QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INVESTIGATION

CITATION:	**Non-inquest findings into the death of Donald Richard Gunthorpe**
TITLE OF COURT:	Coroners Court
JURISDICTION:	CAIRNS
DATE:	10/10/2024
FILE NO(s):	2017/5449
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. Mr Donald Richard Gunthorpe (Mr Gunthorpe) was born on 19 April 1935 and died on 14 January 2017 at 33 Kokoda Street, Idalia. He was 81 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 one of the residents 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. Mr Gunthorpe was suffering Type 2 Diabetes; Legal Blindness; Rectal carcinoma with liver metastases; Dementia; Bilateral Lymphoedema; and Ischaemic Heart Disease. He had moderate cognitive impairment. In addition to being visioned impaired, he had a deficit in hearing in both ears.

14. From the hospital records, it appears Mr Gunthorpe was diagnosed with a large liver metastasis and rectal primary cancer in or around December 2011. He was asymptomatic at the time.

15. Mr Gunthorpe underwent extensive treatment for his cancer. On 29 March 2016, he was referred to palliative care at the Townsville Hospital. On 30 March 2016, an Acute Resuscitation Plan was completed at the hospital. Mr Gunthorpe was noted to be palliative. The doctor records, "*Patient does not want surgery or other invasive management. He would like to be kept comfortable*".

16. On 23 September 2016, Mr Gunthorpe was transferred from the Townsville Hospital to the RACF. He had been in hospital due to cellulitis and multiple falls. An Acute Resuscitation Plan had been completed. He was not for resuscitation.

17. On 27 September 2016, Mr Gunthorpe was reviewed by the GP. He recorded his history, assessment, and management plan. Among other medications the GP prescribed Ordine (oral Morphine) 10mg/ml 1-3ml four hourly as required.

18. In completing a Cornell Scale for Depression Assessment (undated) a clinician recorded,

> *He feels guilty that he is unable to help his wife anymore. He feels like he has got no use anymore as he cannot be with his wife because his health has deteriorated. He wishes he could be well enough to go back home to be with her.*

19. On 4 October 2016, the GP undertook what appears to be a full assessment of Mr Gunthorpe. Under the heading 'Actions', the GP notes Mr Gunthorpe's prognosis is poor and that he has large liver metastasis. He attempted to contact Mr Gunthorpe's wife and left a message. He records, "*Not For Resuscitation. Has decided for quality of life with a conservative approach to maintain dignity and quality rather than length of life and make sure that their comfort is foremost in their care*". The GP prescribed Frusemide for Mr Gunthorpe's swollen legs (due to the liver metastasis) and Morphine 10mg/1ml, 2.5-10mg every two hours as required.

20. On 11 January 2017, Mr Gunthorpe reported cramps in his stomach, he rated the pain as 8 out of 10. He was hypertensive with a blood pressure of 220/114. He was afebrile, his pulse was 92. He was transferred to the Townsville Hospital. The nurse records, "*NO NFR: no answer from GP phone number*".

21. He was admitted to the hospital for abdominal pain and diarrhoea. He was prescribed intravenous Morphine 2.5-5mg PRN (as required) and Oxycodone 5mg four hourly PRN. He was administered one dose of Morphine and two doses of Oxycodone.

22. Under the heading Assessment and Management Plan in the ED records, the Resident Medical Officer (RMO) records:

> *Imp: ?disease progression ?necrotic tumour ?gastroenteritis*
> *Plan:*

Hold off too much IV morphine as this is likely to have caused drowsiness (RN reports much brighter before being given morphine)
Needs CT- ideally with contrast of chest abdo and pelvis
Until we know whether his disease has progressed hard to decide if needs palliative input
Palliative care have agreed to consult on the patient later today – and recommend the CT scan
However GFR is only 41 – therefore will need to pre-hydrate with 100mls/hr fluid prior to contrast
Clinically stable to wait for scan later today
RN to let MO know if any deterioration in meantime.

23. It does not appear palliative care consulted Mr Gunthorpe. At or around 4.06pm a Registrar records his impression as being, "*Pain secondary to chronic abdominal pain related to neuroendocrine tumour mass*". Under the heading 'Plan' he records,

> *1/ Happy for D/c back to NH*
> *2/ Medication chart completed with regular paracetamol*
> *3/ PRN endone available as required for analgesia*
> *4/Encourage oral intake – particularly fluids.*

24. A clinician records in the discharge letter (it is not signed),

> *Whilst here his pain settled, and he no longer had diarrhoea or vomiting. His bloods were unremarkable.*
> *He was reviewed by the medical team and we discussed the merits of performing a CT of his abdomen to further evaluate his known disease but it was felt he would be better in his own environment at the nursing home especially as his symptoms had improved throughout the day. He had been infused a litre of IV fluids throughout the day.*
> *If he deteriorated in the nursing home we can review him again and consider scanning him in that instance.*

25. Mr Gunthorpe returned to the RACF at 5pm. A Registered Nurse records, "*He was settled and no longer had any vomiting. If he deteriorates again, we have to send him to the hospital and do a CT abdomen. He had a little bit of his dinner in his room and is on his bed right now*".

26. On 12 January 2017 at 8.34am, the CNC records,

> *CNC reviewed Donald for moderate to severe abdo pain, Directed EN to give prn tramal and to order End of Life medication including morphine & midazolam, Donald has requested he receive regular morphine to manage his pain. CNC to phone Donald's wife & GP to update & to commence End of life pathway. Donald is resting in bed at present, he has declined breakfast and morning medications.*

27. At 8.54am, the CNC completed an End of Life assessment. She reports there was a case conference at 8.40am with Mr Gunthorpe's wife and the GP. She says the signs and symptoms associated with the terminal phase are:

> *Experiencing day to day deterioration that is not reversible*
> *Requiring more frequent interventions*
> *Becoming semi-conscious, with lapses into unconsciousness*
> *Refusing or unable to take food, fluids or oral medications*
> *Irreversible weight loss*
> *Profound weakness.*

28. The CNC confirms Mr Gunthorpe had three or more signs and symptoms. At 8.51am, the CNC records,

> *CNC phoned Donald's wife Beverley@0845hrs to inform of his deterioration. Beverley was concerned Donald had not been having a bath for the past few days, explained to*

Beverley Donald had been refusing as he has been too fatigued and uncomfortable to get into the shower. Staff have assisted Donald to have hygiene washes as per his request. Advised Beverley Donald will be commencing morphine directly as per End of Life pathway. Informed GP of same, GP directed to Commenced (sic) *palliative medications as charted.*

29. On 12 January 2017 at 9.31am, the CNC completed an End of Life Care Plan. Maxalon was to be given as required and Mr Gunthorpe was to commence Morphine and Midazolam via an Intima (subcutaneous needle). She also records, "*Donald prefer to remain at* [the RACF] *for palliation. Donald's wife the carer of this resident eg. resident Beverly is arranging for their children to be informed & wishes regarding care, advanced visit. Health directive?*".

30. I have identified two medication charts both dated 4 October 2016. One is titled 'Nursing Home Medication Chart' and has among other orders, printed orders for Midazolam 5mg1m, 5mg qid prn (subcut), and Morphine 10mg/ml, 2.5mg-10mg q2h prn (subcut). There are no signatures that the medication has been administered on the medication chart. The second medication chart is headed 'Medication Profile. It has a number of regular medications (there are no signature boxes to sign the medication has been administered). There are no medications recorded in the PRN section. There is what appears to be a handwritten order dated 13 January 2017 for: '*Morphine 10mg 1ml S/C 10mg q4H*' and '*Midazolam 5mg/1ml S/C 5mg q4H'*. It appears to be signed by the GP.

31. The staff document the administration of the medication in the iCare progress records. I have identified the following End of Life medication having been administered to Mr Gunthorpe:

    a. 12 January 2017, 1.06pm – 0.5ml of Morphine (5mg)[1];

    b. 12 January 2017, 3.48pm, 0.5ml Morphine (5mg)

    c. 13 January 2017, 5.28am, 0.5ml Morphine (5mg)

    d. 13 January 2017, 6.20am, 0.5 ml Morphine (5mg)

    e. 13 January 2017, 10.57am, 5mg of Morphine

    f. 13 January 2017, 10.58am, 5mg of Midazolam

32. After this dose, there is a note by a RN,

    S/B GP for palliative review. Ceased all regular oral meds. Prescribed morphine & midazolam regular as per med chart. Unable to tolerate any oral intake now. Comfort measures only.

33. This is consistent with the handwritten order for regular Morphine and Midazolam on the second medication chart referred to above.

34. At 6.54pm, Mr Gunthorpe was administered 20mg of Buscopan (assists with respiratory secretions).

35. At 8pm, the GP was contacted and asked to review due to the 'gurgling'. He advised continue the PRN Buscopan, and to give extra PRN Midazolam to assist gurling and extra PRN Morphia for comfort in addition to regular Morphia and Midazolam.

36. At 11.49pm, Mr Gunthorpe was administered a further 20mg of Buscopan. There is then no formal recording on the medication chart of the medications having been administered.

37. On 14 January 2017, a nurse records at 08:42, 'regular palliative care medications given at 0800hrs', and another entry at 17:33, a nurse records, 'palliative care medications were given

[1] It is assumed all the medication was administered subcutaneously but this is not always recorded

at 1630hrs, though it came up due at 1400hrs'.

38. At 22:15, a nurse records,

> *Donald passed away at 2130 hrs tonight. Following assessments were done – no palpable carotid pulse, no heart sounds or breath sounds, no response to centralised stimuli, fixed dilated pupils. Life extinct form was completed. Family (son) was present. GP notified, Morleys funerals contacted. CN and ARM notified.*

39. Clarification was sought from the RACF regarding the clinical records. A different Medication Profile which is not signed was provided. It has Midazolam and Morphine to be given as regular continuous medications every four hours. This is consistent with the handwritten order of 13 January 2017. I assume the Medication Profile had been updated once the handwritten order had been made by the GP.

40. The 'Single Medication Tracking Individual Resident Report' for all medications was provided. For the Morphine, it has several inconsistencies in the way the administration of the medication is recorded for example, some staff write dosage 1 when administering 5mg, others 0.5. On one occasion the dosage is 10 but there is no record of how much was administered. This was on 13 January 2017 at 3.44, 1.35 and 9.45. I assume the doses given were 10mg doses. There are no entries on this sheet for the administration of Morphine on 14 January 2017.

41. The review by the GP occurred at 12.45pm on 13 January 2017. I assume from this point forward Mr Gunthorpe was regularly administered 10mg of Morphine and 5mg of Midazolam, every four hours until he passed. This though is not clear on the medication charts or clinical records I have been provided. While I do not consider anything turns on this, if it has not already occurred, the documenting of the administration of Morphine to ensure consistency and to clearly confirm the administration of any medication has occurred should be reviewed.

Family's Understanding of Events

42. On 13 November 2020, Mr Christopher Gunthorpe, Mr Gunthorpe's son provided a statement to the Police. Christopher lived in Toowoomba but would return to Townsville to visit his parents as often as he was able.

43. Christopher recalls Mr Gunthorpe being in hospital for about three months waiting for a bed to become available at a nursing home. Mr Gunthorpe had deteriorated cognitively and physically, requiring more care than his family was able to provide.

44. Christopher returned home over the Christmas, New Year period and visited his father each day. They took Mr Gunthorpe home on Christmas Eve and returned him to the RACF on Boxing Day. This had been upsetting for all, but they acknowledged the level of care he required was well beyond their 'skills and facilities'.

45. On 12 January 2017 at 9am, Christopher received a phone call informing him Mr Gunthorpe was nearing the end of his life. He flew to Townsville later that morning. On his arrival to the RACF, he recalls having a conversation with a nurse who advised Mr Gunthorpe was going to be placed on the End of Life Pathway and she briefly discussed what that entailed. He had previously researched the term himself so understood what was involved.

46. Shortly after, he was advised the GP was going to review Mr Gunthorpe. He recalls the GP coming in and examining Mr Gunthorpe. He briefly spoke to Christopher and his mother before he left. He understood the conversation was about what they could expect to occur over the final three to seven days.

47. Christopher's mother was very upset, so he took her home. He immediately returned to the RACF and stayed alone with his father in the room for his final days. He slept at night in a comfortable lounge chair which the staff had moved into Mr Gunthorpe's room for that purpose.

48. Christopher recalls Mr Gunthorpe was conscious when he arrived although not making a lot of sense. He recalls after the GP left, for the remaining days until his father's death, the medication managed Mr Gunthorpe's pain and kept him asleep.

49. Christopher raised some concerns about staffing levels, having to wait 20 minutes on one occasion to speak to a Registered Nurse regarding the positioning of his father. He had understood his father was not to be repositioned given they had been able to control his rattly wheeze, but while he was waiting for the RN, the staff moved Mr Gunthorpe which caused the rattly wheeze to return.

Investigation by the RACF

50. 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.

51. 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.

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

53. 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.

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

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

56. 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.

57. 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 included:

    - 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.

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

59. 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.

60. 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.

61. 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.

62. 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*".

63. 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 a resident [not Mr Gunthorpe] 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 the resident's family being told that the resident [not Mr Gunthorpe] 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.

64. The RACF found another resident [not Mr Gunthorpe], 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.

65. 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.*

66. 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 [not Mr Gunthorpe]. 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.

67. 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

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

69. 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.

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

71. 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 one of the residents was reviewed.

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

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

74. 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 Gunthorpe*, [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 of 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.*

75. 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.

76. The solicitor was asked to clarify the allegation the CNC had falsified documents. The Coroner who was initially investigating the death of Mr Gunthorpe (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 Mr Gunthorpe, the areas of concerns were:

    a. End of Life Assessment and level of consciousness
        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' (terminally ill phase of the resident, as determined by the assessment) and in particular the resident was 'becoming semi-conscious with lapses into unconsciousness'.
        iii. There was conflicting evidence with the conclusions reached in the End of Life Assessment and care plan.

    b. Oral Medications
        i. The End of Life Assessment completed by the CNC states that the resident is 'refusing or unable to take food, fluids or oral medications'.
        ii. The CNC progress notes records that the resident 'declined breakfast and morning medications'.
        iii. The progress notes do not reflect an issue with his ability to take oral medications.

    c. Food and fluids
        i. The CNC recorded in the End of Life Assessment and progress notes that the resident was 'refusing or unable to take food, fluids'.
        ii. The progress notes do not reflect an issue with his food and fluid intake e.g. see progress note 11 January 2017 that state the resident 'had a little bit of his dinner in his room' when he got back from hospital.

    d. Weakness
        i. The CNC recorded in the End of Life Assessment and progress notes that the resident was suffering 'profound weakness'.

ii. The progress notes do not reflect that the resident was suffering any 'profound weakness'.

e. Weight loss
   i. The CNC states in the End of Life Assessment that the resident was suffering 'irreversible weight loss'.
   ii. The progress notes do not reflect that the resident was suffering severe and 'irreversible weight loss'.

The Coronial Investigation

77. 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.

78. 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. 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.

79. 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.

80. 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.*

81. 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*".

82. Regarding the care provided to Mr Gunthorpe,

    a. On the morning of 12 January 2017, he met with Mr Gunthorpe's wife, Mr Gunthorpe and the CNC due to Mr Gunthorpe's increasing pain. Mr Gunthorpe had returned to the RACF the night previously. He did not make any notes of the meeting in his computer as he called in on his way home from rowing and it was not part of his regular clinic. He says, there is though reference to the consultation in the End of Life Assessment completed by the CNC.

    b. If he did not have his computer, it was his usual practice to make a handwritten note which would be scanned into the resident's record. He has not seen any of those documents in the RACF system.

    c. Mr Gunthorpe was suffering increased abdominal pain. His oral analgesia was insufficient.

    d. On 13 January 2017 at approximately 12.30pm he had a long consultation with Mr Gunthorpe and his wife about this return from hospital and the decision to take a

palliative approach. He recalls Mr Gunthorpe's wife did not want him sent back to hospital. He advised, being a case discussion, he usually relies on the accompanying RN to take notes of the conversation due to his need to engage closely with the family. Mr Gunthorpe had metastatic cancer. Due to Mr Gunthorpe's decline and pain, his wife wished Mr Gunthorpe to have comfort cares only.

e. The GP states,

> *In summary, at this stage Mr Gunthorpe was an 81 year old man with multiple comorbidities who presented to Townsville Hospital with nausea, vomiting diarrhea (not mentioned in the RACF notes but in the letter from Townsville Hospital) and severe 8/10 abdominal pain. Blood screen was performed and the results were noted as unremarkable. No other investigations were preformed. He was given IVI fluids and analgesia and then sent back to the nursing home. It was decided against the further investigation in the form of a CT scan due to the palliative nature of his very large rectal carcinoid tumour with liver metastasis and ascites.*

f. He notes on the Townville Hospital medication chart, Mr Gunthorpe had been prescribed palliative doses of Morphine intravenously at 2.5-5mg PRN, and that he had been prescribed Oxycodone 5mg orally every four hour as needed to a maximum dose of 20mg in 24 hours).

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

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

85. 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)

86. 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.

87. It was noted that 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.

Police Investigation

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

89. 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

90. 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.

91. 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

92. 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.

93. 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

94. 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.

95. 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.

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

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

98. 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 Mr Gunthorpe:

    a. Professor Good found the initial does of 5mg of subcutaneously Morphine administered to Mr Gunthorpe to be appropriate. He is critical of the subsequent doses and administration of Morphine. That is, Mr Gunthorpe having been administered 10mg of Morphine every four hours which equated to 60mg in a 24 hour period. He says, this is well above the standard guidelines for patients who had previously not been on regular opioid medication. The 5mg of Morphine Mr Gunthorpe had been administered seemed to be effective for his pain.

    b. It was a reasonable hypothesis that the cancer was the cause of Mr Gunthorpe's pain,

and Mr Gunthorpe's expression to remain at home seemed reasonable.

c. Aside from the dose of 10mg of Morphine at four hourly intervals he thought the End of Life process was appropriately managed.

d. Mr Gunthorpe seemed to be deteriorating rapidly and had a short prognosis from his underlying conditions including the metastatic cancer. It is very difficult to say for certain that the increased Morphine dosage harmed Mr Gunthorpe.

99. 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.

100. 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.

101. 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.*

102. 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.

103. 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.

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

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

106. 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.

107. 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.*

108. Regarding the care provided to Mr Gunthorpe she opined,

a. The dose ranges prescribed by the GP were too high to commence with and there was no adequate documentation as to what dose to start with, the frequency of dosing and the maximal doses in 24 hours. There was also no record to guide the indication for commencing the medications.

b. It was not unreasonable for the GP to chart Mr Gunthorpe for anticipatory medication for pain relief in case he did suddenly deteriorate. She states,

> *My opinion is that the way these medications were charted, the dose range and the lack of clear instructions about how these medications were to be used were not adequate. Best practice would be for the patient to be reassessed as they reach the end of life pathway and medication to be prescribed then, not on admission to a facility when they are not immediately close to end of life.*

c. It was appropriate for the GP to direct the CNC to commence palliative medication. On reviewing the notes from the facility, Mr Gunthorpe had pain, vomiting and nausea. Mr Gunthorpe had been to hospital for assessment with no reversible causes for his symptoms identified.

d. Best practice would be to review the total dose of Morphine given in the previous 24 hours. Mr Gunthorpe had had 25mg. He therefore required a starting regime of 5mg of Morphine four hourly as required. She states,

> *In a palliative care situation, when a patient is experiencing pain, dyspnoea or distress, the dose of medication needs to be reviewed regularly. There is a lack of documentation that makes it difficult to know how well controlled Mr Gunthorpe's symptoms were with the doses of medication prescribed.*

e. It was appropriate for the GP to cease all active treatment. Mr Gunthorpe had received all care according to his Acute Resuscitation Plan at the Townsville Hospital but continued to deteriorate on his return to the RACF. If Mr Gunthorpe's family were in agreement it was reasonable not to return Mr Gunthorpe to the Townsville Hospital for a CT Scan. It was reasonable and compassionate to not proceed with a subsequent visit that may have caused him pain, discomfort, and distress in an unfamiliar environment.

f. It was appropriate to cease Mr Gunthorpe's medications and to commence him on medication to control his symptoms of pain, distress, terminal noisy breathing, and increased secretion.

g. The cause of death recorded by the GP was appropriate.

h. The GP should have recorded progress notes in the RACF computer system on

each visit, there is no excuse not to do this. He should also have maintained comprehensive personal notes to refer to if he was contacted after hours or remotely.

i. The care provided to Mr Gunthorpe over the last few days of his life by the RACF and the GP seemed to be compassionate and caring, aiming to provide comfort to a patient who was end of life from both a metastatic malignancy and other comorbidities.

109. 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.

110. 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 Mr Gunthorpe she opined,

a. The documentation of End of Life discussions is lacking. She was unsure what Mr Gunthorpe, his family and the treating team's decision was about returning Mr Gunthorpe to hospital for further assessment.

b. She thought the End of Life assessment was poorly assessed and documented.

c. Accepting there was a case conference to discuss commencement of End of Life cares, she considers it was appropriate to commence Mr Gunthorpe on an End of Life Pathway.

d. From her experience, very few GPs would write End of Life medication as regular unless they wished for it to go through a syringe driver. In a usual situation the medication is prescribe PRN with parameters round dosage and frequency. She states,

> *Just because Mr Gunthorpe is end of life it is not a certainty that he would need medication in the end of life process, this should be judged on a case by case basis and as with any prn medication an assessment made which shows the reason for medication being given and an evaluation after administration is required. In this case I do not see a clear reason that supports the use of medication and an evaluation that shows the effectiveness.*

e. The progress notes lacked detail regarding Mr Gunthorpe's deterioration and the discussions which were had with his family. The End of Life care plan is poorly completed and lacks details. Family involvement in End of Life is not seen and documented.

111. 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).

112. 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.

113. 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 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.

    e. 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.

    f. 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.

114. 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.

115. 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.

116. On 1 April 2022, the GP provided a response to the OHO's allegations in the referral to QCAT. Concerning Mr Gunthorpe, 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.

117. On 12 May 2022, the RN provided a response to the OHO allegations in the referral to QCAT. She had not administered any End of Life medications to Mr Gunthorpe.

118. 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.

119. 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.

120. 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*".

121. 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.

122. 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.*

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

124. 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 20242, the OHO wrote to the complainant advising of the

[2] This is the correct date

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* [a resident] *indicated that* [the RN] *had documented her reasons (increasing respirations and agitation) as the reasons for providing* [the resident] *with the highest dose of morphine sulphate.*
>
> *In addition to the above information,* [the RN] *provided a detailed submission outlining her recollection of the treatment provided to* [residents] *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.*

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

126. 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.

127. 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.

128. 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.

129. 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.

130. 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.

131. 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 Judicial Member Rinaudo 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.

132. 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

133. The allegations against the CNC pressed by OHO at QCAT concerning Mr Gunthorpe were:

On 11 January 2017 Mr Gunthorpe was admitted to and then discharged from the Townsville Hospital, having experienced painful stomach cramps. On 12 January 2017 Mr Gunthorpe continued to experience abdominal pain and requested morphine to manage his pain. [The GP] *directed the respondent to commence palliative medications. Other practitioners administered 5mg doses of morphine sulphate to Mr Gunthorpe on five occasions between 12.55pm on 12 January 2017 and 11.00am on 13 January 2017.*

On 12 January 2017, the respondent undertook a review of Mr Gunthorpe's condition, related clinical steps and actions which were recorded in the progress notes.

At 8.54am on 12 January 2017 the respondent completed an End of Life Assessment Form for Mr Gunthorpe listing signs and symptoms present including irreversible day to day deterioration, needing more frequent interventions, becoming semi-conscious with lapses into unconsciousness, and refusing or being unable to take food, fluids or oral medications.

Despite the respondent listing these signs and symptoms in the End of Life Assessment Form the respondent had failed to maintain adequate progress notes so as to justify the End of Life Assessment Form being completed.

At 12.30pm on 13 January 2017 [the GP] *reviewed Mr Gunthorpe. The respondent was not involved in Mr Gunthorpe's care after this time. Mr Gunthorpe died at 9.30pm on 14 January 2017.*

134. 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.*

135. 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. Ms McGregor considered the routine continuous medications for the end of life medications was an error and thought they were intended to be provided PRN (as outlined above this was not an error but the intention of the GP when he reviewed Mr Gunthorpe on 13 January 2017).

d. Ms McGregor as well as the other experts proceeded on the basis there was no face to face conference with Mr Gunthorpe, the GP, and the CNC on 12 January 2017 (there is conflicting evidence as to when the face to face conference occurred).

e. Ms McGregor's concerns about the CNC's administration of the medications to Mr Gunthorpe were that from her review it appears prior to 11 January 2017, there was:

    (a) *Limited documentation regarding a decline in Mr Gunthorpe's condition.*

    (b) *There is no evidence in Mr Gunthorpe's records that he suffered irreversible weight loss.*

    (c) *There was no sign that Mr Gunthorpe was becoming semi-conscious, with lapses into unconsciousness.*

    (d) *The only evidence that Mr Gunthorpe was refusing or unable to take food, fluid or oral medications was on the morning of 12 January 2017 when he*

refused breakfast and medications. Despite this, at 0900, Mr Gunthorpe took his daily medications.

136. 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

137. 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.

138. 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.

139. 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.

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

141. 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.*

142. 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 now not 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.

143. 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.*

144. 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 Mr Gunthorpe 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.

145. 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.*

146. 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.*

147. 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.*

148. The CNC has outlined a detailed version of events concerning her care of Mr Gunthorpe. In summary,

    a. Mr Gunthorpe's admission to the RACF was on the basis he was for palliative care only and not for resuscitation.

    b. Mr Gunthorpe's family all understood what palliative care entailed and did not have any expectation of care beyond providing comfort at the RACF.

    c. Mr Gunthorpe's health was deteriorating in the weeks leading up to his palliation.

    d. Mr Gunthorpe's room was either next to or very close to her office, so she saw him more than any other resident. From her observations of him, and from information she received at handover, she was aware of his daily condition even though she had not provided him direct care.

    e. Mr Gunthorpe had been excessively tired over the previous few weeks. He had been in and out of sleep. During her conversations with him his consciousness waned, and he struggled to maintain a conversation with her.

    f. Mr Gunthorpe's appetite had been decreasing and he had stopped wanting to eat things or have medication orally. He had also been refusing showers and had increasing pain.

    g. Mr Gunthorpe was no longer able to get himself to the bathroom whereas he had previously.

    h. To her, it appeared Mr Gunthorpe had lost weight, she did not consult a weight chart.

149. Regarding the events in the two days leading up to Mr Gunthorpe's death, the CNC states,

> *12 January 2017*
>
> *I note that at 8.05am* [a nurse] *administered Tramadol to Donald. She would have had*

a handover with the night shift staff who received Donald back from the Townsville Hospital following their examination of him.

I was asked to review Donald by [the nurse] *shortly after I commenced work.*

[The nurse] *said that Donald was continuously in pain despite a recent hospital admission and sought my advice as to how to care for him going forward.*

It was normal practice to assess residents visually before making any decisions.

When I went to observe Donald on 12 January 2017, I was cognisant of my observations of him over the previous couple of weeks gained, from seeing him myself and reading his progress notes.

When I assessed Donald, I first chatted to him to see how he was feeling. Donald said he was in pain but that he did not wish to return to hospital. Donald was an RN in his professional life and therefore as his health deteriorated over the years he had a very good understanding of his health conditions and, I assume, the way they could end his life.

Although at the time that Donald was deteriorating he had mild dementia, he was still cognisant of his health situation in that he understood that he had metastatic cancer and that his condition was terminal. He understood he was in the Facility to receive palliative care.

My assessment of Donald at this time was that he had entered a non-reversable state of deterioration because of the factors I mention above.

At 8:34am I made the following entries in the progress notes:
'CNC reviewed Donald for moderate to severe abdo pain. Directed [an EN] *to give PRN Tramal and to order End of Life medication including Morphine and Midazolam. Donald has requested he receive regular Morphine to manage his pain. CNC to phone Donald's wife & GP to update and commence end of life pathway. Donald is resting in bed at present, he has declined breakfast and morning medications.'*

I had not actually spoken with Donald's wife at the time I made this note.

I contacted his wife Beverley shortly after making it.

Donald and Beverly were a lovely couple. They were very close and from time to time Beverley would take Donald back to their retirement village for sleepovers for one night. She was very involved in his care at the Facility. Donald explained to Beverley on many occasions what was happening with his health because of his RN training. I had no concerns that Beverley did not understand what was happening with Donald's health care and his deterioration.

I recall Beverley agreed to the administration of end of life medication. After this phone call I contacted the GP by phone to inform him of my discussion with Beverley and the GP advised to commence the palliative medication as charted. The charted medications at that time were l0mg/mL two hourly of Morphine and 5mg/mL four times per day of Midazolam.

It was not possible to have conference between Beverly, the GP and I because the GP was visiting another facility.

At 8:50am I made the following entries in the progress notes:
'CNC phoned Donald's wife Beverley @ 0845hrs to inform of his deterioration. Beverley was concerned Donald had not been having a bath for the past few days, explained to Beverley Donald has been refusing as he has been too fatigue (sic) *and uncomfortable to get into the shower. Staff have assisted Donald to have hygiene washes as per his*

request. Advised Beverley Donald will be commencing Morphine directly as per End of life pathway. Informed GP of same, GP directed to Commenced (sic) palliative medications as charted.'

In the progress notes I stated that I 'advised Beverley Donald will be commencing Morphine directly as per end of life pathway.' I did not make this decision without consultation with Beverley. She had consented to the medication. I would never tell a family member that we would commence Morphine without their consent.

At 8:54am I completed my End of Life Assessment for Mr Gunthorpe.
At around this time, I also completed an iCare End of Life Care Plan.

At about 10.00am Beverley and her son Chris came in for a case conference to talk about Donald's palliative care plan. I entered the resident case conference form into iCare after this conference at some stage. The form shows the data being entered at 5:28 pm. If you open an assessment form and do not complete it until a later time it shows the time the form is last edited. I was often interrupted many times a day at [the RACF] *to attend to urgent matters. I may have started the form around the time of the conference and not been able to complete it until later in the day. I cannot specifically recall what happened during the case conference because it was such a long time ago however I am sure that I would remember if there were any objections raised or concerns raised by Beverley or Chris about the way the Facility and* [the GP] *were managing Donald's care. I believe that Beverley and Chris were in agreement with the care plan.*

13 January 2017

My only involvement in Donald's care this day was to participate in the GP review.

On 13 January 2017, [the GP] *was in the facility and reviewed Donald. I was present when he was seeing Donald.* [The GP] *decided to cease all of Donald's regular oral medications because he was unable to tolerate anything orally. He amended the medication chart by crossing out all oral medications and adding a notation in writing that the only medications were Morphine and Midazolam. The dosages did not change from the earlier prescription for these drugs.*

At 12:45pm I made the following progress notes:
'S/B GP for palliative review. Ceased all regular oral meds. Prescribed Morphine and Midazolam regular as per meds chart. Unable to tolerate any oral intake now. Comfort measures only.'

I made an addition to that note on the same day which said:
'CNC discussed with GP if a syringe driver would be of benefit. Advised not at this stage as Donald is now well controlled with regular analgesia. Continue to monitor and informed GP if there are any changes.'

I made this extra note because I forgot to note it down earlier when making the note at 12.45pm.

I was not involved further in his care.

I was not present at the Facility when Donald passed away at 9.30pm on 14 January 2017.

RACF's Executive Manager's Response

150. The toolkit referred to by the CNC indicates the 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.

151. 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.

152. 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 those responses out 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.

153. 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.

154. 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.

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

Further Expert Evidence

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

In my opinion, adequate records were maintained by the respondent in relation to Mr Gunthorpe. There was a documented deterioration in Mr Gunthorpe's condition from 11.1.17 with a subsequent documented hospital admission, worsening abdominal pain, a subsequent documented hospital admission, worsening abdominal pain, a subsequent discussion with the patient's wife and the patient's GP and commencement of an 'end of life assessment and plan'. These documented records were attended to by the rostered nurses at the time as well as the respondent. This is all in the setting of a patient with a very clear palliative care diagnosis. Although the quality of documentation may not be of the highest standard/practice, in my opinion it does not qualify as unsatisfactory professional performance or unprofessional conduct on part of the respondent.

157. 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.*

158. Concerning Mr Gunthorpe, she advised,

> *From my review of* [the CNC's] *statement, she had had conversations with both* [the GP] *and Mr Gunthorpe's family on the 12th January. All were aware of his deteriorating condition and the need for him to receive both morphine and midazolam for symptom control.*
>
> [The CNC's] *document clarified records of discussions she had with* [the GP] *and the patient's family…She also completed an end of life assessment an iCare end of life (EOL) plan and case conference form.*
>
> *…*
> [The CNC] *was not involved in Mr Gunthorpe's day to day care and therefore not responsible for iCare documentation.*
>
> *In my opinion, the documentation presented by* [the CNC] *in her response document in relation to this incident seems adequate.*

Explanation from OHO

159. 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 a coronial brief had not been compiled but information that was available was shared with the OHO.

    d. On 5 November 2019, the OHO sought the former Coroner's view on proceeding with its investigation. On 7 November 2019, the 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.

    e. 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 the investigation to be finalised earlier.

f. 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.

g. 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.

h. 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.

160. The OHO has confirmed none of the family of any of the deceased residents made a complaint to the OHO. They therefore were not identified as 'complainants' under the *Health Ombudsman Act 2013* and there were therefore 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

161. 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.

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

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

164. I accept the contemporaneous clinical documentation supports there had been a deterioration in Mr Gunthorpe's condition in the period leading up to his death and being commenced on End of Life medications. Mr Gunthorpe had end stage metastatic cancer.

165. There seems to be a factual dispute as to whether the GP attended the RACF on the morning of 12 January 2017. The GP recalls attending after rowing. The CNC recalls making a telephone call as the GP was consulting at another facility. There is no contemporaneous record of the GP attending the RACF in person. Given the passage of time, the reliability of the clinician's memories will have been affected. Mr Gunthorpe's son recalls having a conversation with the GP with his mother and was told about what to expect over the ensuing days after the medication had been commenced. On this basis I find there was a family conference, there is though some uncertainty as to when that occurred and if a consultation occurred prior to the commencement of the End of Life medications. I accept though a joint decision between Mr Gunthorpe, his family and the staff were made about the commencement of End of Life cares.

166. According to the preponderance of expert evidence, I find the decision to commence Mr Gunthorpe on End of Life treatment was reasonable.

167. 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 in a general sense. Dr Ulcoq thought it was a dangerous practice, but conceded in this case it was appropriate given Mr Gunthorpe's diagnosis, trajectory, and possible urgent need for relief. Others thought anticipatory prescribing was a practical solution in what can be a challenging environment in aged care.

168. The balance of the expert evidence is critical of the way in which the GP prescribed End of Life 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 nurse after consultation with a doctor. His 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.

169. 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.

170. In Mr Gunthorpe's case, the GP was advised the End of Life medications were to be commenced and agreed with the CNC. The original doses of Morphine were administered at 5mg. This at the nurse's discretion. It was not until the GP changed the order on 13 January 2024, that the dose was increased to 10mg and to be provided regularly every four hours. This decision was made after the GP had reviewed the resident and discussed the likely course of events with the CNC and Mr Gunthorpe's family.

171. There is no documentation to explain why 10mg of Morphine was felt to be appropriate, when the 5mg dose seemed to have been effective.

172. 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. There is no evidence to support why the dose of Morphine was increased to the maximum dose after it seemed the 5mg had been effective. He sates, "*I think doubling the morphine from 25mg in the previous 24 hours to 60mg in the next 24 hours without clear documentation of need/symptom issues is substantially below a reasonable standard*".

    b. Dr Ulcoq considered the prescription of regular Morphine and Midazolam by the GP was appropriate on the basis the medication was to control Mr Gunthorpe's symptoms of pain, distress, terminal noisy breathing and increased secretion (she though notes there is a lack of documentation that makes it difficult to know how well controlled Mr

Gunthorpe's symptoms were).

c. Ms McGregor opined it is standard practice for RNs administering PRN medications to administer the lowest 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.

173. On considering the clinical records, the statement from Mr Gunthorpe's son, and the information provided by the CNC and the GP, I consider it is difficult to establish the increase in the dosage and prescription of the regular dosing of the End of Life medications was inappropriate in this case. Mr Gunthorpe had been in significant pain and distress and seeking relief from his symptoms. On balance, I consider the administration of the End of Life medications were appropriate in the care provided to Mr Gunthorpe. The documentation by the GP and the nursing staff regarding why the dosing was changed was though lacking.

174. 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 circumstances were relevant in this case. The CNC was an experienced nurse and had experience in palliative care. She made an appropriate decision to commence End of Life processes for Mr Gunthorpe. There has been some criticism of her documentation and she has accepted that could have been better.

175. 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. It is not clear if the case conference occurred before or after the End of Life process was commenced. I am satisfied the RACF has taken appropriate steps to attempt to avoid a similar situation from occurring again.

176. 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***.

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

178. Mr Gunthorpe and the 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 to continue the medications at the highest end of the range for other residents at the RACF was not consistent with prudent practice. This did not apply in Mr Gunthorpe's case. While not started at the lowest end of the range, he was commenced on 5mg of subcutaneous Morphine. This was after oral analgesia had been ineffective. The dose only increased to 10mg on 13 January after he had been reviewed by the GP, and the order was changed to administer Morphine and Midazolam on a regular basis due to the symptoms Mr Gunthorpe was experiencing.

179. Mr Gunthorpe seemed to be deteriorating rapidly due to his end stage metastatic cancer. He had indicated he wanted regular Morphine to control his symptoms. This occurred.

180. Without an autopsy it is not possible to establish with any degree of certainty, Mr Gunthorpe's cause of death. Professor Good opined the cause of death of metastatic cancer was reasonable. I therefore accept the cause of death of 'Carcinoid Tumour (metastasis)'.

181. It has been close to seven years since the concerns regarding Mr Gunthorpe 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 Mr Gunthorpe's son 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.

182. I acknowledge how long it has taken to finalise this investigation. I extend my condolences to Mr Gunthorpe's family and friends for their loss.

I close the investigation.

Melinda Zerner
Coroner

15 August 2024