insulin and poorly controlled blood sugar levels. Mrs Paluszak's daughter agreed to take her mother to her Geriatrician for review.

33. On 1 February 2017, Mrs Paluszak was reviewed by her Geriatrician. Due to Mrs Paluszak's non-compliance with insulin, her diabetes was controlled by oral medication. This though was also ceased due to Mrs Paluszak's renal dysfunction. While Mrs Paluszak's blood sugars continued to be high it was agreed her quality of life was now paramount and that strict compliance with her medication as considered less important particularly given her difficulties

with medication. The same occurred with Mrs Paluszak's blood pressure control medication which the Geriatrician thought could be stopped but left the final decision to Mrs Paluszak's GP.

34. On 3 February 2017, there was a verbal order from Mrs Paluszak's GP to the CNC to cease Mrs Paluszak's insulin. It seems after the insulin was ceased. Staff also stopped checking Mrs Paluszak's blood sugar level.

35. There is evidence Mrs Paluszak was challenging to manage. She frequently went into rooms of other residents and at times would physically touch staff and residents. She could become verbally and physically aggressive. Voluminous Behaviour Management Forms were completed by staff. On 28 July 2017, it is recorded in the Behaviour Management form, "Socially inappropriate behaviour that impact on other residents". This was commonly recorded in the records.

36. From 1 July 2017, the words "CONSERVATIVE TREATMENT AS PER FAMILY" were added under the heading 'Special Needs/Diagnosis' to all of Mrs Paluszak's forms.

37. In mid-August 2017, there is an entry by a RN, "*Lotte has had obvious weight loss over past few months, most likely gums have atrophied and denture no longer adequately fit onto gums. Dental apt to review. Continue Texture B modified diet as unable to chew very well*". Mrs Paluszak's family thought she would not comply with instructions if she was to visit a dentist and decided not to proceed with a dental review. She was provided fortified meals with additional supplements.

38. On 7 September 2017, the CNC completed an Activities of Daily Living Profile. Mrs Paluszak was noted to be independent with transfers and walking. She was otherwise dependent for all activities of daily living. She was noted to be incontinent of urine and faeces.

39. On 25 September 2017, Mrs Paluszak was seen by her GP for a 'routine annual review'. No concerns were identified. It was noted she was still eating well despite often refusing to wear dentures.

40. On or around 5 October 2017, Mrs Paluszak was seen by a Dietician. It was noted she had had a weight gain of 3.95kg from 25 August 2017. Her weight on 26 September 2017 was 63.25kg (similar to the weight immediately prior to her admission to the RACF).

41. On 6 October 2017, Mrs Paluszak was found on the ground in the garden. She did not appear to have any injuries and her observations were not concerning.

42. On 13 October 2017, a personal care worker (PCW) noted Mrs Paluszak had been in good spirits and had wandered around the gardens in the afternoon chatting to staff and other people.

43. On 22 October 2017, Mrs Paluszak was noted to have had a fall and to be incontinent of faeces.

44. On or around 31 October 2017, Mrs Paluszak was noted to not be herself again (the previous few days she had been very tired and at times was not eating). She was very lethargic, and staff were to obtain a urinalysis. Staff requested she be reviewed by her GP due to her low mood. She was noted to be on maximum antidepressants. It was reported that her daughter had been emailed to inform her of the review by the GP. There is a record by a PCW 'UA obtained' (I understand 'UA' to be urinalysis). I did not locate the result of the urinalysis in the material.

45. On 31 October 2017, the GP reviewed Mrs Paluszak. He records, "*has some depression; check urine; has bene (sic) a little worse then normal; make sure not a uti"* -this was the GP's last physical review of Mrs Paluszak before her death.

46. On 2 November 2017, the RN undertook a random blood sugar level check of Mrs Paluszak. It was 24.1. The RN records:

Asymptomatic with the same. Discussed with CNC, Lotte has a history of being non compliant with Insulin and is on maximum oral medication for her diabetes. Family are aware of the same, and have been with her previously when she has seen the renal specialist. As per CNC, no need for regular monitoring of BGL levels. Still refuses to wear her dentures.

47. On 5 November 2017, a PCW wrote, "*Lotte ate a very substantial breakfast, 2 bowls of porridge, ate a small lunch but finished desert. Lotte seems a lot brighter today*".

48. On 6 November 2017, Mrs Paluszak was observed to fall on her bottom in the garden area. An Enrolled Nurse (EN) assessed Mrs Paluszak. A PCW recorded, "*Resident doesn't seem to have any problems with mobility after her stumble. Resident ate a healthy lunch and seems quite content, and no complaints of pain*".

49. On 7 November 2017 at 10am, Mrs Paluszak had another fall. A RN records:

    Resident was found sitting in the garden at 1000am, nil injury noted, no pain observed. Ate and drank well her B/P still elevated, call her [the GP], and notify him. Gp is aware of her elevated B/p. I rang NOK and her other daughter Monika answered the phone, I have notified her about her mum's healthy (sic) status and told her to notify Petra. Tried to do BSL on resident, but she refused, pushing staff away, didn't want her finger pricked again. Staff will continue monitoring her.

50. Later that evening at 9.40pm, Mrs Paluszak was noted to be on the floor with her head leaning against the bottom bedrail of her bed. She was returned to bed with assistance, and someone stayed with her for reassurance. Her observations were checked. It was noted the CNC and family were notified via email and a note was placed in the doctor's book 'for review'.

51. On 8 November 2017, Mrs Paluszak was noted to be tired. She had a fast and irregular pulse. She was also noted to be unsteady when walking. A sensor mat was placed next to her bed. That day she had a good breakfast and had good fluid intake. She remained unsteady on her feet and stated she felt tired. At 1pm she was seen to be falling asleep. In the evening she was noted to be very drowsy and unsteady on her feet. She was put in a wheelchair to get to the dining area and to her room. She ate a full dinner. It appears she was visited by her daughter Mrs Anderson.

52. At 8pm, Mrs Paluszak's Risperidone was withheld due to her drowsiness and being unsteady on her feet. During the night, Mrs Paluszak required two people to assist her to the toilet as she was very unsteady. Later, though, when a PCW went to answer the buzzer Mrs Paluszak was found in the toilet already.

53. There are no entries concerning Mrs Paluszak on 9 November 2020. There were also no vital signs recorded wherein they had been regularly recorded the previous day. Mrs Paluszak was a little tachycardic throughout the previous night with her pulse ranging from 107 to 137. Her vital signs at 5.30am on 8 November 2020 were temperature 36.5, pulse 95, respiration 18, and systolic blood pressure of 100.

54. On 10 November 2017 at 8.59am, the CNC records:

    Lotte became semi-conscious at breakfast table at 0830hrs, unable to lift her limbs or communicate with staff. Assisted back to her bed by PCW & CNC. BGL taken-reading was (HI) unable to determine exact mmol due to significant high range. CNC phoned GP for advice – nil intervention is appropriate at RACF. To discuss with NOK if they would like Lotte to be transferred to TTH. Consider conservative treatment as same episode will occur again due to long term refusal of insulin. Same issue has been previously discussed with GP & daughter Petra. Endocrinologist also previously confirmed no further treatment could be offered. CNC phoned NOK daughter Petra to inform of Lotte's current status, message left on mobile phone to call back urgently. Lotte has been made comfortable in her bed and closely monitored by staff Residential Manager aware of situation.

55. At 10.40am on 10 November 2017, Mrs Paluszak was found on the floor in the bathroom. Her vital signs at 10.50am were recorded as pulse 106, respiration 18 and systolic blood pressure 131. Her temperature is not recorded. No other vital signs are recorded after this time. Her oxygen saturations were 96% which were normal for Mrs Paluszak. She was noted to be responsive and moving herself in bed. She had range of movement in all her limbs.

56. At 11.33am, another entry is recorded by the CNC, she states:

> *Lotte has since had a fall in her bathroom attempting to toilet herself. Nil injuries noted. However, she is becoming weak and agitated. CNC phoned both daughters Petra & Monika back to discuss Lotte's condition. They have both confirmed they do not want Lotte transferred to hospital and they wish her to be cared for at [the RACF]. They are happy for her to be given palliative medication as required. CNC phoned GP to advise of NOK wishes. GP directed to give Midazolam for agitation and Morphine if required.*

57. At 12.09pm, the CNC administered 5mg of Midazolam and 10mg of Morphine for palliation.

58. An 'Incident Report – Immediate' form was completed by an RN at 12.10pm. She records, "*RN notified: assessment for injuries attended: observations attended and assisted back to be (sic) (manually assisted to stand self and walk with 2 staff assist)*". Further, "Lotte transferred herself to the toilet – she was previously happening (sic) immediately before observed lying in bed. Unwitnessed transfer and fall".

59. An 'Incident Report – Follow up' form was completed by the CNC at 12.15pm. Under the heading 'Investigation/Observation Findings' she states,

> *Lotte was restless in relation to acute on chronic medical condition. Previously found in toilet and assisted by staff to return to bed before this fall occurred". Under the heading "Immediate actions taken to prevent/minimise incident recurrence' she records "Staff x 1 on 1 currently sitting with Lotte in her bedroom and GP notified – order for PRN medications to prevent further agitation/restlessness".*
>
> *Under the heading 'Further Actions Required' she records,*
> *GP notified – medication regime reviewed and order for PRN regime authorized.*

60. At 1.55pm, the CNC completed an 'End of Life Assessment'. With respect to a recent case conference, she records "*Conducted today with CNC, Petra and Monkia*" (Mrs Paluszak's daughters). Under the heading 'Signs and Symptoms associated with the terminal phase, the CNC records:

> *Experiencing day to day deterioration that is not reversible*
> *Requiring more frequent interventions*
> *Becoming semi-conscious, with lapses into unconsciousness*
> *Increasing loss of ability to swallow*
> *Refusing or unable to take food, fluids or oral medications*
> *Irreversible weight loss*
> *An acute event has occurred, requiring revision of treatment goals*
> *Profound weakness*
> *Changes in breathing patterns.*

61. The CNC notes three or more signs and symptoms are associated with terminal phase. An End of Life Care Plan was put in place. Mrs Paluszak was to be administered subcutaneous Midazolam for agitation, subcutaneous Morphine for pain and subcutaneous Hyoscine for respiratory difficulties. The medications were to be administered via an Intima (subcutaneous needle). There is a nursing entry after these entries which records: '…*NBM due to unconscious state'*.

62. A RN on the afternoon shift records,

Resident remain poorly, checked regularly on pm shift, nil pain or agitation observed on pm shift, was asleep through out breathing normal. pressure care attended. Daughter present on pm shift and is going to sleep onsite tonight.

63. A RN on the night shift records,

> *Lotte remained asleep the whole night. Did not exhibit any signs of pain or agitation. Routine mouth care and pressure area care done. Daughter was with her since PM and just left at 0230. Breathing remains regular.*

64. On 11 November 2017 at 11.27am, the RN administered 10mg of Morphine, 5mg of Midazolam and 20mg of Hyoscine for discomfort and respiratory distress. She administered a further 10mg of Morphine at 1.36pm. The RN records,

> *Lotte twitching and unresponsive at 0930hrs. Respiration rate 28-32. Skin hot to touch and very flushed looking on face, arms and body. Repositioned and personal cares attended at 1000hrs. Frequent mouth care and regular repositioning PRN. Lotte given S/C Morphine, Hyoscine and Midazolam with effect. Twitching decreased throughout the shift, and respiration rate gradually decreased. Daughter Petra present and respiration rate gradually decreased. Daughter Petra present and stayed with her mother throughout the day. Lotte was given PRN Morphine last at 1330hrs S/C with good effect. Settled and appears very comfortable. Lotte DECEASED at 1515hrs, with daughter Petra present.*

65. The PCW looking after Mrs Paluszak records,

> *Lotte was repositioned at regular intervals during am shift. She was hot and restless early morning but settled after medication given. Mouth swab done and skin moisturised and pad changed in the morning 1000 hrs. No fluids were given as she did not awake. Daughter with her most of the morning.*

66. On the Form 9, Cause of Death Certificate, the GP recorded Mrs Paluszak's cause of death as being Diabetes Mellitus due to, or as a consequence of Dementia – Alzheimer. With duration of each illness noted as being 'years'. On the Cause of Death Certificate, the GP ticked the box indicating her death was not a reportable death under the *Coroners Act 2003* ('the Act').

67. On 14 November 2018, the GP wrote a retrospective prescription for the Midazolam and Morphine.

Recollection of staff

68. There is conflicting evidence between the staff. A RN and PCW both familiar with Mrs Paluszak and who were working on the relevant day denied Mrs Paluszak was or had been unconscious before End of Life treatment was commenced. The PCW says Mrs Paluszak was a 'bit woozy'. The RN refused to administer the End of Life Medication when asked to by the CNC. She was, though, agreeable to administering Midazolam to provide relaxation to Mrs Paluszak.

69. According to the EN who checked out the Morphine with the CNC, the CNC told her that Mrs Paluszak was in a lot of pain and that she thought her agitation was related to pain. The EN thought Mrs Paluszak had a cerebral condition as she was trying to get off the bed and seemed confused.

70. The Residential Manager who sat with Mrs Paluszak before End of Life treatment was commenced thought Mrs Paluszak looked very unwell with periods of agitation, periods of sleep and that she felt clammy to touch.

Family's Understanding of Events

71. On 6 March 2018, Mrs Andersen, Mrs Paluszak's daughter, provided a statement to the Police. As referred to above Mrs Andersen is an assistant in nursing and was Mrs Paluszak's primary carer before she began residing in the RACF. Mrs Andersen had previously worked at a number of RACFs.

72. Mrs Andersen says she had trouble taking her mother's blood glucose level as it hurt, and she did not understand due to her dementia. Mrs Andersen said, *"…she would be difficult at times with most things and on other occasions she was happy with me doing anything. Her eating was the same in that she would not eat for a while then she would eat everything that she would see*".

73. Mrs Andersen recalls that shortly after Mrs Paluszak was admitted to the RACF, she had a conversation with a staff member at the RACF and the Director of Nursing. She says in that discussion they decided that if palliation were to be required that it was to be managed in the RACF.

74. Months before Mrs Paluszak passed away Mrs Andersen recalls having a conversation with the GP. He advised Mrs Paluszak was resistant to receiving insulin injections and he advised that he would be stopping the insulin. He said it would not have had much of an effect because she coped with a high blood glucose level every day.

75. Other than not being able to walk as far as previously Mrs Andersen did not notice any significant change in her mother until a couple of weeks before she passed away. Mrs Andersen says it was not uncommon for Mrs Paluszak not to get out of bed for days then she would spring to life late in the afternoon and be active throughout the night.

76. Mrs Andersen visited her mother once or twice a week but in August 2017 went away on an extended trip. On her return in mid-October, she did not notice any dramatic change in her mother's physical appearance.

77. The week prior to Mrs Paluszak's passing, Mrs Andersen and her husband took Mrs Paluszak for a drive. She thought Mrs Paluszak looked spaced out and she barely spoke which was unusual. She thought there was something not quite right with Mrs Paluszak. She wondered if she might have had a urinary tract infection and is pretty sure she mentioned that to staff.

78. On Friday 10 November 2017, when Mrs Andersen was getting ready to go to the RACF to see Mrs Paluszak, she received a phone call from the CNC. Mrs Andersen recalls the CNC saying, "*Mum's in a coma, I don't think that she is going to make it through the weekend", then "She's resting peacefully at the moment*". She says she was also told a '*heap of jargon'* which she did not understand.

79. Mrs Andersen also recalls the CNC saying, "*Charlotte's diabetes is really high the machine can't read it. We could send her to Hospital but she is resistant to Insulin so we would end up in the same boat as we are in now*". Mrs Andersen formed the impression Mrs Paluszak had had some sort of turn. She asked that the CNC ring her sister Monika to explain what was happening.

80. Mrs Andersen says she consulted her siblings, and it was decided to keep Mrs Paluszak at the RACF and manage her condition there. When Mrs Andersen went up to the RACF later that day Mrs Paluszak was resting peacefully. She states, "*It looked like she was going to be there for a really long time. Charlotte was not struggling to breathe; her skin was a good colour. I could not see that Charlotte was in any pain at all, she looked like she was just asleep*". Mrs Andersen stayed during the night and did not see Mrs Paluszak wake or stir. There were no signs of any pain and her breathing had not deteriorated.

81. Mrs Andersen left the RACF at around 3am and returned at around 8am. She did not notice any visible change in Mrs Paluszak. Later that day Mrs Paluszak started twitching which had not been observed previously. She advised a nurse, and two staff members came in to attend

Mrs Paluszak. A nurse administered more medication to Mrs Paluszak.

82. Mrs Andersen states, "*I did not understand why Charlotte was being given all of these drugs. I did not see Charlotte being in any pain. There was no contortion in her face and she was unconscious so she could not speak. I just did not see any symptoms or signs that Charlotte was in any pain*".

83. Mrs Andersen recalls soon after the medication was administered for the twitching, Mrs Paluszak's condition deteriorated gradually. Within an hour or so she could hear Mrs Paluszak's breathing becoming raspy (gurgling sound). Mrs Andersen was present when her mother passed away at around one or two o'clock that afternoon.

84. Mrs Andersen did not see and speak with the GP at any time during this period.

Investigation by the RACF

85. On 21 November 2017, the RACF was advised that an anonymous complaint had been made to the OHO. The complaint was made by a non-clinical staff member who worked at the RACF.

86. Executive Management from the head office of the RACF reviewed the iCare record of the residents. Nothing untoward was found but they were aware the GP did not use the iCare system but printed off hardcopy notes for filing in a resident's chart. There was no evidence of a case conference with the respective families before the GP commenced End of Life care.

87. A decision was made that two executive managers (the investigators) would fly up to Townsville the following morning to commence an investigation.

88. The RACF wrote to the CNC concerning a number of serious allegations which had been raised with the Aged Care Complaints Commissioner ('ACCC'). [It appears the ACCC had also notified the OHO of the allegations]. The CNC was stood down with pay and directed not to attend the site unless otherwise advised. The facility manager who had been on sick leave was told not to come to work.

89. Several staff from the RACF were interviewed with all interviews recorded and transcribed.

90. There were a number of allegations aimed directly at the CNC. She was interviewed by the investigators.

91. The CNC advised she had completed a Bachelor of Nursing at the James Cook University in 2012. This was in addition to a Diploma of Nursing Care that she obtained from the Central Queensland Institute of TAFE in 1999. Prior to working at the RACF, the CNC had held the Senior Clinical Nurse role at another RACF from October 2014. She had commenced work at the RACF on 7 November 2016.

92. It appears the CNC had previously received specialised training with The Palliative Approach Toolkit for Residential Aged Care Facilities, a National Government Incentive Comprehensive Evidence Based Palliative Approach in Residential Care Project. Following the training she became a palliative link nurse with her employer for three years which included ongoing support and training. The CNC provided extracts from the Palliative Care Palliative Approach Toolkit. She indicated the symptom criteria for End of Life Pathway include:

    - Experiencing day to day deterioration that is not reversible.
    - Requiring more frequent interventions.
    - Becoming semi-conscious with lapses into unconsciousness.
    - Increasing loss of ability to swallow.
    - Refusing or unable to take food, fluids or oral medications.
    - Irreversible weight loss.
    - An acute event has occurred requiring revision of treatment goals.
    - Becoming increasingly tired and weak.

- Breathing may become more difficult.

93. The CNC strongly denied the allegations made against her.

94. The RN subject to the complaints was not aware that the RACF End of Life policy required the GP to review the patient and case conference with the family before commencing the process.

95. On 24 November 2017, the RACF wrote to the RN advising that she had been stood down immediately on full pay until the investigation had been concluded. She was advised that the RACF was investigating complaints raised by the OHO. The allegation was the use of various medications to sedate, incapacitate and what appears to be intentionally deteriorate a resident's wellbeing.

96. The RACF investigators approached the Police. The Police advised that they had already received a complaint a number of weeks prior and had commenced an investigation. They spoke with the investigating Police officer. He enquired about the CNC and her role at the RACF.

97. The investigators found there was a practice at the RACF for the GP to prescribe End of Life medications on a resident's admission to the facility. This was not a practice of other facilities or other GPs. The GP was asked why he did this, and he told one of the investigators it was his normal practice. He said, "*I do this in all the facilities in which I work. My girls* (meaning the nurses) *know that they just ring me – it's never been a problem anywhere else*".

98. On 5 December 2017, the RACF sent a letter to the CNC. The letter outlined an overview of the investigation concerning the various allegations. The RACF found:

    (a) Residents were not commenced at a low dose of Morphine with an increase in the dosage subject to pain. Accordingly, the RACF policy had not been followed;

    (b) The CNC's response relating to the moving of Mrs Paluszak to the End of Life Pathway were not supported by accounts from other staff, nor her account into the events relating to the morning of 10 November 2017. Further, it was not supported by the site CCTV footage;

    (c) the allegation concerning Mrs Paluszak's family being told that Mrs Paluszak was resistant to insulin and that therefore End of Life palliation was commenced was not substantiated and that she was resistant to having blood glucose checked but not insulin. Further, she had a blood glucose level taken just prior to the End of Life Pathway being commenced. The RACF found therefore on the balance of probabilities the allegation was substantiated.

99. The RACF found another resident, was moved to an End of Life Pathway without appropriate procedures being followed. It was noted Morphine was given for pain but there was no pain assessment. The procedure was undertaken by another RN who reported to the CNC. The allegation that documents had been falsified for accreditation purposes could not be substantiated but it was found that documentation processes were not being followed or being adhered to according to the RACF policies.

100. In conclusion, the RACF advised the CNC:

> *Therefore, after investigation into all documentation, interviews with staff and on the balance of probabilities, the RACF have formed the view that it is unsafe to residents to continue your employment in the position of CNC. As such, we are terminating your employment effective from close of business, Wednesday, 6 December. You will be paid out two weeks in lieu of notice plus all outstanding entitlements owed to you.*

101. On 11 December 2017, the RACF wrote to the RN with an outcome of the investigation concerning the allegations that had been made. The allegation was concerning the inappropriate administration of Morphine and other medication without proper assessment, had been

substantiated. This related to two residents. A similar reason was provided as that to the CNC. That is, it was unsafe to residents to continue her employment and she was terminated on the same basis as the CNC.

102. On 31 January 2018, the solicitors for the RACF advised a full investigation was being undertaken internally by the RACF and that the solicitors had been engaged to undertake the investigation. The solicitor advised that a copy of an investigation report would be provided when the investigation was completed.

The Solicitor Report

103. The Solicitor Report is a 42-page document, dated 30 August 2018.

104. The Solicitor Report refers to an internal investigation conducted by the RACF. That investigation included reviewing the records of all residents who died at the RACF since it opened until they became aware of the complaint. The investigation revealed concerns in the End of Life care for the deceased persons.

105. In addition to terminating the CNC and the RN, the RACF manager was also terminated. The RACF reported all three nurses to the OHO.

106. The investigation involved a review of iCare, scanned paper files, and progress notes for five deceased residents. It also included a review of the Dangerous Drug Registers. The investigators also reviewed the records of meeting with staff and conducted further interviews with additional staff. Further, the various policies and procedures were considered, and CCTV footage relevant to Mrs Paluszak was reviewed.

107. I have been provided with a copy of the suite of relevant policies which were in place at the time. They were comprehensive.

108. The investigators communicated with the families of the deceased residents.

109. The summary of findings is stated as:

(a) *We have identified concerns with the actions taken by the CNC in relation to the End of Life care provided to Paluszak*, [other residents].

(b) *We have also identified some minor issues in relation to the processes followed with respect to* [resident] *however the issues identified in relation to* [resident's] *End of Life care primarily relate to documentation. The decision to commence End of Life treatment was made in consultation with [resident's] GP and his wife and appears to be reasonable and consistent with* [resident's] *wife's wishes*.

(c) End of Life medication was commenced for the five residents in a manner that was inconsistent with the RACF's policy, procedures and guidelines and without apparent appropriate review and oversight by the resident's GP.

(d) Although it was the actions of principally [the CNC], that was inappropriate (and on a number of occasions the RN under [the CNC's] *instruction), we have identified areas where the systems in place to identify issues with the End of Life treatment failed in that the issues were not identified by the organisation until the complaint was received.*

(e) [The CNC] *appears to have falsified documents which made the issues more difficult for the RACF to identify from an organisational perspective as her actions circumvented the systems that were in place to provide safe and reliable End of Life care.*

(f) End of Life medication was administered in accordance with the orders of the GP

(except for where [the RN] *administered Midazolam to* [resident] *outside of Doctor's orders, as detailed below).*

(g) *Pain assessment prior to administering Morphine was inadequate and on a number of occasions the dose was commenced at the maximum range of the PRN order rather than commencing at a lower dose. This action was particularly high risk in relation to* [resident] *who was commenced on 10mg Morphine Sulfate in circumstances where the documentation does not demonstrate that due consideration was given to the effects of the medication taking into account* [resident's] *low weight.*

110. With respect to recommendations, the author of the Solicitor Report states,

(a) *We recommend that* [the RACF] *takes a number of improvements and we acknowledge that at the date of this report these steps have already been taken by the RACF:*

i. *reviews systems and processes around the commencement of End of Life care (we acknowledge this has been done and improvements have been made – we recommend that* [the RACF] *closely monitors these improvements);*
ii. *considers whether checks can be built into the system to audit whether decisions made about care recipient's care based on signs or symptoms are consistent with documentary evidence of the care recipient's condition (rather than just the spoken word of one staff member);*
iii. *reviews whistleblower policy and revisits whistleblower training for staff (we acknowledge this process had been undertaken for* [the RACF] *– we recommend it is considered for other* [*RACF facilities too);*
iv. *continues to closely monitor* [the RACF] *and its staff.*

111. The solicitor was asked to clarify the allegation in the report that the CNC had falsified documents. The Coroner who was initially investigating the death of Mrs Paluszak (the former Coroner) was advised the findings in the Solicitor Report were based on a review of the limited evidence available at that time in relation to each resident.

Regarding Mrs Paluszak, the areas of concerns were:

(a) Ceasing insulin and diabetes management
i. The CNC reports continued refusal of insulin by the resident.
ii. No consistent evidence of refusal or non-compliance by the resident.
iii. The progress notes do not reflect an ongoing problem with the administration of insulin.
iv. Diabetic medication ceased without resident review.

(b) End of life assessment
i. The CNC completes End of Life Assessment and partially completes a care plan.
ii. End of Life Assessment and care plan records that resident was experiencing signs and symptoms associated with the 'terminal phase'.
iii. There was conflicting evidence with the conclusions reached in the End of Life Assessment and care plan.

(c) Progress notes and observations
i. The CNC's progress note of 10 November 2017 is inconsistent with the CCTV footage and progress notes of other staff and do not reflect back a lack of consciousness in the resident as

described by the CNC in her progress notes and End of Life Assessment.

(d) Administration of Morphine and Midazolam

i. The CNC's progress note at 12.09 on 10 November 2017 state that she administered 5mg of Midazolam and 10mg Morphine with the indication for palliation.
ii. Progress notes do not record resident was in pain.
iii. Progress notes record resident agitated.

The Coronial Investigation

112. As I have previously explained to the families of the deceased residents, in circumstances where disciplinary proceedings have been commenced, it is necessary and entirely appropriate in some circumstances for the presiding Coroner to wait until that process has been finalised. This to ensure the discipline proceedings are not compromised and all persons are afforded procedural fairness and natural justice. This was considered such a case given the nature of the allegations, and the extensive investigation initially by the Police, and then by the OHO.

113. The statements and the expert opinions obtained by the OHO and the Police were considered. A request for a statement was provided to the CNC. She was non-responsive to the request, and it was eventually agreed that the former Coroner would await the outcome of the OHO disciplinary proceedings.

114. A request for a statement was provided to the GP. The GP advised,

(a) He had always held an interest in Geriatric Medicine, particularly RACFs which he says is very demanding and poorly serviced by the medical profession.

(b) From February 2008 to 4 September 2019, he regularly serviced 10 RACFs with patient numbers at any one time ranging from 330 to the mid 400's.

(c) He would visit each RACF on a weekly basis and provide 24-hour phone support.

(d) In 2012, he sat the Diploma of Geriatric Medicine in the United Kingdom. It included a written exam and a face-to-face assessment in London. He regularly engaged in educational studies or courses which encountered Geriatric Medicine, for example, 'Training in palliative care'.

(e) He had developed a close working relationship with the Palliative Care Team at the Townsville University Hospital due to many of his patient's requiring palliative care.

(f) He knew the CNC from working with her previously at another RACF. She would help organise and assist him in his regular weekly ward rounds. In the after-hours situation she could be a person of contact at times depending on her roster when after-hours calls were required. He says he was always contacted by the CNC both in and after hours.

115. Regarding the prescription of End of Life medications on admission he states,

> *A letter was placed in all medication charts that these drugs could not be started without my instruction. That requirement was reinforced verbally many times to all nursing staff and pharmacies at all Nursing Homes. I also asked that those End of Life drugs not be supplied to the Nursing Home without my approval from the Pharmacy. This was reinforced to the staff and to the Pharmacy.*

116. He explained the reasons the drugs were written up on admission was because,

(a) Most residents in a Nursing Home will expire there rather than in Hospital. The

expectation generally is that this is where they lived and the Nursing Home is where they should die if they so wish. Most nursing home patients and families feel the nursing home is the most appropriate and comforting place for their final time. I believed writing medications up on the PRN chart to be best practice in nursing homes in the circumstances I experienced so as to minimise pain and discomfort to residents in their final days. I adopted this approach as a result of hearing a presentation by Dr Richard Corkill (Palliative Care Director, Townsville Hospital) in which he stated this was best practice in nursing homes where palliative care could be very substandard. There was a big effort to educate, provide the ability and tools to increase the standard of Palliative Care in nursing home patients where a significant percentage of Palliative care is required.

(b) *For a controlled drug to be given their* (sic) *must be a written order. Without that order most nursing staff will not take a verbal phone order, let alone give the drug. I would not expect them to do so. Due to the nature of my practice I may be several hours away on a day to day basis. I provide services to Charters Towers which is 138km from my practice centre. It may take me eight hours or more to attend the Nursing Home if I have been travelling. I also work every Wednesday often from 0700 to 2000 as a surgical assistant. During that work I am unable to leave the premises to attend a home.*

(c) *Few people have an interest in Aged Care making it very difficult to access help. If a patient is in pain or distress, I have no one to see the patient for me as I am a solo GP. The system had developed (with knowledge of my Specialists, nursing staff and Directors of Nursing) where, if needed, a dose of morphine or midazolam could be given when the patient was assessed by the RN and the CN (Charge Nurse) and her colleagues and, after consultation with me and, if possible, the EPOA. Sometimes the EPOA do not answer their calls or they do not have an EPOA as family. If someone is in pain and does not want to be transported to the local Hospital I believe it would be wrong to let them suffer. I would visit the patient as soon as possible and ask the nursing staff to remind me if I forget with my busy schedule.*

(d) *Due to the difficulty in obtaining locally trained staff the nursing homes employ a considerable number of overseas staff. English may not be their first language or they may have an accent which is difficult to comprehend for me or vice versa, especially on a mobile phone. In order to minimize the possibility of drug errors I have written these clearly and documented the reason to give the drug after I have been informed and the appropriate clinical context has been discussed with the CNC and Charge Nurse of the area if I am not in a situation to attend immediately and the patient needs urgent relief and does not wish to be transferred to the hospital.*

117. The GP advised the process was in place at every RACF he attended, and he had received positive feedback from many stakeholders. He states, “Consistent with standard medical and nursing practice, they are educated to start at the lowest dose and then assess the patient’s response”.

118. Regarding the care provided to Mrs Paluszak,

(a) On 10 November 2017, he was rung by the CNC at around 8.59am. She advised Mrs Paluszak had become semiconscious at the breakfast table and that she had been unable to lift her limbs or communicate with staff.

(b) He understood Mrs Paluszak was to be treated conservatively and remain at the RACF. He asked that the CNC confirm with the family this remained their position.

(c) He was working at another RACF and was unable to go to the RACF to physically assess Mrs Paluszak.

(d) The CNC telephoned him back to confirm the family had decided on a palliative approach for her care. He had a discussion with the CNC whether Mrs Paluszak met the requirement for commencing a resident on the End of Life Pathway. On the basis

he believed Mrs Paluszak would meet the criteria, he gave consent to commence her on Midazolam and Morphine, if and when required.

(e) In normal circumstances he would go to the RACF after his morning clinic or for a RN to call him if there had been a change in circumstances. His normal practice was to attend a patient who may be on End of Life medications once or twice a day depending on the situation.

(f) He was not phoned until the following day when Mrs Paluszak died. He would normally be rung to inform him of how the patient was progressing and to ask him to review the patient if required. This did not occur.

(g) The End of Life Assessment document was completed to assess if a person meets the criteria for the End of Life Pathway to commence. All RACFs in the Townsville district used the Queensland Government Residential Aged Care End of Life Pathway.

(h) In considering Mrs Paluszak's medical history and progress notes in the context of the Pathway, he is of the opinion Mrs Paluszak met the conditions for commencing the End of Life Pathway.

(i) He had no direct conversations with Mrs Paluszak's family after he was contacted by the CNC about the deterioration in Mrs Paluszak's condition.

119. The former Coroner was advised by the Police they had completed their investigation. (I refer to this further below).

120. In or around November 2019, the coronial investigation was held in abeyance until the outcome of the OHO disciplinary proceedings were complete.

121. Following the relatively recent notification by the OHO that QCAT had handed down its decision concerning the CNC, I obtained the voluminous investigation material which had been gathered by the OHO. I reviewed that material along with the information which had already been gathered by the former Coroner. I sought additional information from the OHO and from an expert who had provided an opinion to the OHO.

Aged Care Complaints Commissioner (now Aged Care Quality and Safety Commission)

122. The ACCC received a number of complaints in relation to the RACF. In February 2018, the ACCC referred the matter to the Australian Aged Care Quality Agency (AACQA). In October 2020, the AACQA was known as the Quality, Assessment and Monitoring Group within the Aged Care Quality and Safety Commission.

123. It was that noted a number of other agencies, including the Police and the OHO were investigating the allegations. The case was closed on 16 May 2018 on the basis that it was better dealt with by other agencies.

124. Mrs Paluszak's case was considered by the ACCC and Mrs Paluszak's family were contacted. They confirmed they held no concerns and that they were happy with the way the circumstances were currently being managed and as such did not wish to proceed with a complaint. No investigation was undertaken by the ACCC.

Police Investigation

125. The Police undertook an investigation into the alleged deaths. That included interviewing several staff and obtaining an expert medical opinion from a Forensic Physician.

126. On 4 June 2019, the former Coroner was advised that the investigation had been terminated as

a review of the medical evidence did not support a criminal prosecution of any involved person.

AACQA Audit and Accreditation

127. An audit of the RACF was undertaken by the AACQA from 5 December 2017 to 19 December 2017. The purpose of the audit was to review the RACF against 44 expected outcomes of the Accreditation Standards pursuant to the Aged Care Act 1977. A copy of the confidential version of the Audit Assessment Information Report (the Audit Report) was formally released to OHO by the AACQA on 9 March 2018.

128. The Audit Report identified that the facility had failed to meet six of the expected outcomes in the following areas:

- Human resource management
- Information systems
- Continuous improvement
- Clinical care
- Medication management
- Palliative care

129. A subsequent audit found that the facility failed again to meet the six expected outcomes listed above and three additional outcomes in pain management, continence management, and behavioural management.

130. A third audit was conducted in July 2018. The RACF met all 44 expected outcomes and has continued to be compliant with the standards since that date. The RACF is currently accredited until 7 October 2025.

OHO Investigation

131. The OHO commenced an investigation on 6 December 2017 under the Immediate Action Investigations Team and sought clinical advice concerning the deceased persons. The named persons in the complaint included the GP, the CNC, and the RN.

132. OHO investigators travelled to Townsville in March 2018 to undertake interviews with several witnesses who had not already been interviewed by the Police. They returned in September 2018 and worked with the Police to obtain further witness statements. The interviews were recorded, and a written summary of the evidence was made. Twenty-two statements were obtained by the OHO.

133. The OHO and the Police shared all statements and recorded interviews. These statements and recorded interviews were subsequently provided to this Court.

134. In addition, information was obtained from the RACF, the practitioners, other related parties, the Police, the ACCC, the AACQA, the THHS, other treating practitioners, the Coroners Court, and an independent clinical expert.

135. The independent clinical expert opinion was from Professor Phillip Good, Palliative Medicine. He provided his opinion concerning each of the deceased persons. I provide a summary of Professor Good's findings in relation to Mrs Paluszak:

(a) Professor Good was critical of the administration of 10 mg of subcutaneous Morphine as the initial dose to the resident. He states, "*I think this practice is substantially below the standard reasonably expected of a health practitioner with an equivalent level of training or experience*." Professor Good indicated that there are valid reasons for writing up palliative medications in advance, but this is on the basis that it has been explained to the patient and/or carers as they will have to pay for the prescription in

advance of the need for the medication. The problem if the medication is not written up is that the medications will not be available when they are required for symptom control. This can be a particular issue after hours and on weekends.

(b) A way to balance the risks is to have the medications written up in such a way that they are in safe doses, compliant with guidelines and administered by nurses after consultation with a doctor. The clinician should start with the lowest dose unless there are clear, documented reasons to start at a higher dose.

(c) Professor Good notes that multiple practitioners at the RACF had administered an initial dose of Morphine that was at the highest end or substantially higher than the lowest PRN dose. He says this practice is substantially below the standard reasonably expected of a health practitioner.

(d) Professor Good is of the opinion with the resident's various other conditions including dementia and her non-compliance with monitoring and injections of insulin, it would have been reasonable to treat her on a symptomatic basis as was adopted by the RACF. Professor Good says that in a patient who has long term high blood glucose readings due to non-compliance, it is highly likely that at some stage they may develop a hyperosmolar hyperglycaemic state. Professor Good says it is likely that she would have required acute treatment and that the decision to remain at the RACF was appropriate in the circumstances.

(e) Professor Good considers the phone conversation between the GP and the CNC was appropriate in terms of a discussion about the acute deterioration of the resident on that day which was on the background of a high risk of deterioration with chronic hyperglycaemia and the likely fact that she was entering the end stage of her life. He again is critical of the use of the higher end of the range when choosing the dosage of Morphine to be administered to the resident.

136. Professor Good concluded from his review of the material and the questions posed of him, that there were a number of good aspects of palliative care management demonstrated with the patients:

(a) The recognition that each of these people had advanced progressive illnesses and were at significant risk of deterioration.

(b) In almost all instances there was communication in advance with the patient's families about their medical condition and risk of deterioration.

(c) In the case of deterioration, the family was informed, and usually a discussion around return to hospital, staying at RACF, and goals of care.

(d) Appropriate medications were used for symptom control – Morphine, Midazolam and Hyoscine for pain, dyspnoea, agitation, and respiratory secretions.

137. The main ongoing concerns were the wide dose ranges of Morphine written up, the use of high (or highest) doses of the dose range, and the increase of Morphine doses without clear inadequate symptom control documentation.

138. Professor Good provided a number of 'Therapeutic Guidelines'. In the 'Starting opioid therapy in palliative care patients' guideline, the author states,

> *The initiation of an opioid requires cautious adjustment and frequent review because individuals vary markedly in their response. Best practice in starting opioid therapy is to start with a low dose and slowly adjust the dose until it controls the patient's pain. The initial opioid dose is determined by the previous medication used and the severity of the pain. Ensure the patient and their carers know who to contact if there are unexpected problems or concerns.*

139. On 9 May 2018, the OHO took immediate registration action against the CNC. Conditions were imposed on her registration which included she was not to have any involvement in the provision of any patient's End of Life or palliative care/treatment unless certain criteria were met; that she was not to administer any medication for palliative care on a sliding scale; and that she was to maintain and submit a log detailing contact with every patient who she provided palliative treatment and who was administered medications.

140. On 26 July 2019, the OHO took immediate registration action against the GP. Conditions were imposed on his registration which included that he was not to practise in a Residential Aged Care Facility; that he was not to be involved in any End of Life or palliative care/treatment in a Palliative Care setting; and that he was not to sign any Medical Certificate of Cause of Death.

141. On 3 March 2020, the OHO issued an information notice to the GP requiring a written response. This was provided.

142. On 27 August 2020, the OHO issued an information notice to the CNC requiring a written response. The CNC did not provide a response.

143. On 19 November 2020, the Coroners Court was advised the OHO had engaged three separate clinical experts to provide an independent opinion concerning the actions of each health professional.

144. On 1 December 2020, Dr Ulcoq an experienced GP with a special interest in palliative care provided her expert opinion to the OHO. She stated,

> *There are excellent resources available to the Medical Practitioner with clinical guidelines, flow charts and research around best practice in prescribing for End of Life medications in aged care settings. These guidelines are based around our legal requirements as a treating doctor and continually updated. These documents have been present in some format since 2013 or earlier.*
>
> *The practice of anticipatory prescribing of these medications when the patient is not on an 'End of Life' pathway is inappropriate and puts the patient, the nursing staff and the doctor at risk. In my opinion this is a dangerous practice.*

145. Regarding the care provided to Mrs Paluszak she opined,

(a) It was not appropriate to prescribe the End of Life medications on admission to the RACF as she was stable and not suffering a medical condition that would require an 'End of Life' Plan without clinical review by a doctor. She states, "*Anticipatory prescribing of these medications at this point in time was not appropriate*".

(b) It was not appropriate for the GP to agree to commence End of Life intervention when no assessment had been undertaken to identify a potential reversible cause for her semi-conscious state when she had been functional in the week or so prior. This could have included transfer for acute assessment and treatment.

(c) If urgent transfer for acute assessment had not been agreed by the family, then urgent assessment and examination by her treating doctor or a deputising service would have been an alternative. It was the doctor's role to meet with staff and her family before the 'End of Life' pathway was commenced. Mrs Paluszak had been functional prior to her acute deterioration.

(d) Without an autopsy or recent investigations prior to her death the cause of her deterioration is unknown. Type 2 diabetes and dementia are chronic conditions. The cause of death could have been sepsis, cerebrovascular accident (stroke), subarachnoid haemorrhage, electrolyte disturbance from her poorly treated type 2 diabetes mellitus, hypercalcemia and chronic kidney disease.

(e) The GPs conduct and performance were not substantially below the standard

reasonably expected of a GP. He provided basic care of her health issues as they arose, he referred her for review of her Type 2 diabetes and her vaginal prolapse and treated her ear infection. He made assumptions about her final illness that he believed to be correct but did not examine the patient to exclude a reversible cause.

146. On 8 December 2020, Ms Ashleigh Thain, a RN with Certificates III and IV in Community and Aged Care, and a Certificate IV in Training and Assessment provided her expert opinion to the OHO. She advised,

    (a) Aged Care is responsible for a large majority of Palliative Care delivery with only highly acutely unwell patients with uncontrolled symptoms being transferred to the hospital setting.

    (b) RNs in these settings play a pivotal role in the assessment and delivery of satisfactory 'End of Life' that reduces suffering and discomfort. They need adequate training and support as they are often autonomous in their practice.

    (c) The ethos of Palliative Care is neither to hasten nor postpone death. This is a difficult line to navigate with the strength of medications prescribed for 'End of Life' and the frailty of a dying body. A truly experienced, competent practitioner treads exceptionally lightly so as to provide comfort and alleviate distress without causing harm.

147. Regarding the care provided by the RN to Mrs Paluszak, she opined,

    (a) Failing a more descript record of the resident's pain, the initial dose of 10mg of Morphine to control respiratory symptoms was too high of a start dose. Mrs Paluszak was opioid naïve, and a safer option would be to titrate the dose in increasing amounts to gauge her responsiveness to the drug.

    (b) About the subsequent dose of 10mg of Morphine. On the records, it appears the medication was administered in response to 'increasing resps/agitation'. Morphine is not indicated for agitation as per the Palliative Care Standards and is not a reason to administer the drug. While it can suggest pain and discomfort, this was not appropriately documented. If Mrs Paluszak was suffering respiratory symptoms with an increased respiratory rate, this would warrant administration of a titrated dose, commencing at 2.5mg.

    (c) The documentation by the RN was of a low standard, with little information provided about the patient's status and level of comfort. She states,

        As an observer I find it very difficult from her documentation alone to follow the reasoning for her administration of schedule 8 medications and her decision-making process.

    (d) The RN appears to have lacked training or understanding required to deliver safe and competent care to these patients.

148. In relation to the prescription of the medications she states,

    I also believe that the prescribing range of the medications were too broad and did not provide the administering staff enough guidance to its use. The prescribing allowed an unnecessary risk to be taken.

149. On 19 January 2021, Ms Kate McGregor, Nurse Manager, Palliative and Aged Care, provided her expert opinion to the OHO. She provided an overview of the role of a CNC. Regarding the care provided to Mrs Paluszak she opined,

    (a) The documentation by the GP was unclear regarding the ceasing of insulin. The CNC should not have ceased the insulin without the GP documenting this and a case conference with the family.

(b) If the GP had made the decision to stop the insulin, there was still a requirement to monitor the resident. This could have included monthly blood tests or continuing blood glucose monitoring as the resident allowed. Mrs Paluszak did not appear to be consistently refusing the tests.

(c) When Mrs Paluszak became unwell on 10 November 2017, a transfer to hospital would have been considered best practice. Mrs Paluszak ate breakfast indicating she was feeling relatively well. A high blood sugar level usually signals a medical emergency.

(d) Notwithstanding Mrs Paluszak should have been transferred to the hospital, recommended best practice regarding the administration of Morphine and Midazolam is to start with the lowest dose possible to ensure a resident is comfortable and pain free. In addition, a pain assessment should be completed prior to Morphine being administered and Mrs Paluszak's renal impairment should have been taken into consideration.

(e) Mrs Paluszak did not meet the requirement for 'End of Life'. High blood sugar levels are generally reversable and should have been an indication for hospital transfer not palliative care.

(f) There is an indication Mrs Paluszak ate breakfast and spilt a drink. It is therefore not accurate that she was semi-conscious with lapses into unconsciousness. She was documented as moving in bed and had attempted to stand and fell, which could evidence weakness, but this does not support evidence of profound weakness or changes in her breathing patterns.

(g) It was inappropriate to cease Mrs Paluszak's oral medications without an assessment and clear documentation with a follow up conversation with the patient's GP. Best practice in this case would have been to transfer Mrs Paluszak to hospital for assessment.

(h) The progress notes are poorly written and lack any depth and the clinical decision making around the clinical care that was provided.

(i) It was inappropriate to take Mrs Paluszak out into the garden after she administered the End of Life medications as the CNC did not know how Mrs Paluszak would react to the medications.

150. On 25 January 2021, the Coroners Court was advised by the OHO that the Health Ombudsman had decided to refer the matter concerning the RN to the Director of Proceedings and it was for the Director of Proceedings to refer the matter to the Queensland Civil and Administrative Tribunal (QCAT).

151. On 26 February 2021, Mr Andrew Brown (who was the then Health Ombudsman), signed off on the OHO investigation report into the actions of the GP.

152. On 19 October 2021, an expert opinion was obtained by the OHO from Associate Professor Peter Gonski, a Geriatrician. He advised,

(a) The three major anticipatory medications prescribed by the GP all had a wide dosage range. The wide range of oral and subcutaneous Morphine left a lot of the decision making to nursing staff as to the dose to provide. He states,

> *There is a bottom dose and a top dose but it does not actually suggest a starting dose or how to increase the dose. Usually the starting dose would be the lower dose but I believe the range is very broad. Some doctors do write up this broad range although I would be inclined to suggest a smaller range to begin with. The expected standard would be providing more specific direction for these doses either in writing or subsequent verbal direction via GP or*

specialist at the time of patient deterioration. I do not believe that [the GP's] treatment is substantially below the standard which one would expect of him.

(b) The oral Morphine dose would usually be started at 2.5mg to 5mg not 10mg, the Morphine solution given subcutaneously is an adequate dose. The Midazolam would often be started at 2-2.5mg, rather than 5mg, particularly in someone who appeared quite frail.

(c) Frail elderly residents living in aged care facilities can deteriorate quite quickly and it is reasonable practice to have the medications prescribed in case of rapid deterioration, if the decision has already been made that acute deterioration will not be treated with acute medical treatment.

(d) He does not agree that transfer to hospital for Mrs Paluszak when she was deteriorating before her death would have been necessary and it seems she was rightly started on an End of Life Pathway.

(e) He agrees that the GP's communication and lack of physical presence during deterioration was substandard but did not believe his treatment overall was substantially below the standard one would expect of a GP.

(f) He agrees with Professor Good's opinions. The lower medication doses have been mentioned as being too high and the communication regarding increasing doses was lacking.

(g) The prescribing of anticipatory medications is reasonable practice. He states,

However as the time of the patient's/residents deterioration is not known there is a need for further communication with the GP with regard to starting the medication, what dose of medication is started and how quickly the medication dose should be increased. Regular follow-up either by phone or in person (a better alternative) by the doctor is required to review the patient's condition, their comfort and to review all medications.

153. On 30 July 2021, the Coroners Court was advised by the OHO that the Health Ombudsman had also referred the CNC and the GP to the Director of Proceedings for consideration of referral to QCAT.

154. On 12 November 2021, the Director of Proceedings referred the GP and the CNC to QCAT for discipline proceedings. A decision was pending concerning the RN.

155. On 1 April 2022, the GP provided a response to the OHO's allegations in the referral to QCAT. Concerning Mrs Paluszak, he says,

(a) The range of Morphine on an 'as required' basis was not excessive.

(b) It was not necessary or appropriate to provide nursing staff with an exact starting dose for PRN End of Life medication because the dosage required, if any, was not known at the time.

(c) Unless otherwise directed by a medical practitioner to commence at the higher dose, it is accepted nursing practice to administer the lowest prescribed dosage of any PRN medication when the medication is commenced.

(d) If an increase in dose is considered by nursing staff to be required, the medical practitioner must be consulted and provide that instruction based on the patient's clinical needs at that time.

(e) He frequently verbally educated nursing staff that End of Life medications cannot be started or increased without a specific verbal authority from him.

156. On 12 May 2022, the RN provided a response to the OHO allegations in the referral to QCAT. Concerning Mrs Paluszak, she says, having regard to the level of agitation and discomfort, it was appropriate for her to administer the dose she administered.

157. On 31 May 2022, the OHO advised the Coroners Court that on 23 December 2021, the Director of Proceedings had referred the RN to QCAT for discipline proceedings. The OHO indicated it was unlikely any hearing would occur before October 2022.

158. On 3 June 2022, the Coroners Court identified that the families of the deceased persons had not been advised of the disciplinary referrals by the Health Ombudsman (on 30 November 2021, the OHO had advised due to confidentiality restrictions under the Health Ombudsman Act 2013, the OHO was unable to inform the Next of Kin but had no objection to the Coroner informing the family). The family were subsequently informed by this Court.

159. On 3 June 2022, Professor Gonski was asked to consider the response by the GP. He did not form the opinion the actions by the GP were of an unprofessional or unsatisfactory professional performance. He did though think the dosages and prescribing could have been better. He says, "Nursing staff who have experience in palliative care and End of Life care would be able to use this range optimally".

160. On 13 July 2022, Ms Kym Pointon, Clinical Nurse Consultant – Geriatric Evaluation, was asked to provide an opinion concerning the actions of the RN. She advised she could not find any comprehensive assessment detail and findings in the records.

161. On 5 October 2022, the Coroners Court was advised on 5 August 2022, the Director of Proceedings had withdrawn the disciplinary proceedings against the GP. His conditions on his registration were revoked and there was to be no further regulatory response by the OHO. The OHO advised the GP's legal representatives,

> *It is necessarily the case that for disciplinary referrals regarding professional practice (as opposed to, for example, boundary issues or other referral conduct), the Director of Proceedings is informed and guided by professional advice.*
>
> *On this occasion, the Director maintains that the referral was validly made to the Tribunal on the basis of clinical opinion at that time. However, subsequent clinical advice was obtained which has caused the Director to no longer maintain these proceedings.*

162. The hearings concerning the RN and the CNC were not to occur prior to March 2023.

163. On 9 February 2023, the Coroners Court was advised on 9 February 2023, after submissions and material were provided by the RN to the Director of Proceedings, the referral notice to QCAT was withdrawn. On 22 February 2024[1], the OHO wrote to the complainant advising of the outcome concerning the RN. In detailed submissions by the RN, she denied the allegations made against her. In the letter, OHO states,

> *After the referral notice was filed,* [the RACF] *produced the End of Life Care Pathway for* [resident] *where* [the RN] *had documented that* [the resident's] *symptoms included agitation, respiratory difficulties, rattling respirations and pain which all required further actions.*
>
> *A careful review of the Further Care Action Sheet in the End of Life Care Pathway for Ms Paluszak indicated that* [the RN] *had documented her reasons (increasing respirations and agitation) as the reasons for providing Ms Paluszak with the highest dose of morphine sulphate.*
>
> *In addition to the above information,* [the RN] *provided a detailed submission outlining*

[1] This is the correct date

her recollection of the treatment provided to [residents] *and Ms Paluszak and the significant personal consequences she had suffered since 2017, partly due to the publicity this matter had attracted and partly due to tragic personal consequences.*

The Director also obtained external legal advice.

On the basis of the further information and submissions from [the RN]*, the Director decided to withdraw the disciplinary proceedings on 25 October 2022 after again considering the factors in section 103 of the Act.*

164. The hearing in QCAT concerning the CNC was delayed and a time had not been allocated.

165. On 30 May 2023, the Coroners Court was advised by the OHO that expert medical and nursing evidence had been filed in QCAT, and that an expert conclave was to potentially occur. The OHO was awaiting a determination from QCAT.

166. On 21 August 2023, the Coroners Court was advised by the OHO that the parties had reached a joint position on findings and sanction for the CNC. The OHO was awaiting directions from QCAT for the matter to proceed on an agreed basis.

167. On 10 October 2023, the Coroners Court was advised by the OHO that QCAT had issued directions for the parties to provide submissions and material to QCAT, with QCAT to determine the matter on the papers or alternatively list it for a hearing as soon as practicable after 20 November 2023.

168. On 4 December 2023, the Coroners Court was advised the parties were to provide written submissions by 15 December 2023, and the hearing brief by 18 December 2023.

169. On 27 March 2024, the OHO advised the Corners Court that QCAT sought submissions from the parties as to whether either party required an oral hearing. Both parties indicated to QCAT that an oral hearing was not required.

170. On 30 May 2024, I was advised the proceedings against the CNC had been finalised and that Judicial Member Rinaudo had handed down his written decision in QCAT. The decision is relatively brief at five pages. Judicial Member Rinaudo said the agreed facts can be broadly summarised as inadequate record keeping by the CNC. The CNC accepted that the criticism of her record keeping justified a conclusion of professional misconduct having regard to the context in which it occurred. In conclusion the judicial member states,

> *In this case, the Tribunal is satisfied that the agreed sanction and conditions are appropriate, having regard to the respondent's conduct.*
>
> *However, the Tribunal notes that:*
>
> *(a) it is concerned that some of the fault must fall on systemic issues and not solely on the respondent; and*
>
> *(b) insofar as the conditions are concerned, the Tribunal is sceptical that they will, given the time that has elapsed since the events the subject of the allegations took place, and the significant time the respondent has had for self-reflection, have much beneficial effect.*
>
> *Noting these observations, the Tribunal considers that the proposed sanction does not fall outside of the permissible range.*

171. Judicial Member Rinaudo made the following Orders:

> *Pursuant to s 107(2)(b)(iii) of the Health Ombudsman Act 2013 (Qld), the respondent has behaved in a way that constitutes professional misconduct.*

Pursuant to s 107(3)(a) of the Health Ombudsman Act 2013 (Qld), the respondent is reprimanded.

Pursuant to s 107(3)(b) of the Health Ombudsman Act 2013 (Qld), conditions are imposed on the respondent's registration as follows:

(a) the respondent shall undertake education and successfully complete a program/s of education, approved by the Nursing and Midwifery Board of Australia, including a reflective practice report in relation to medication and maintaining appropriate records within the palliative care setting; and

(b) the respondent shall be, when practicing as an enrolled or registered nurse, required to consult with a registered nurse of not less than 10 years' experience in the area of practice of the respondent, approved by the Board, on a monthly basis, for the purpose of reviewing a sample of the respondent's records kept during the preceding month and receiving feedback and guidance as to those records for a minimum of six months and until the supervising registered nurse is satisfied with the respondent's record keeping.

Pursuant to s 196(3) of the Health Practitioner Regulation National Law (Queensland), the conditions imposed on the respondent's registration are subject to a review period of 12 months.

Pursuant to s 62(2)(a)(ii) of the Health Ombudsman Act 2013 (Qld), the immediate action imposed by the Health Ombudsman (effective from 9 May 2019 and varied on 11 July 2019) is set aside.

No order as to costs.

The OHO Material

172. The allegations against the CNC pressed by OHO at QCAT concerning Mrs Paluszak are:

Mrs Paluszak's health declined during 2017.

On the morning of 10 November 2017, a personal care worker reported to the respondent that Mrs Paluszak had lost strength in her arms and legs and had become unconscious.

The respondent observed that Mrs Paluszak:
(a) was not aware of her surroundings;
(b) was weak and unstable on her feet;
(c) was speaking in her native German;
(d) did not appear to understand what was said to her;
(e) had very high blood sugar.

The respondent recorded some of her observations of Mrs Paluszak at 8.59am and spoke to [the GP].

Later that morning Mrs Paluszak collapsed. The respondent again contacted [the GP] *by telephone.* [The GP] *directed that Mrs Paluszak be given midazolam "for agitation" and Morphine "if required".*

On 10 November 2017, at 12.09pm the respondent administered 5mg midazolam and 10mg Morphine sulphate by injection, the highest dose of Morphine sulphate in the End of Life prescription range prescribed by [the GP]. *Later that afternoon the respondent prepared an End of Life Assessment Form and an End of Life Care Plan for Mrs*

Paluszak.

The respondent did not provide any care to Mrs Paluszak on 11 November 2017.

Mrs Paluszak died at 3.15pm 11 November 2017. The respondent was not present.

The respondent:

(a) administered the highest dose of Morphine sulphate by injection in the prescription range, without documenting any pain assessment or sufficient reason to justify the dose administered;

(b) failed to maintain appropriate records in relation to the care that she provided to Mrs Paluszak, in that the records she made did not include various information and observations…

173. Further, in its submissions, the OHO states,

> *The respondent has provided what she considers to be mitigating circumstances. Her explanations in this regard are not consistent with that of the former Executive Manager Aged Care Services for* [the RACF] *Community Services Group which managed* [the RACF] *and the respondent. The applicant submits that in circumstances where the parties have an agreed position as to determination and sanction in the form proposed, it is not necessary for the Tribunal to resolve this conflict.*

174. The OHO relied on the evidence of:

(a) Professor Good who in essence, maintained his position that it would be standard practice to start at the lower end of the dose range unless there were particularly severe symptoms. The note that Morphine was commenced for 'palliation' did not explain its use.

(b) Ms McGregor outlined the expectations of a CNC working in an aged care facility and opined,

> *An End of Life process should not be commenced without discussing this process with the resident's GP, the resident (if they have capacity) and the resident's next of kin (NOK). Best practice is that the GP reviews a resident prior to commencing an End of Life pathway. The GP will be signing the death certificate and they may have more knowledge around medical decisions including whether a patient should or should not be transferred to hospital, medication changes that need to be made once commencing an End of Life pathway and recommendations around dosages of End of Life medication at the specific time.*

(c) Her concerns about the CNC's administration of the medications to Mrs Paluszak were:

(a) The progress notes do not detail why Morphine was administered. 'Palliation' is not a sufficient reason to provide medications. Reasons for providing medications would include pain, agitation etc. It is standard practice for RNs when administering PRN medications that sufficient details are documented to explain why the PRN medication was administered.

(b) It is standard practice for RNs administering PRN medications to administer the lowest/low dose and then monitor to assess the effectiveness and side effects of the PRN medications.

(c) Where a decision is made by an RN to administer a higher dose of PRN medication, this should be clearly documented in the records.

(d) There is no indication that Ms Paluszak was in any pain requiring Morphine. The records indicate Ms Paluszak was agitated. In that instance, it would have been appropriate to have administered midazolam in a lower dose to ascertain if this medication was effective in dealing with Ms Paluszak's agitation.

She is of the view in the records, there is no evidence of:

Significant weight loss.
Deterioration that is not reversible (because no medical practitioner assessed Ms Paluszak).
Ms Paluszak refusing or unable to take food, fluids or oral medications in the weeks prior to her death.
Changes in Ms Paluszak's breathing patterns.
Ms Paluszak was at breakfast and was moving sufficiently enough to try and toilet herself. This is inconsistent with the assessment that Ms Paluszak was semi-conscious and had profound weakness.

175. The OHO considered the evidence of the Executive Manager from the RACF. This related to the iCare system (electronic record system), and the employment and training of the CNC. In summary the Executive Manager advised,

(a) Computers with access to iCare were located in strategic areas and staff were required to use the computers to access iCare.

(b) Each staff member had an individual login username and password to access the system.

(c) All users could enter new records such as progress notes into the system.

(d) The CNC was provided the Employee Guideline Handbook on commencement. The Handbook contained a section about how to access resources including policies and procedures on site. [I have reviewed the Handbook, it contains around 50 pages of information]

(e) On 1 November 2016, the CNC signed an acknowledgement of the RACF employee guidelines confirming that she would work within the framework of the RACF employee guidelines.

(f) On 7 November 2016, the CNC signed the position description for her role.

(g) As part of her induction, the CNC attended a three day orientation program, and she signed to confirm the training had been provided. Her training included the RACF's intranet and search functions. This included where to find the RACF's policies and procedures. The training also included use of the iCare system.

(h) On 8 November 2016, the CNC undertook a medication assistance test and indicated she was aware of the RACF Medication Management policies and procedures could be located in the intranet library. [I have reviewed this document, and noted that, it has been countersigned by another clinician]

(i) On 28 December 2016, a skill assessment was undertaken to confirm the CNC could complete a variety of iCare tasks. The documentation completed indicated the CNC was proficient in the use of iCare, including completing assessment documentation in iCare. [I have reviewed the Skills assessment documents. It appears there was no 'assessor' and that the CNC completed the document herself. The exception being the MedMobile which was counter signed by an 'assessor'].

The CNC's Version of Events

176. The CNC provided a detailed version of events by affidavit dated 14 March 2023. This was the CNCs first fulsome explanation provided outside of her initial interview with the RACF investigators in late 2017.

177. The CNC outlined her employment history. Relevantly,

    (a) From 1999 to 2013, she worked in both the aged care and acute care settings as an Enrolled Nurse (EN).

    (b) In 2011 and 2012, while completing her Bachelor of Nursing Science she achieved the highest overall scores for the cohort in clinical competency assessments.

    (c) In March 2013, she commenced work as a Registered Nurse in an aged care setting. From April 2014, she was the Acting Clinical Nurse Manager and from October 2014 to November 2016 she was the Senior Clinical Nurse.

178. The CNC has provided a detailed list of the continuing professional development she had completed since becoming a Registered Nurse. Relevantly,

    (a) On 3 December 2013, she undertook training in the Palliative Approach Toolkit for Residential Aged Care Facilities, a one-day course run by Queensland Health in collaboration with Griffith University which focused on use of the Toolkit that had been developed.

    (b) In May 2014, she participated in a three hour Clinical Workshop for Nurses that included a module on Specific Care Issues for Older People and discussed pain and palliative care.

    (c) On 13 July 2016, she undertook eight hours of study through the Palliative Care Curriculum for Undergraduates.

179. The CNC commenced at the RACF and completed her orientation between 7 and 9 November 2016.

180. The CNC says in the first two weeks of her employment, the Care Manager was terminated, and states,

> *As a consequence of this, I did not have a proper orientation because the person I was reporting to was no longer there. This was extremely difficult because I did not have the appropriate knowledge and understanding of the organisation to do my work efficiently at this time.*

181. The CNC is critical of the policies and procedures manual advising that, because of its size, it was difficult to navigate. She says there was no index and only a basic search function. She says she does not recall the End of Life policy and procedure being provided to her. She may have seen the Advanced Care Planning Clinical Practice Guideline or the Pain Management Clinical Practice Guideline but could not now recall. She only recalls a vague policy on End of Life and having access to the End of Life Assessment and End of Life Care Plan forms in iCare.

182. The CNC says she created a 'Departure Kit' (similar to what she had used in her previous role). It included, the basic End of Life policy, the relevant iCare forms, the life extinct forms, a list of funeral homes and their contact details, and a document she created which was a form to be filled out detailing the deceased person's name, date of birth and next of kin. The CNC states,

> *I accept that the processes and procedures around End of Life care and this kit should have been more comprehensive than this but this was the best that I could do at the time. I created the Departure Kit when I had a very significant workload due to the Facility being in the 'commissioning stage'.*

There was, in my view, inadequate support from upper levels of management who were responsible for the organisation's policies and procedures around these matters and there was not the time to be able to develop these resources more thoroughly at this time. It was my intention to do so however an opportunity did not arise due to the work I was required to do.

183. The CNC first met the GP in 2000 when she was working as an EN in a RACF the GP visited. She says she did not have much to do with him because she was an EN at the time. She also worked with him on and off for about five years prior to working with him at the RACF where Mrs Paluszak resided. She was of the view they had a good working relationship. He would visit on Tuesdays and given the number of patients and RACFs he was attending it was very difficult for him to come outside his scheduled day. She states,

> *If a resident was deteriorating and entering the palliative stage,* [the GP] *would try and come out within 24 hours of being notified however sometimes that was not possible.*

184. Regarding medication administration, the CNC acknowledged the GP would order a sliding scale. She states,

> *When I administered medication in accordance with one of these orders, I would usually commence administration at the lowest dose on the sliding scale unless there was a reason not to.*

185. The CNC sets out her duties. She advised there were five different Care Managers at the RACF in the first 12 months and states,

> *It was extremely chaotic because there was no consistent leadership for the duration of my employment and it meant that I was often given duties of the Care Manager to perform in addition to my duties of Clinical Nurse. I often did not have anyone to discuss important issues with and help me make decisions.*

186. The CNC outlined the burden of her role and the impact the ongoing commissioning of the RACF had on her. She states,

> *It was an extremely busy time and so it was hard for me to meet all the requirements of my job description. The physical care of the residents always came first, therefore documentation was frequently sacrificed to ensure adequate care was given. This meant assessments, progress notes and clinical follow ups were often delayed and not always documented or documented thoroughly.*

187. The CNC has outlined a detailed version of events concerning her care of Mrs Paluszak. In summary,

    (a) From handovers she had heard Mrs Paluszak had been deteriorating over the seven weeks before her death.

    (b) On 10 November 2017, she was notified of an acute episode in the dining room where Mrs Paluszak became semi conscious. She thought in the context of the recent deterioration that her deterioration was rapidly accelerating.

    (c) She went to the dining room and assessed Mrs Paluszak and then assisted the PCW get Mrs Paluszak back to her room. She was noted to be weak and unstable on her feet. Observations were taken and Mrs Paluszak's blood glucose was high.

    (d) Mrs Paluszak was left in the care of the PCW and while she went to check on another patient, Mrs Paluszak had a fall. She was placed back to bed.

    (e) She noticed Mrs Paluszak was becoming quite agitated and was again in and out of consciousness.

(f) She telephoned the GP to inform him of Mrs Paluszak's condition. The GP was in Charters Towers visiting a RACF. She reported the events of the morning. He told her to call Mrs Paluszak's family to see how they wanted her treated.

(g) She tried calling Mrs Paluszak's daughter but was unable to get hold of her. She left an urgent message to call back. In the meantime, at 8.59am, she made an entry in the progress notes.

188. Shortly after she was able to speak with Mrs Paluszak's daughter. From this point forward, the CNC states,

> *I told Petra what had happened with Lotte that morning and that I considered she was very unwell. I said to Petra that her collapsing was very similar to her episodes of her collapsing in the last few weeks.*
>
> *I said that we had tried to get a blood sugar reading however her blood sugar so high that we could not take a reading. I said that I thought her high blood sugar levels were probably contributing to her semiconscious state.*
>
> *I asked Petra what she would like us to do specifically, whether she would like us to send her mum to hospital or keep her at the facility and monitor her here.*
>
> *Petra stated that she did not want her mum to be moved and she wanted us to continue monitoring her at the facility. She said that sending her to a hospital would be traumatic and disorientating to her because of her dementia.*
>
> *I explained there was medication we could give her at the facility to keep her comfortable and I explained what it was. She said she was happy for us to give the medication to her Mum. We did not discuss treating the diabetes due to the previous decision to stop insulin.*
>
> *I advised Petra that I would be calling the doctor straight away so that I could discuss. I told Petra I would call her back after I spoke to the doctor.*
>
> *I also made a phone call to Petra's sister, Monica* (sic)*, to explain the same things to her. She was in agreement with Petra that Lotte should stay at the Facility.*
>
> *I then called* [the GP]. [The GP] *told me he had already spoken to* [a nurse] *about Lotte's fall in the meantime and told her to start the palliative medication if required.*
>
> *He gave me an order for Lotte to be given Morphine and Midazolam in accordance with the End of Life medication prescribed at the commencement of her residency at the facility.*
>
> *He said not to give any insulin because she had not had any insulin for many months and was very combative. He said it may not help the situation and could create too much fluctuation in her blood sugar levels. After this phone call I spoke to Petra and Monica, and I advised them of* [the GP's] *views. They both advised me that they agreed for Lotte to be palliated and said to me words to the effect that they wanted her to be comfortable and pain-free.*
>
> *I had a discussion with* [a nurse] *about setting up and preparing a subcutaneous needle to administer the Morphine and Midazolam.*
>
> *I then advised* [a nurse] *of the situation and the conversations I had had with Lotte's daughters.*
>
> *At 11:33am I made the following records in the progress notes:*
> *'Lotte has since had a fall in her bathroom attempting to toilet herself. Nil injuries noted.*

However, she is becoming weak and agitated. CNC phoned both daughters Petra and Monika back to discuss Lotte 's condition. They have both confirmed they do not want Lotte transferred to hospital and they wish her to be cared for at [the RACF]*. They are happy for her to be given palliative medication as required. CNC phoned GP to advise of NOK wishes. GP directed to give Midazolam for agitation and Morphine if required.'*

[A nurse] *and I then set up the subcutaneous needle and we went to the drug cupboard to remove the Midazolam and Morphine. I removed one Morphine 10mg /mL 1 ml ampoule and on Midazolam 5mg/mL 1 mg ampoule.*

I then returned to the room with [a nurse] *and I administered 10 mg of Morphine and 5 mg of Midazolam to Lotte subcutaneously.*

In the case of Lotte, I considered 10mg of Morphine was warranted because:
(a) she was very agitated ;
(b) she had a lot of strength in her, meaning I did not think the highest dose would be too much for her to handle;
(c) she had significant discomfort which I observed by strong facial grimacing, elevated body temperature and being belligerent;
and
(d) it would make her more comfortable for longer.

Because of her significant pain and agitation I considered that if I started at a lower dose and it was not high enough she would be in pain until the next dose could be given.

At 12:09 pm I made the following record in the progress notes:
'Morphine 10 mg given for palliation.'

The medication started to work within 15 or 20 minutes. Lotte's agitation reduced somewhat however she was still trying to get out of bed and I was concerned that she might succeed and have another fall. This would be even more likely given that she was being medicated.

I decided that the room and all the people in it might be making her agitated so it would be beneficial to take her outside briefly in the wheelchair.

I assisted her into a wheelchair with another staff member but I cannot recall who.

I took her outside for 10 minutes. She was awake in the wheelchair but was getting drowsy. I took her back to her room when she got drowsy.

When we returned to the unit, [a nurse] *hoisted Lotte into her bed and made her comfortable.*

After Lotte was settled I did not care for her again on this shift.

At 1 :07pm I made the following record in the progress notes:
' Lotte settled well, resting in bed, nil further agitation or distress. '

At 3:50 pm I made the following record in the progress notes:
'All oral medications have been ceased. Palliative medications are being given via subcut.'

At 1:55pm I completed an End of Life Assessment for Ms Paluszak.

At 2:24pm I completed an iCare End of Life Care Plan for Ms Paluszak.

I did not conduct a written pain assessment because there was a standing order in place that allowed us to give medication to treat her pain levels and I had conveyed all

relevant information to [the GP].

On 10 November 2017, at 4.00pm I completed a RAC EoLCP for Ms Paluszak.

I kept in contact with [a nurse] *who was checking on her throughout the rest of my shift.*

During the handover I advised the afternoon staff of what had transpired and the doctor had directed that Lotte be palliated with the consent of the family.

I was not rostered to work 11 November 2017.

Professor Good's response

189. Professor Good opines Morphine is not used for 'agitation'. Agitation is an indication for the use of Midazolam.

190. There is no clinical basis for choosing a higher dose of Morphine – unless a lower dose had been tried and found not to be effective.

191. Having severe or significant discomfort could be an appropriate clinical justification and would need to be documented.

192. To try and make a patient more comfortable for longer is not a clinical justification to give the highest dose in the range. If the lowest does is used and the patient still has ongoing symptoms before the time is allowed for the next PRN dose, it is appropriate to contact the prescriber to discuss what should be done.

193. Mrs Paluszak suffered chronic renal failure which warranted an even more cautious use of Morphine.

RACF's Executive Manager's response

194. The toolkit referred to by the CNC indicates doses of medications being proportionate to the severity of symptoms and response to treatment should be regularly assessed. The Executive Manager states,

> *The toolkit recommends at pages 15, 17 and 19 residents on End of Life care require two hourly symptom assessment to enable emergent symptoms to be detected quickly and treated pharmacology. The efficacy of administered medications should be evaluated and documented.*

195. She states regarding the use of the Morphine and Midazolam,

> *The toolkit provides advice at page 9 that midazolam could be used for anxiety, seizures, terminal agitation/restlessness and/or sedation.*
>
> *Morphine sulphate could be used for pain and/or shortness of breath. The toolkit advises at page 9 that Morphine sulphate is not tolerated in residents with poor renal function as it can cause confusion, myoclonus and other effects of narcotic toxicity. It also recommended at pages 15 and 17 that opioid naive residents requiring opioids to manage pain should be commenced on the lowest opioid dose possible and that careful upward titration minimises the risk of toxicity.*

196. The Executive Manager has set out in detail a response to the allegations by the CNC that she did not have proper orientation; that she did not have appropriate knowledge and understanding of the organisation; and that there was no consistent leadership; and that she did not have anyone to discuss important issues with and help her make decisions. I do not set out those

responses herein but, in essence, she outlines the information and support which was available to the CNC and rejects several of the assertions by the CNC. She makes what I consider to be a relevant observation:

> *The Respondent was an experienced Level 3 Registered Nurse (often referred to as a Clinical Nurse Consultant or Clinical Manager) with extensive experience in aged care. In my experience the duties and responsibilities of a level 3 Registered Nurse are the same or very similar across residential aged care facilities. Given the level of experience of the Respondent, I would expect that she would be familiar with the overarching principles of providing End of Life care and the level of documentation expected when providing this care.*

197. The Executive Manager opines opioid naivety, stock availability, and staff concerns are not valid reasons for not commencing administration of End of Life medications at the lowest dose.

198. Regarding staffing and access to the computer systems, there is no evidence of understaffing on the relevant shifts and there is no evidence the computer system, iCare, was not operational. There were computers able to be accessed on each floor of the RACF.

199. The RACF does not accept the CNC was involved in the extent of commissioning of the RACF as alluded to by the CNC.

Further Expert Evidence

200. Mr David Ruzicka a Nurse Practitioner in palliative care provided an opinion on behalf of the CNC. Regarding the care provided to Mrs Paluszak, he advised,

(a) The highest dose of subcutaneous Morphine administered by the CNC would be considered high in the circumstances, including that she had not previously been administered Morphine orally or subcutaneously before.

(b) Mrs Paluszak was not completely opioid naive as she had had Tramadol 50mg as PRN doses (equivalent to about 10mg of oral Morphine).

(c) The reference ‘given for palliation’ would not constitute a reasonable rationale for administering this type of dose of PRN medication.

(d) Despite the reasoning for giving a dose of 10mg, he states,

> *Although this gives greater depth to the (CNC’s) clinical reasoning, it still would have been more aligned to best practice to keep the initial SC Morphine dose to within 2.5-5mg which is the typical range of SC Morphine used in anticipatory prescribing for End of Life care.*

(e) The dose administered was still within the parameters of the PRN order made by the GP.

(f) The assessment by the CNC prior to administering the highest dose of subcutaneous Morphine was ‘certainly below what would be considered best practice’.

(g) The clinical reasoning subsequently provided by the CNC would be sufficient to suggest Mrs Paluszak was in pain and would benefit from the administration of Morphine. However, it would have been more aligned to best practice to keep the initial SC Morphine dose to within 2.5-5mg. He states,

> *I do believe that it is important to consider the context of the situation as has been previously noted: that the dose administered was still within the prescribed PRN parameters by the GP, was being administered for an appropriate palliative care symptom/s as per the respondent’s affidavit and was*

> *in the setting of a deteriorating patient with a palliative care diagnosis in documented consultation with the patient's family and GP, with the goal of care to remain in the residential aged care facility for palliation/End of Life care and to avoid a hospital admission.*

201. Professor Janet Rea Hardy, a physician who has an international profile in palliative care research and management, provided an opinion on behalf of the CNC. As a general observation she states,

> *In my opinion,* [the CNC] *had the advantage of knowledge of the patients in question and their deteriorating conditions prior to the events under review and assessed them adequately under the guidance of* [the GP]. *In my opinion, from review of the records only, all patients in question were approaching the end of life.*

202. Concerning Mrs Paluszak, she advised,

    (a) Accepting the reasons for giving the 10mg of Morphine were that the patient was very agitated; was in significant discomfort; needed prolonged sedation until time of the next charted breakthrough dose, she states,

    > *While many would have given a mid-range dose in this situation (5mg), review the effect and repeat if necessary, in my opinion, the dose delivered in this instance was consistent with a reasonable, considered treatment plan for the patient and was given in accordance with medication orders confirmed by [the GP].*

    (b) From her view, adequate records were kept concerning Mrs Paluszak.

    (c) In her opinion, the decision to commence Morphine was adequately considered by the CNC under the guidance of the GP.

    (d) Concerning the opinion expressed by Professor Good, she states,

    > *The CNC role at* [the RACF] *is to "to practice independently, whilst supporting a team and to "adopt a problem solving approach" (CNC position description).* [The CNC] *had the advantage of having reviewed the patients under review over a period of time prior to their terminal event; these events did not occur in isolation. It was the practice of* [the GP] *to chart the same range of medications for all patients in anticipation of the need for palliation/End of Life care, and to rely on the expertise of senior nurses to use their judgement in delivering same (GP note: ..." Morphine s/c may be used at the RN's discretion").This seems reasonable in the environment in which the clinicians were working. In my experience, nursing staff will often initiate treatment at the upper range doses if they are concerned by patient distress/symptom burden. In most hospital/hospice based practices, patients as described above would have been commenced on a continuous subcutaneous infusion of Morphine (commonly known as a syringe driver) with extra doses (prns) as indicated.* [The CNC] *did request this to be started on one occasion…but the GP advised "not at this stage as now well controlled..." The use of syringe drivers on a regular basis is presumably not practicable at* [at the RACF]*, presumably because of the need for 24 hourly review and re-charting according to the number, of extra (prn) doses given. This is another reason why prn doses had to be sufficient to relieve symptoms until the next dose was due.*
    >
    > *Professor Good states that* [the CNC] *"did not appropriately detail the reasons for providing the highest dose of morpine in the range". These reasons have subsequently been provided by* [the CNC] *both in her general statement and when discussing each of the cases.* [The CNC] *also states that on many occasions, she had delivered Morphine at the lower end of the range consistent*

with the patients symptoms…

It is common practice in the palliative care/hospice setting to deliver opioids that are not dependent on renal function for their elimination eg fentanyl or buprenorphine. There is no option for the delivery of any other opioid other than Morphine in the cases described above.

Morphine and its metabolites accumulate in patients with renal impairment. This can be advantageous when palliating patients with renal failure at the End of Life as the analgesic effect lasts longer, thus reducing the need for repeated doses.

The RN's Version of Events

203. The RN says given the level of agitation and discomfort displayed by Mrs Paluszak, it was appropriate to administer the doses of medication she did. She says she was influenced in her clinical decision making because the same dose had been administered previously to Mrs Paluszak and that she had tolerated that medication. Further, that she had understood the previous administration had been determined in consultation with the patient's medical practitioner and a Clinical Nurse (the CNC). In submissions made on behalf of the RN, the author of those submissions writes,

> *The individual clinician remains responsible for the assessment and has authority to administer within the range prescribed based on that assessment. The practitioner that is present at the time of making the assessment is the only person with a full picture of the patient's condition.*

Response by Ms Pointon and the OHO

204. The OHO relied on the evidence of Ms Pointon. She maintained her opinion that it was not appropriate to deliver a dosage at 10mg without a formal clinical assessment. She is of the view opioid naïve residents requiring opioids to manage symptoms should be commenced on the lowest opioid dose possible with careful titration upwards to minimise the risk of toxicity. Second hourly monitoring of efficacy and symptoms is recommended.

205. Ms Pointon was also critical of the RNs limited documentation and felt the overall standard of clinical care provided to the residents was below an acceptable standard and lacked a holistic approach.

206. The OHO conceded after a careful review of the Further Care Action Sheet in the End of Life Care Pathway for Mrs Paluszak that the RN had documented her reasons (increasing respirations and agitation) as the reasons for providing Mrs Paluszak with the highest dose of Morphine sulphate.

Explanation from OHO

207. It took approximately six and half years for the OHO investigation and proceedings to be completed. I sought an explanation from the OHO. I have been advised,

    (a) There was a delay in the investigation between March 2018 and the end of August 2018 due to the need to defer the investigation at the request of the Police to ensure the criminal investigation was not compromised. After this time the Police and the OHO worked in tandem in gathering information, including statements.

    (b) On 4 April 2019, the OHO sought a copy of the Police brief of evidence but was deferred to this Court. A request was made to the former Coroner on 31 May 2019 and 30 July

2019.

(c) On 2 August 2019, the OHO was advised the coronial brief had not been compiled but information that was available was shared with the OHO.

On 5 November 2019, the OHO sought the former Coroner's view on proceeding with its investigation. On 7 November 2019, the former Coroner confirmed an inquest was not scheduled and the former Coroner advised she would be assisted by receiving the outcome of the OHO's investigation prior to making a final determination as to whether an inquest was to be held. The OHO subsequently decided to proceed with its investigation.

(d) The OHO has advised,

> *The OHO considers that from December 2018, the OHO was awaiting confirmation from the QPS that OHO interviewing the practitioners would not compromise the QPS investigation and/or the coronial process and was awaiting receipt of the additional information contained in the brief. During this period, no active investigation was being undertaken. OHO accepts that these outstanding issues should have been followed up more promptly, and the issues raised with Coroner Wilson on 5 November 2019, would have been more appropriately raised earlier (for example in April/May 2019) to have enabled the OHO investigation to be finalised earlier.*

(e) Between November 2019 and early 2021, the OHO sought additional material, including from the relevant practitioners, and experts. The materials were reviewed, and investigation reports prepared. The matter was then referred to the Director of Proceedings (DOP).

(f) Following referral by the Director of Proceedings in November/December 2021, there was a delay in the proceedings by several months due to an application by the RACF to be joined to the disciplinary proceedings. Ultimately the application was withdrawn.

(g) In April 2022, the CNC filed material that she did not accept the allegations made against her. Eventually on 4 August 2023, the parties advised QCAT they had reached an agreement on a joint proposal of findings and sanction. An amended agreed facts was filed on 25 October 2023. All material was filed with QCAT on 21 December 2023. The parties provided submission in January 2024 that an oral hearing was not required.

208. The OHO has confirmed none of the family of any of the deceased residents had made a complaint to the OHO. They therefore were not identified as 'complainants' under the Health Ombudsman Act 2013 and there were restrictions on releasing information to the family. Those parties/persons who made complaints were provided regular updates throughout the progress of the matter. The OHO had understood, the presiding Coroner would keep the family advised of the OHO investigation. This occurred.

Conclusion

209. This has unfortunately been a very protracted matter. Under s45 of the *Coroners Act 2003*, I am required to determine five elements, that is:

(a) Who the deceased person is;
(b) How the person died;
(c) When the person died;
(d) Where the person died, and in particular whether the person died in Queensland; and
(e) What caused the person to die.

210. After considering the material obtained during the coronial investigation, I consider I have sufficient information to make the necessary findings in relation to Mrs Paluszak's death.

211. In considering subparagraph b, namely 'how' Mrs Paluszak died, it is necessary to consider the appropriateness of the commencement of the End of Life treatment, and the medication Mrs Paluszak was administered because of commencing the End of Life treatment.

212. The contemporaneous clinical documentation does not support there had been a deterioration in Mrs Paluszak's condition in the seven weeks prior to her death. On 7 September 2017, Mrs Paluszak was assessed as being independent with her transfers and walking. In addition, her daughter who visited Mrs Paluszak once to twice a week had not noticed any dramatic change in her mother's physical appearance when she had returned from an extended trip in mid-October 2017.

213. I accept based on the clinical contemporaneous records that there had been a deterioration in Mrs Paluszak's condition in or around the end of October 2017 (that is, the week to two weeks prior to her death). Mrs Paluszak had had a number of falls and there was a rather sudden deterioration in her mobility, and at times, her level of alertness.

214. While the GP was contacted by telephone about the fall on the morning of 7 November 2017, he was not contacted over the following two days to discuss the changes in Mrs Paluszak's deteriorating mobility, her drowsiness (to the point of nursing staff ceasing her Risperidone), her tachycardia, and that she had had a further fall.

215. The cause of Mrs Paluszak's deteriorating condition was not established and cannot now be established. There is a myriad of possibilities.

216. Despite whatever the cause was for Mrs Paluszak's deterioration, it had been decided and documented in July 2017 that Mrs Paluszak was only for conservative treatment. This is consistent with the consultation Mrs Paluszak had with her Geriatrician in February 2017, wherein it was agreed to cease her insulin due to non-compliance, and to cease one of her diabetic medications due to her poor renal function. It was agreed that while Mrs Paluszak would continue to have high blood sugar levels, her quality of life was paramount. In such circumstances I am of the view it was reasonable for the staff to have stopped regularly checking Mrs Paluszak's blood glucose levels.

217. On the morning of 10 November 2017, Mrs Paluszak appeared to have some sort of acute episode in the dining room. A blood glucose reading noted it was 'HI'. While this would not have been unexpected, it may have been the cause of her symptoms.

218. The CNC reported to the GP Mrs Paluszak was semi-conscious, not able to communicate or lift her limbs. There is no evidence of any vital signs having been taken, a neurological assessment (Glasgow Coma Scale) or a physical assessment, having been undertaken when the CNC spoke with the GP.

219. While Mrs Paluszak may have had an acute medical episode around 8.30am, there is an entry at 10.50am which records Mrs Paluszak had a pulse rate of 106 (this was below the previous readings recorded on 8 November 2017), a respiration rate of 18 (normal), a systolic blood pressure of 131 (normal) (noting her diastolic blood pressure was elevated at 99), and oxygen saturations of 96% (normal for Mrs Paluszak). She was also noted to be responsive and moving herself in bed. She had range of movement in all her limbs.

220. It is difficult to reconcile the observations of Mrs Paluszak at or around 10.50am with the findings made by the CNC in the End of Life assessment.

221. On the information available to me, I accept:

    (a) Mrs Paluszak was experiencing day to day deterioration, but this was fluctuating, and it had not been established if it was reversible as she had not been assessed by the GP (or any other medical officer).

    (b) Mrs Paluszak was requiring more frequent interventions which resulted from frequent

falls and a deterioration in her mobility.

(c) An acute episode had occurred in the dining room but according to the records at 10.50am, there had been an improvement in Mrs Paluszak's condition.

222. On the information available to me, I do not accept:

(a) Mrs Paluszak was becoming semi-conscious with lapses into unconsciousness. [She had got herself out of bed, albeit she had a fall, and on assessment she was responsive and able to move herself in the bed. Her vital signs were relatively stable].

(b) Mrs Paluszak had an increasing loss of ability to swallow. [There is no reference to a difficulty in swallowing in any of the material. Prior to the event that morning, Mrs Paluszak was eating albeit not wanting to wear her dentures].

(c) Mrs Paluszak had irreversible weight loss. [Following the introduction of fortified meals and Sustagen, she had gained weight].

(d) Mrs Paluszak had profound weakness. [While this may have occurred during the acute episode in the dining room, she had recovered to the point of being able to move herself in bed - I accept there was a recent deterioration in her ability to mobilise which was put down to weakness].

(e) Mrs Paluszak had changes in breathing patterns. [This is not supported by the objective data of respirations of 18 and oxygen saturations of 96%. While subjectively Mrs Paluszak may have been observed to have changes in her breathing patterns, this is not recorded in the material. It is possible due to agitation that morning her breathing patterns may have appeared altered - I accept that Mrs Paluszak was agitated].

223. I am of the view the CNC did not carry out an appropriate assessment of Mrs Paluszak and that what she has documented in the End of Life Care Plan is inconsistent with the balance of the evidence. There seemed to be a sense of urgency by the CNC which I put down to her concerns about the level of Mrs Paluszak's agitation, which she had interpreted was due to pain Mrs Paluszak was experiencing.

224. The GP was reliant on the information which was imparted to him by the CNC. They had a congenial working relationship, and the GP had trust in the CNCs clinical judgment.

225. The GP concluded from the information he had been provided, that there was no intervention which could be implemented at the RACF. That is, if Mrs Paluszak was to be further assessed or treated, she would need to be transferred to the THHS.

226. I accept there were no interventions that could have been undertaken at the RACF to attempt to establish the cause of Mrs Paluszak's recent deterioration and acute episode that morning, and that Mrs Paluszak needed to be medically assessed. The GP was not available to undertake that assessment, so the only option was to transfer Mrs Paluszak to the THHS.

227. The CNC contacted Mrs Paluszak's daughters. They were reliant on the information provided to them by the CNC. Regardless of the information provided by the CNC and consistent with previous decisions, it is likely Mrs Paluszak would not have been transferred to the THHS for further assessment. This because such intervention would likely have caused further distress, agitation, and confusion for Mrs Paluszak.

228. On this basis, the decision was made to commence Mrs Paluszak on End of Life treatment. According to the preponderance of expert evidence, this was reasonable:

(a) Professor Good considers given Mrs Paluszak's chronic conditions it was appropriate for her to remain at the RACF. He also formed the view it was likely Mrs Paluszak was entering the end stage of her life.

(b) Professor Gonski is of the view Mrs Paluszak was rightly started on an End of Life Pathway.

(c) Professor Hardy notes the CNC had the advantage of having reviewed Mrs Paluszak over a period of time prior to the terminal event. She accepts it was appropriate to commence Mrs Paluszak on End of Life treatment.

229. I accept Mrs Paluszak had reached the end stage of her life and even if there was an assessment with a diagnosis, she would likely have been treated conservatively. That is, it was appropriate to treat Mrs Paluszak's symptoms to ensure she was kept comfortable as she continued to deteriorate.

230. The GP had a standing order for End of Life medications. He had the uncommon practice of writing that medication up when he assessed a resident on admission to the RACF. There are opposing opinions by the experts as to whether this is appropriate. Noting Dr Ulcoq thought it was a dangerous practice, the consensus of the other medical experts was that it is a practical solution in what are at times challenging circumstances in the aged care environment. I note the GP had reviewed his standing orders on a relatively frequent basis since Mrs Paluszak's admission to the RACF.

231. The order by the GP was, 'if the patient is still in pain after oral stepwise pain ladder has been used and failed to relieve symptoms then Morphine s/c may be used at the RN's discretion'. This suggests there is a progression or escalation in the use of the medication based on a resident's symptoms.

232. The balance of the expert evidence is critical of the way in which the GP prescribed the medication:

(a) Professor Good opined that a way to balance the risk of anticipatory prescribing is for medications to be written up in safe doses, compliant with guidelines and administered by nurses after consultation with a doctor. He was concerned about the wide dose range of Morphine.

(b) RN Thain was of the view the prescribing range of the medications were too broad and did not provide the administering staff enough guidance to its use. It allows an unnecessary risk.

(c) Professor Gonski notes the wide range of dosing and is critical in that there is no guide for a starting dose or how to increase the dose. Further, he opines the range is very broad. In the context of anticipatory prescribing, when a resident deteriorates, further communication is required to discuss the starting dose and how quickly it should be increased.

233. The GP was of the view unless otherwise directed by a medical practitioner, it is accepted nursing practice to administer the lowest prescribed dosage of any PRN medication when the medication is commenced. Professor Gonski accepted that while prescribing could have been better, nursing staff who have experience in palliative care and End of Life care would have been able to use the range provided optimally.

234. I am of the opinion the GP erred in his clinical judgement in prescribing anticipatory End of Life medications in such a broad range. The GP would understand there are levels of experience of registered nurses who work in aged care, and he did not mitigate the risk of a nurse not commencing at the lowest end of the range he had prescribed. While he had a good working relationship with the CNC, I am of the view he should have discussed what the appropriate starting dose of the medication was to be given to Mrs Paluszak. The GP made no further contact and did not arrange to visit Mrs Paluszak after agreeing she was to commence End of Life medications.

235. The CNC says it was her usual practice to commence administration at the lowest dose on the sliding scale unless there was a reason not to. She has provided her rationale for starting at the

highest end of the range.

236. I note Mrs Paluszak had an elevated diastolic blood pressure which may have been indicative of agitation and/or pain. The CNC observed Mrs Paluszak grimacing and told the EN she thought Mrs Paluszak's agitation was related to pain. Another RN did not consider Mrs Paluszak had any symptoms requiring Morphine, but accepted Mrs Paluszak was agitated requiring Midazolam.

237. I acknowledge assessing pain in a patient with Dementia is difficult. Very unfortunately in this case, the assessment and documentation of Mrs Paluszak on the morning of 10 November 2017 was lacking. There are no reports of Mrs Paluszak whimpering, moaning, or crying. There is no evidence of Mrs Paluszak rocking or guarding a part of her body. There were no obvious injuries observed with Mrs Paluszak having full range of movement in her limbs.

238. The experts have considered the doses administered,

    (a) Professor Good indicated it was standard practice to start at the lower end of the dose range unless there were particularly severe symptoms. He says there is no clinical basis for choosing a higher dose of Morphine, unless a lower dose had been tried and found not to be effective. If the does is ineffective it is appropriate to contact the prescriber. There is no evidence in this case that the GP could not be contacted to obtain a further order or advice in managing Mrs Paluszak's symptoms remotely.

    (b) Ms McGregor opined it is standard practice for RNs administering PRN medications to administer the lowest/low dose and then monitor and assess the effectiveness and side effects of the PRN medications. When a higher dose is administered it should be clearly documented.

    (c) The Executive Manager of the RACF opined there were no valid reasons in this case for not commencing administration of End of Life medications at the lowest dose.

    (d) Mr Ruzicka opined the highest dose of subcutaneous Morphine administered by the CNC would be considered high in the circumstances. He says it would have been more aligned to best practice to keep the initial Morphine dose to within 2.5-5mg. He considers this is the case even to address pain Mrs Paluszak may have been in.

    (e) Professor Hardy says many would have given a mid-range dose of 5mg, review its effect and repeat if necessary. She though is accepting of the dose delivered by the CNC.

239. The balance of the expert evidence is that the CNC inappropriately administered the highest range dose of medications to Mrs Paluszak. Professor Hardy who was retained by the CNC, is the outlier.

240. I accept Mrs Paluszak was agitated and may have been showing signs of some discomfort through facial grimacing, but I do not accept she was in severe pain or that she had symptoms warranting the administration of the highest end doses of Morphine and Midazolam. I am of the opinion the CNC erred in her clinical judgment and that Mrs Paluszak should have been administered the lowest prescribed dose of the medications. This particularly in circumstances when Morphine was administered with the sedative, Midazolam.

241. While there is competing evidence between the CNC and the Executive Manager of the RACF regarding orientation, leadership, resources, and polices, I do not consider any of the alleged mitigating circumstance are materially relevant. The CNC was an experienced nurse and had experience in palliative care. In my view on the morning of 10 November 2017, she made a poor clinical decision.

242. After Mrs Paluszak was administered the medication, Mrs Paluszak did not regain any level of consciousness. Her family thought she looked like she was asleep when they arrived. She did not appear to be in pain.

243. By the afternoon the nursing staff refer to Mrs Paluszak being made Nil by Mouth due to her unconscious state. An entry by a RN on the afternoon shift states, "…nil pain or agitation observed on pm shift. Was asleep through out breathing normal".

244. The night shift RN noted Mrs Paluszak remained asleep the whole night and that she did not exhibit any signs of pain or agitation. This is consistent with her daughter's observation who stayed with her until 3am. That is, that Mrs Paluszak did not wake or stir.

245. On 11 November 2017, the RN was caring for Mrs Paluszak on the day shift. At 11.10am she administered Morphine 10mg for discomfort and respiratory distress. At 11.27am she administered Midazolam for agitation. The clinical records by the PCW and the RN reflect Mrs Paluszak was restless and agitated. She had increased respiration rate of 28-32, twitching and was hot to touch.

246. I accept Mrs Paluszak was restless, agitated, had respiratory difficulties, and was likely in pain (as contemporaneously documented) and it was appropriate to administer further End of Life medications. Given the effects of one dose of Morphine and Midazolam the day prior, it is questionable whether the highest dose of the medications was warranted. I however acknowledge the RN was following the lead of the CNC in what had been administered the previous day, and that on her assessment in the context Mrs Paluszak had been unconscious for close to 24 hours, the medications were warranted.

247. The RACF had an appropriate End of Life policy in place at the time. It required the GP to review the resident and case conference with the family before commencing the process. I accept this was not practicable in this case. It is the very reason why safeguards in prescribing are required and why it is important for medical practitioners to provide direction to staff on the first dose of End of Life medication to be administered to a resident. I am satisfied the RACF has taken appropriate steps to attempt to avoid a similar situation from occurring again.

248. As one of the experts opined, ***the ethos of palliative care is neither to hasten nor postpone death. It is a difficult line to navigate but a prudent practitioner is to tread lightly as to provide comfort and alleviate distress without causing harm***.

249. I find the clinical staff did not set about to cause harm to Mrs Paluszak and the other residents at the RACF. The intention was to provide relief and comfort.

250. Mrs Paluszak and the other residents were at the end of their lives. The decision to commence End of Life medications was reasonable. The standing order of the anticipatory prescriptions for Morphine and Midazolam was too broad, and the decision by the clinical staff to commence and continue the medications at the highest end of the range was not consistent with prudent practice.

251. Mrs Paluszak had chronic high blood sugars which it had been decided was not to be treated. In the recent days prior to her death, she had a number of falls. On 11 November 2017, she was agitated and thought to be in pain. The administration of one dose of Morphine and Midazolam caused Mrs Paluszak to either be in a very deep sleep which she did not wake from, or to lose consciousness.

252. I canvassed an opinion from Professor Good as to whether the administration of the Morphine in this case hastened Mrs Paluszak's death. He advised that Mrs Paluszak's condition seemed to be deteriorating rapidly and she had a short prognosis from her underlying condition. He opines it is very difficult to say for certain that the Morphine administration hastened the death of Mrs Paluszak.

253. While I suspect commencing with the highest dose of the End of Life medications may have hastened Mrs Paluszak's death, given there are so many variables I accept it is not possible to determine this with the sufficient degree of evidence to make that finding.

254. There was no autopsy in this case as the death was not identified in the first instance as a reportable death. Based on Professor Good's reference to Mrs Paluszak potentially having hyperosmolar hyperglycaemic state, on balance I find the cause of death is complications

associated with Diabetes Mellitus.

255. It has been close to seven years since the concerns regarding Mrs Paluszak were raised. There has been an extensive investigation by the Police and the OHO. The CNC has had conditions imposed on her registration. I am not satisfied that it is in the public interest to hold an Inquest (formal court hearing). I have though sought approval from Mrs Paluszak's daughters to publish these findings so other clinicians and other RACFs are able to consider and reflect on the events which occurred in this case. Further, that this case may result in the implementation of certain safeguards when considering the prescription and administration of End of Life treatment in a RACF.

256. I acknowledge how long it has taken to finalise this investigation. I extend my condolences to Mrs Paluszak's family and friends for their loss.

I close the investigation.

Melinda Zerner
Coroner
15 August 2024