QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INVESTIGATION

CITATION:	**Non-inquest findings into the death of Jean Alice Dowson**
TITLE OF COURT:	Coroners Court
JURISDICTION:	CAIRNS
DATE:	10/10/2024
FILE NO(s):	2017/5412
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.

Table of Contents

Introduction

1. Ms Jean Alice Dowson (Ms Dowson) was born on 18 August 1937 and died on 10 April 2017 at 33 Kokoda Street, Idalia. She was 79 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. Ms Dowson was very frail, was dependent on oxygen and weighed only 29kg at the time of her death. She was generally orientated and cognitively intact.

14. Ms Dowson had been residing in her own home when on 15 September 2016 she had a fall and fractured her left pubic ramus (part of the pelvis). While she lived alone, she was supported by her daughter who would attend to shopping, cooking, cleaning, and showering Ms Dowson. Ms Dowson developed hospital acquired pneumonia, this in the context of her pre-existing history of severe Chronic Obstructive Pulmonary Disease (COPD) and Bronchiectasis. She was discharged on 31 October 2016.

15. On 2 November 2016, Ms Dowson was readmitted back to the hospital with pleuritic pain and shortness of breath. She was discharged on 12 December 2016. She was again admitted to the Emergency Department (ED) on 13 December 2016 with shortness of breath and bilateral lower thoracic chest pain.

16. On 11 January 2017, Ms Dowson was again transferred to the ED at the Townsville Hospital. This was for increased respiratory effort/distress. She was commenced on antibiotics and discharged home.

17. On 30 January 2017, Ms Dowson moved into the RACF. On or around 31 January 2017, Ms Dowson was seen by the GP who had taken over her care. He records her history. Under the heading 'Management', he states,

> *Drugs Midazolam, hyoscine (Buscopan) and morphine which are given Subcutaneously are to be used as End of Life drugs.*
>
> *If the patient is still in pain after oral stepwise pain ladder has been used and failed to relieve symptoms then morphine s/c may be used at the RN's discretion.*

18. The Medication Profile includes regular and PRN (as required) medications and originated on 1 February 2017. There was what appears to have been a review of the order on 14 March 2017, by the GP. Ms Dowson was ordered Midazolam 5mg by subcutaneous injection four times a day when required and Morphine 2.5-10mg by subcutaneous injection every two hours when required. I understand this is the order which the staff used to administer the End of Life medications to Ms Dowson.

19. On 7 February 2017, the GP appears to have completed an extensive history and physical assessment of Ms Dowson. He ordered several blood tests and concluded that there was little to do but to keep her comfortable. He suggested dietician review for supplements.

20. On 8 February 2017, a Resident Case Conference was conducted by the CNC. One of the questions on the form is 'Preferred options for palliative care'. The CNC records "*Happy to remain at* [the RACF] *for palliation & comfort cares*". Ms Dowson had an Advanced Health Care Directive in place.

21. On 13 March 2017, Ms Dowson had a fall, no injuries were identified.

22. On 15 March 2017, a Cornell Scale for Depression Assessment was completed by the CNC.

Ms Dowson reported being as lonely as she was at home. She also had a sense of loss in losing her independence and her home following her fall and broken pelvis. The CNC records, "*Jean tearful when she explained that she realizes she will be in an aged care home for the rest of her life now due to her physical health*".

23. Around 31 March 2017, Ms Dowson was having increased episodes of shortness of breath requiring additional oxygen at times. She also refused her medications.

24. On 4 April 2017, Ms Dowson was reviewed by the GP. He does not record anything in the clinical note except 'Surgery Consultation'. He prescribed Ordine (oral liquid morphine) ¼ - 3mls every four hours as required.

25. On 5 April 2017, Ms Dowson was administered Ordine for her shortness of breath. It assisted in settling her.

26. On or around 7 April 2017, Ms Dowson's daughter contacted staff as she could not visit due to a sick grandchild. A RN recorded:

> *…afternoon to report that her grandson who visited Jean earlier in the week has since developed a viral infection with high fevers and she was concerned Jean might become unwell from exposure. Ursula was also concerned that she thought Jean was confused during previous visits/phone calls and is worried she might have a urinary infection starting. Requested staff to closely monitor her temperature, check U/A, encourage regular fluids (like cold water) and if we were at all concerned to send Jean to hospital, as she has history of severe chest infections – also requesting Flu Vaccination to be attended when available. Jean has remained afebrile all shift – SATS & observations within normal range – refer Vital signs chart – waiting for U/A as bowels opened in pan this evening. She has accepted small regular drinks of cold water and small meals which is normal for Jean. Weight checked this evening – small weight loss since admission. Jean was orientated to time, date and place this shift and was appropriate in all conversations – no signs of confusion. When asked if she felt unwell Jean stated she was tired but OK …*

27. On 8 April 2017, the GP was contacted to convey Ms Dowson's daughter's concerns. Ms Dowson remained afebrile and had no complaints of feeling unwell. Ms Dowson refused all her medications and refused to eat or drink anything. She became short with staff if they tried to insist, she eat or drink. She also declined all offers of assistance with cares.

28. On 9 April 2017 at 4.06pm, Ms Dowson was administered Ordine 10mg for breathlessness. She was struggling with shortness of breath and was visibly distressed. On three occasions her oxygen saturations were down to 60%. She settled following the Ordine. She refused her evening medications but accepted several regular sips of water throughout the shift. At around 9.30pm, Ms Dowson was transferred to the Townsville Hospital for assessment due to her ongoing respiratory distress.

29. A RN wrote a transfer letter to the hospital. Family had requested hospital assessment. She noted the Advanced Health Directive requests for antibiotic treatment in 'terminal phase of incurable illness'.

30. The Townsville Hospital records note Ms Dowson had an altered level of consciousness. She was diagnosed with dehydration. An intern records,

> *Jean was transferred from her Nursing home by ambulance due to decreased GCS (GSC 10) post Oxynorm and decreased oxygen saturation. Jean has an ARP not for resuscitation. According to nursing staff notes, she had decreased oral intake throughout the day. She was given Naloxone to some effect and IV fluid for dehydration. Her urine dipstick was negative. She was transferred back to the Nursing Home via ambulance to continue care as usual. Her daughter was contacted but was unable to be reached during the night.*

31. On 10 April 2017, Ms Dowson was returned to the nursing home at around 8am. Her oxygen saturations were only 59% on the oxygen concentrator, and when changed to the cylinder, they increased to 90%. Ms Dowson advised she felt ok and smiled during her interaction with the RN.

32. At 3.03pm, the CNC administered 10mg of Morphine and 5mg of Midazolam (I assume subcutaneously). The CNC records, which appears to have been after the administration of the medication:

> *Jean returned from hospital this morning weak and continued to decline throughout the day. She has been semi-conscious for most of the shift and having difficulty maintaining oxygen saturation with O2 via Hudson mask on 9L/min. Jean expressed to staff she doesn't want to fight to breathe anymore and wanted her family to be contacted. Daughter Ursula phoned to attend directly. Observed Jean to have frequent muscle spasms and laboured breathing making it very difficult to relax. CNC discussed with daughter, Jean had now become palliative. Ursula agreed she felt her mother had given up and just wanted her to be comfortable. CNC phoned GP to notify of Palliative status. Confirmed to commence End of Life medications as prescribed on med chart. Ursula happy with this. CNC inserted intima into right buttock for adequate subcutaneous fat to absorb medication. Morphine & Midazolam given subcut as ordered. Jean now settled. Family remains by Jean's side. Comfort cares given hourly & as required. Family attending to mouth toilets & emotional support for Jean.*

33. Ms Dowson was noted to be resting comfortably. Her daughter Ursula was in attendance. Ms Dowson's other daughter Stacey arrived at 11pm, and Ms Dowson passed away at 11.25pm.

Recollection of Staff

34. A RN who assisted the CNC in administering End of Life medication to Ms Dowson recalls speaking to the CNC and Ms Dowson's family but does not recall the content of the conversation. She recalls Ms Dowson was not awake or talking and that her family were crying. She does not remember if she or the CNC administered the medication.

Family's Understanding of Events

35. On 3 March 2018, Ms Ursula Dowson (Ursula) provided a statement to the Police. Ursula visited her mother regularly at the RACF. Her mother was frail, weighing only 30kg and being dependent on oxygen due to emphysema. Ursula found it difficult to speak with the GP and it took a number of weeks after her mother developed loose bowels for him to engage with her but then he did not assess her mother.

36. Ms Dowson struggled to eat and drink and could not feed herself. Ursula was worried about her mother's hydration and nutritional status. She increased her visits to the nursing home to try and encourage her mother's eating and drinking. She is critical of the staff at the nursing home for at times not feeding her mother and not encouraging her to drink.

37. On 9 April 2017, Ursula was contacted and advised her mother was having trouble breathing and requested to go to hospital. Ms Dowson was diagnosed with severe dehydration and was discharged the following day. Ursula visited her mother but says she had been unable to see her for the five days prior due to her sick grandchild (she thought they may be contagious). She had though rung the nursing home each day. On seeing her mother, she thought she had significantly deteriorated.

38. After about half an hour of arriving, Ursula's mother started to spasm. She went to discuss her mother's condition with the CNC. The CNC told Ursula she had spoken to her mother a few days ago about her End of Life procedures and that she had advised that she could give her a needle if she started to spasm and that her mother had agreed to that. Ursula wondered why

she was not advised of the conversation on the End of Life when she had been ringing the nursing home each day.

39. Ursula returned to see her mother and told her what the CNC told her. She asked her mother if she wanted the injection and if so to squeeze Ursula's hand. Ms Dowson squeezed her hand. Shortly thereafter Ms Dowson was injected with medication. Ursula recalls the CNC saying, "*This will settle down the spasms but there is no coming back from it*". Ursula says her mother settled and was no longer in discomfort from the spasms.

40. Ursula notified her family of her mother's condition. Further medication was held off so that Ursula's sister Stacey could arrive to say goodbye, and their mother passed away about 15 minutes after Stacey's arrival.

41. Ursula says the only concerns she had was why she was not told about her mother's health and that she had deteriorated, until after she returned from the hospital. She did not have any issue with the End of Life procedures.

Investigation by the RACF

42. 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.

43. 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.

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

45. 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.

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

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

48. 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.

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

    i. Experiencing day to day deterioration that is not reversible;
    ii. Requiring more frequent interventions.
    iii. Becoming semi-conscious with lapses into unconsciousness.
    iv. Increasing loss of ability to swallow.

v. Refusing or unable to take food, fluids or oral medications.
vi. Irreversible weight loss.
vii. An acute event has occurred requiring revision of treatment goals.
viii. Becoming increasingly tired and weak.
ix. Breathing may become more difficult.

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

51. 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.

52. 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.

53. 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.

54. 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*".

55. 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 Ms Dowson) 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 a resident's family being told that the resident (not Ms Dowson) 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.

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

57. 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.*

58. On 11 December 2017, the RACF wrote to the RN with an outcome of the investigation concerning the allegations that had been made. The allegation was concerning the inappropriate administration of Morphine and other medication without proper assessment, had been substantiated. This related to two residents. A similar reason was provided as that to the CNC. That is, it was unsafe to residents to continue her employment and she was terminated on the same basis as the CNC.

59. 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

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

61. 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.

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

63. 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 resident was reviewed.

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

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

66. 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 Dowson and* [other residents].

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

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

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

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

f. *End of Life medication was administered in accordance with the orders of the GP (except for where* the RN *administered Midazolam to* [resident] *outside of Doctor's orders, as detailed below).*

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

67. 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 whilsteblower 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.*

68. The solicitor was asked to clarify the allegation in the report the CNC had falsified documents. The Coroner who was initially investigating the death of Ms Dowson (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 Ms Dowson, the areas of concerns were:

    a. The CNC's progress note at 5pm on 10 April 2017 records that resident 'has been semi-conscious for most of the shift'. This progress note is inconsistent with the progress notes of Agency Registered Nurse of same date in two separate progress notes at 10am and 11.15am respectively that 'Ms Dowson returned from hospital she stated that she started to feel okay and that she was smiling during interaction' and in another entry that 'some water given. Calm and relaxed, responsive to talk and touch'.

    b. Progress notes do not record resident was in pain.

The Coronial Investigation

69. 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 OHO.

70. 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.

71. 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.*

72. 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 RACF 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.*

73. 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*".

74. Regarding the care provided to Ms Dowson,

    a. He was on holiday leave from 8 April 2017 until 18 April 2017 and did not have a locum and as such if a resident was ill, they were to be transferred to the Townsville Hospital.

    b. On 8 April 2017 (while on leave) he received a telephone call from a nurse asking if Ms Dowson could be started on prophylactic antibiotics for a urinary tract infection. As she was afebrile, and her other observations were normal he did not order antibiotics but asked that a urine specimen be collected for testing.

    c. On 10 April 2017 he states,

    I believe the family were contacted by the Registered Nurse and the situation was discussed with the CNC and the family. I was rung that afternoon and updated about the situation. I made it very clear that I was away on holidays in Brisbane and unable to see Jean. The description of Ms Dowson was that she very (sic) *destressed. I advised (as I do in all these cases when I am not available) she should return to the Emergency Department at Townsville Hospital.* [the CNC] *told me that the family did not want her to return to the Hospital and that the family and Ms Dowson wanted her to be cared for at* [the RACF] *as they felt she had reached the end. I expressed strongly that I could not see her and had no one to see her. All the doctors and colleagues who I knew were away on holidays or did not wish to attend a nursing home. I was told that despite the unavailability of medical support Ms Dowson and her family still wished for Jean to remain at* [the RACF] *and wanted her to be comfortable at the nursing home.*

    With reservations I gave permission that Morphine and Midazolam could be given because I could not have Ms Dowson in such distress and discomfort. I told [the CNC] *I would try to ring friends who were doctors to come around and see her. Unfortunately, it was school holidays and my colleagues were away. I then proposed to catch a flight from Brisbane to Townsville early the next morning to review Ms Dowson but was informed she had died that night.*

    d. The GP advised after speaking with the CNC he agreed Ms Dowson met the End of Life commencement guidelines and medications could be started. He confirmed he had no direct conversation with Ms Dowson's family.

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

76. In or around November 2019, the coronial investigation was held in abeyance until the outcome

of the OHO disciplinary proceedings were complete.

77. 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)

78. 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.

79. 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

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

81. 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

82. 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.

83. The Audit Report identified that the facility had failed to meet six of the expected outcomes in the following areas:
    x. Human resource management
    xi. Information systems
    xii. Continuous improvement
    xiii. Clinical care
    xiv. Medication management
    xv. Palliative care

84. 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.

85. 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

86. 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.

87. 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.

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

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

90. 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 Ms Dowson:

    a. Professor Good found it difficult to reconcile some of the documentation in the RACF record. He accepts the documentation on Ms Dowson returning from the hospital suggested she was quite ill. He notes there is reference to Ms Dowson being on high flow oxygen but says in persons with severe COPD there is a risk of them developing CO2 retention, which he says can also make people drowsy. He suggests the reference that she 'didn't want to fight to breath anymore' suggested she was experiencing discomfort. He states,

        I note that Jean had severe COPD, weighed less than 30kg, was very frail, and was at high risk of deteriorating towards the end of life trajectory.

    b. The dose of medication administered was outside the recommended range. The recommended dose would have been Morphine 2.5mg and Midazolam 2.5mg, subcutaneously. The reason 'palliation' does not explain their use.

    c. The use of Morphine +/- Midazolam for treating shortness of breath and pain, in a patient with severe COPD, at the end of life is appropriate and considered good symptom control.

    d. The usual practice is for the smallest dose of the PRN medication to be given initially, unless there are clear, well documented reasons why a higher dose is used. He states,

        If nurses then begin with the doses substantially higher than the smallest dose, then there is potential harm. The reason for writing a range of prn dose is that so if the smallest initial dose is ineffective then a higher dose can be used next time. This is standard practice to ensure adequate symptom control and minimise potential for adverse effects.

    e. Professor Good indicated that there are valid reasons for writing up palliative medications in advance, but this is on the basis that it has been explained to the patient and/or carers as they will have to pay for the prescription in advance of the need for the medication. The problem if the medication is not written up is that the medications will not be available when they are required for symptom control. This can be a particular issue after hours and on weekends.

    f. A way to balance the risks is to have the medications written up in such a way that they are in safe doses, compliant with guidelines and administered by nurses after

consultation with a doctor. The clinician should start with the lowest dose unless there are clear, documented reasons to start at a higher dose.

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

h. Ms Dowson seemed to be deteriorating rapidly and had a short prognosis from her underlying conditions including severe COPD. It is very difficult to say for certain that the increased Morphine dosage harmed Ms Dowson.

91. 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.

92. 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.

93. 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.*

94. 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.

95. 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.

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

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

98. 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.

99. 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.*

100. Regarding the care provided to Ms Dowson she opined,

    a. It was not appropriate to prescribe the End of Life medications on admission to the RACF. She states,

    It is my opinion given her age, frailty, low weight (<50kg) and her risk of respiratory depression, that it would have been best practice to only prescribe these medications when she was on an 'end of life' trajectory, after review by the doctor and the doses to be commenced at a much lower range and titrated up cautiously. The range of dosing was too high and not enough documentation was made to advise the staff what dose to commence and indication for commencing.

    b. Ms Dowson was in the terminal stages of her illness. She states,

    On review of her chart it is my opinion that Ms Dowson was end of life, she fulfilled the criteria to enter an end of life pathway, she was not opioid naïve and had previously tolerated similar doses of morphine. I believe her deterioration precipitating her review at TTH was related to her disease process rather than a consequence of her morphine dose. When she was not admitted to TTH for IV antibiotic therapy for this deterioration (previously she had been) it was appropriate to consider this her terminal illness.

    c. It was not appropriate for the GP to agree to commence End of Life intervention when he had not reviewed Ms Dowson.

    d. It is the doctor's role to be involved in the decision to commence palliative medications. If there were physical constraints this could have been done via telephone or video conferencing.

    e. Ms Dowson was at the terminal stage of an incurable illness, and she fulfilled the criteria to enter an End of Life Pathway. The main issues were lack of documentation, communication, and timely review of the resident.

101. 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.

102. Ms Thain was not asked to provide an opinion regarding the care provided to Ms Dowson as she was only briefed to provide an opinion concerning the care the RN provided to other residents. The RN was not involved in the administration of Ms Dowson's End of Life medications.

103. 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 Ms Dowson she opined,

a. There is evidence in the progress notes of a conversation with the Next of Kin around Ms Dowson's request and the NOK agreeing Ms Dowson had given up and that her NOK supported the approach to stay at the RACF.

b. There is evidence of the family being present and assisting with some cares. She states,

This to me indicates that they were involved in the care and care planning of Ms Dowson. It could be argued that this formed the basis of assessment to start of the formulation of the end of life pathway.

I believe that starting Ms Dowson on an end of life care plan appropriately but I would expect to have seen an end of life assessment completed prior to the end of life pathway being started. As it is the assessment that formulates the care plan.

c. Based on the clinical documentation, it was appropriate for the CNC to commence an End of Life Pathway prior to Ms Dowson's GP reviewing her. She notes on 7 December 2017, the GP had recorded, 'little to do apart from keep comfortable'.

d. It was inappropriate to commence Ms Dowson on the maximum dose, she states,

This was the maximum dose available to give and a usual practice would be to start with a lower dose of a medication and assess for the effectiveness and side effects. In this case Ms Dowson had been transferred to hospital for side effects of oxynorm and as such it would have been even more important to start on a low dose of medication and assess the effectiveness and ensure that the dosage managed the symptoms displayed.

e. The progress notes were exceptionally limited. They lacked depth of assessment, planning, resident, and family involvement.

104. 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).

105. 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.

106. 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 with Dr Ulcoq's discussion regarding Ms Dowson.

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

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

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

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

107. 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.

108. 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.

109. On 1 April 2022, the GP provided a response to the OHO's allegations in the referral to QCAT. Concerning Ms Dowson, 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. Before subcutaneously injected end of life drugs are considered, the patient must still have pain after oral forms of analgesia have been used and proved insufficient to relieve the patient's symptoms.

d. 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.

e. 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.

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

g. He believes he verbally specified a starting dose of 2.5mg in accordance with his usual practice for most women or patients of low weight.

110. 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 Ms Dowson.

111. 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.

112. 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.

113. 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".

114. 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.

115. 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.*

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

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

> *After the referral notice was filed,* [the RACF] *produced the End of Life Care Pathway for* [resident] *where* [the RN] *had documented that* [the resident's] *symptoms included agitation,*

[1] This is the correct date

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.*

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

119. 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.

120. 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.

121. 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.

122. 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.

123. 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.

124. 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 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.

125. 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

126. The allegations against the CNC pressed by OHO at QCAT concerning Ms Dowson were that she:

> a. Failed to complete an End of Life Assessment Form or End of Life Care Plan for Ms Dowson;
>
> b. Administered the highest dose of Morphine in the prescription range for Ms Dowson, without documenting any pain assessment or sufficient reason to justify the dose administered;
>
> c. Failed to maintain appropriate records in that she did not:
>
> i. Detail her observations of Ms Dowson that Ms Dowson was refusing care, water and food and voicing that she was in pain.
>
> ii. Sufficiently detail her reasons for selecting the doses of medication administered

127. 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.

128. 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. She is not critical of the decision to commence Ms Dowson on an End of Life Pathway prior the GP reviewing her, given the discussions that were documented in the records.

d. Ms McGregor is critical of the CNC's administration of the medications to Ms Dowson:

a. The progress notes do not detail why these medications were administered. ' Palliation' is not a sufficient reason to provide medications. Reasons for providing medications would include pain, agitation etc. It is standard practice for RNs when administering PRN medications that sufficient details are documented to explain why the PRN medication was administered. It is unclear to me whether the medications were administered for pain or shortness of breath.

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

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

d. Ms Dowson had a very low body weight. There is no documented consideration that the Respondent has taken this factor into account when determining to administer the highest dose of midazolam and morphine.

e. Ms Dowson was having significant difficulties maintaining her oxygen saturations whilst being administered oxygen. There is no documented consideration that the Respondent has taken this factor into account when determining to administer the highest dose of midazolam and morphine.

f. Whilst it might have been appropriate to have administered midazolam and morphine, there is no clear reasons for administering both documented in the records. In my opinion given Ms Dowson's body weight and oxygen saturations, it would have been important to clearly consider the impact of these medications and document the reasons for commencing on a higher dose.

129. 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

130. 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.

131. 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.

132. 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.

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

134. 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.*

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

136. 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.*

137. 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 Ms Dowson 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.*

138. 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.

139. 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.*

140. 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.*

141. The CNC has outlined a detailed version of events concerning her care of Ms Dowson. I provide in whole the events of the day of Ms Dowson's death.

    a. The CNC had not seen Ms Dowson regularly in the weeks leading up to Ms Dowson's death. She does recall being informed that Ms Dowson had an increased number of falls and that she was of a very low weight and struggled intermittently with breathing and requiring oxygen therapy in order to allow her to breathe.

    b. The CNC was not involved in Ms Dowson's care until in the afternoon of 10 April 2017. She states,

    > *I do not recall providing any care to Jean until the end of my shift on this particular day. I do not recall any of the registered staff raising any issues with me until the afternoon handover time. Around this time,* [a nurse] *came to report to me that* [a RN] *had handed over to her that Jean had significantly deteriorated during the course of the shift. I was extremely concerned by this because* [a RN] *had not reported these things to me during her shift and had left to go home before having a discussion with me about it.*
    >
    > [a nurse] *told me that:*
    >
    > *a. Jean was reasonably good in the morning however around lunchtime she stopped eating and appeared in significant discomfort;*
    >
    > *b. she was having muscle spasms from this time;*
    >
    > *c. she was having significant difficulty breathing; and*
    >
    > *d. she had expressed to the staff (I do not know which staff) that she did not want to fight to breathe anymore and wanted her family to be contacted.*
    >
    > [a nurse] *gave me this information either during the handover or shortly afterwards.*
    >
    > [a nurse] *and I then went to Jean's room where I would have asked her how she was going if she was awake. 1 cannot specifically recall if she was awake when I was in the room due to the passage of time.*
    >
    > *Based on information provided to me verbally by* [a nurse] *about Jean's deterioration during the day and my observation of her I agreed with* [her] *assessment. While I was with Jean she was having very laboured breathing and significant muscle spasms all*

over her body including her limbs.

Having had some involvement with Jean's care over the month of her admission I was aware that she was an extremely stoic person and generally refused pain medication.

The clinical picture presented to me by [a nurse]*, and that I witnessed myself, was that Jean was experiencing an acute deterioration. This was indicated to me by her refusal of care, water and food and her voicing that she was in pain. In light of the fact that she had been discharged from hospital and that there did not appear to be any reason for readmitting her to hospital, I decided that it was appropriate to speak to Jean's next of kin, Ms Ursula Dowson, her daughter. I have a vague memory that Jean asked me to call Ursula but I cannot specifically recall.*

I knew that Ursula had regularly visited her mum over her admission and would have a very good understanding of her condition and whether she was acutely deteriorating as I suspected she was.

I called Ursula after I left Jean's room and when Ursula arrived I talked to her about her mum's condition. Ursula and I had a conversation for quite a while, probably about 15 minutes or so. During that conversation I went in detail through the notes I read for times I was not present about Jean's decline and also added in my personal observations of her deterioration which I have described above. Ursula shared these views and said that she had noticed over the last few weeks that her mum was refusing to eat drink and her cares had declined and it was clear that she had deteriorated.

I would have explained to Ursula, as was my usual practice, that the medications that were chartered to relieve Jean's symptoms were Morphine and Midazolam and that these would need to be confirmed with the doctor. Ursula was in agreement with us talking to [the GP] *about commencing end of life medication. This conversation occurred in the presence of Jean and I recall that she also agreed with this course of action by nodding or using the word ' yes.* [A nurse] *and I then went to the office to ring* [the GP]. *I rang him on speakerphone so that* [a nurse] *and I could both talk to him at the same time as I had not been involved in Jean's care that day or in previous weeks in any meaningful way. I cannot specifically recall all of what I said to* [the GP] *however based on my usual practice in these general circumstances, I would have outlined the events described above. I recall I stated to* [the GP] *that Ursula, Jean's daughter, was present and that she had agreed for her to commence end of life medication as had Jean. I also recall I said that Ursula agreed with our assessment of Jean's condition that she was in the end of life stage.*

[the GP] *advised us to commence the end of life medications in accordance with his order mentioned above. He said that he would be in the next day to review Jean.*

[the GP] *did not give any guidance to us or orders in relation to the starting doses of Morphine.*

At about 3:00pm [a nurse] *and I administered l0mg of Morphine and 5mg of Midazolam to Jean via an Intima butterfly in her buttocks.*

At this time Jean weighed approximately 29kgs as she had not been eating properly for a long period of time. It was impossible to find anywhere in her stomach to administer the subcutaneous injections, which is where we would normally inject them.

I then decided the best place to administer or inject the needle was in her buttocks. As she was already lying on her side, we did not need to move her to do this. In my view Jean most needed the Midazolam to relieve the spasms and the pain the spasms were causing. I administered the Midazolam first. Because Jean was so small and emaciated some of the lmL of liquid which I injected leaked out of the site. This was because there was not enough fat to inject into.

In deciding what dose of Morphine to administer I considered a few different things.

Because of her lack of body fat we were having trouble injecting. Jean may not receive the full dose because some of the Midazolam had already leaked out and, as Morphine was the second injection, even less would absorb than the first injection.

In aged care we cannot give intravenous morphine except with a doctor's order. Usually, the doctor would attend the facility to perform the cannulation. Given [the GP's] *availability this would not be possible. Effectively, I was only able to deliver the drugs subcutaneously. Another consideration was that she had significant pain and distress from the spasms and was struggling to breathe which was making her very distressed and uncomfortable.*

Jean was very strong and resilient to pain so another consideration for me was the fact that she was expressing pain that suggests to me it must have been extremely strong pain. Jean was not opiate naive, having had Tramadol and Ordine the week before.

A further consideration was that because the PRN medication order only enabled us to give the Morphine and Midazolam every two hours, if starting at the lower end of the range was ineffective as it might be in the case of extreme pain, the resident could then be in pain for the remainder of the two hour period until a further dose could be administered.

At 3:03pm I made the following entry into the progress notes:
'Morphine 10 mg administered for palliation as per GP. '

At 3:03pm I made the following entry into the progress notes:
'Midazolam 5 mg administered for palliation as per GP. '

Wherever possible I made detailed notes about the reasons medication or a particular dose was given but sometimes because of the many demands on me as the CNC I was not able to write a detailed note.

Wherever I could I would later write a more detailed, retrospective note if my note had not been detailed enough. However it was not possible to do this if the iCare resident record had been closed. Where a resident died [the RACF] *would usually close the iCare record 24 hours after the death, which meant I could not make a note retrospectively beyond then.*

I cannot recall if I attempted to make a retrospective note for Ms Dawson (sic) *but if I did I may not have been able to for this reason.*

I also made additional notes in relation to both of the above entries at 4:49pm as follows:
'Given PRN Morphine for good effect'
'Given PRN Midazolam for good effect'
For added comfort when a resident is being palliated it is common to provide the following:

- *(a) lip balms;*
- *(b) moisturisers;*
- *(c) mouth swabs to hydrate the mouth after dipping them in fluid;*
- *(d) extra blankets and pillows;*
- *(e) aromatherapy lamps; and*
- *(f) music.*

We also arrange things to make the family more comfortable so that they can stay in the room as long as possible with the resident including overnight sleeping if they wish to.

In the case of Jean, I noticed that when I had arrived to see her after handover she

already had a number of these items in her room.I assume they had been put there in the morning by the staff on shift.

After administering the medication to Jean, she had in my opinion enough of the things she needed to keep her and her family comfortable however I asked Ursula and Ursula's daughters who were there at that stage whether they wanted us to arrange anything else. They indicated that they were happy to provide all of the cares to her mum going forward and did not need anything and so [a nurse] *and I left the family alone after this point.*

The next thing I recall I did was write a progress note around 5:00pm. This was the first time I had the opportunity to properly document what had happened during the day because of the way that this matter had been sprung on me unexpectedly and my other usual duties.

At 5:02pm I made the following notation in the progress notes:
'Jean returned from hospital this morning weak and continued to decline throughout the day. She has been semi conscious for most of the shift and having difficulty maintaining oxygen saturation with 02 via Hudson mask on 9L/min. Jean expressed to staff she doesn't want to fight to breath anymore and wanted her family to be contacted. Daughter Ursula phoned to attend directly. Observed Jean to have frequent muscle spasms and labored breathing making it very difficult to relax. CNC discussed with daughter, Jean had now become palliative. Ursula agreed she felt her mother had given up and just wanted her to be comfortable. CNC phoned GP to notify of Palliative status. Confirmed to commence End of Life medications as prescribed on med chart. Ursula happy with this. CNC inserted intima into right buttock for adequate subcutaneous fat to absorb medication. Morphine & Midazolam given subcut as ordered. Jean now settled. Family remains by Jean's side. Comfort cares given hourly & as required. Family attending to mouth toilets & emotional support for Jean.'

I also popped in to see Jean and her family before I left work to check if they needed anything else and to see how Jean was going. I do not recall anything unusual when I visited the room. I do not specifically recall what was happening, so I believe that Jean was peacefully resting and her family were with her.

I did not detect any concerns from Jean or her family about the care we provided to Jean. They were very involved in her care and appeared to be happy with the care that was provided to Jean.

I was not involved further in Jean's care.
I did not complete an End of Life Assessment or End of Life Care Plan in relation to Jean as I assumed this would be carried out by the registered staff currently looking after Jean, given their involvement was more in depth than mine and they would continue to provide care for the rest of the day.

I did not conduct a written pain assessment in relation to Jean. Details of Jean's status was conveyed directly to [the GP] *so I did not think it was necessary.*

I was not present at the Facility when Jean passed away at 11.25 on 10 April 2017.

Professor Good's Response

142. The reference given for 'palliation' is not a clinical justification. He does not consider the leaking of the injection to be a justification for administering the medication. Such leaking would usually mean the site is changed, not that the highest dose of a PRN range should be used.

143. Ms Dowson having had some opioids in the last week prior does not make it appropriate clinical reasoning to give a higher opioid dose. She was not 'opioid tolerant' that is, had been taking opioids on a daily basis for symptoms.

144. Professor Good maintains it would be normal clinical practice to start at the lower end of the PRN dosage range as it would be unknown how she would respond to the lowest dose and that the lowest dose would generally be expected to provide pain relief given she was not opioid tolerant and having a low bodyweight. He states,

> *The whole point of a dose range and timing of the prn medication – is to try and provide symptom relief, and safety, and minimise adverse effects. If the lowest dose of prn medication – then the appropriate clinical response is to contact prescriber and discuss what should be done next – it is not a clinical justification to give the highest dose in a range.*

145. Professor Good makes some observations about Ms Dowson's weight, he states,

> *Ms Dowson was stated in this affidavit to weigh 29kgs. Whilst in adult palliative care practice morphine and midazolam are not generally given on a weight based calculation – it is prudent to be cautious with dosing when a patient is such a small weight. And would generally be accepted to start at the lower dose range when the weight is so small.*

146. In response to Professor Hardy's opinion (referred to below), Professor Good says the current version of Therapeutic guidelines, Palliative Care referred to be Professor Hardy have the following guidelines for initiating Morphine and Midazolam medications for shortness of breath:

    a. Morphine 0.5 to 1mg subcutaneously, repeated as required 1-2 hourly;
    b. Midazolam 2.5mg subcutaneously, repeated as required in 1 hour.

RACF's Executive Manager's Response

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

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

148. 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.*

149. 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 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.

150. 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.

151. 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.

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

Further Expert Evidence

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

    a. The highest dose of subcutaneous Morphine administered by the CNC would be considered high in the situation given she had never received the medication via the subcutaneous route before.

    b. Ms Dowson had received oral Morphine 10mg three times prior for difficulty breathing with a documented good temporary effect. This would indicate she seems to be tolerating the doses satisfactorily.

    c. The reference 'for palliation as per GP' does not sufficiently explain what symptom the dose was administered for as well as why the highest dose of Morphine was chosen. He states, "*Ultimately, the dose administered in this circumstance was not the most appropriate and did not align with best practice*".

    d. The CNC could have sought guidance from the GP but that was not necessary as there was already a standing/PRN order in place, there was a documented discussion in the resident's chart with her daughter and the GP regarding her deteriorating condition and palliative status.

    e. What was lacking is appropriate documentation, justifying the use of the highest dose of subcutaneous Morphine at the time of administration, however the CNC's affidavit provided justification of their clinical reasoning at the time.

    f. The assessment by the CNC prior to administering the highest dose of subcutaneous Morphine was 'well below what could be considered best practice'. Documenting, 'Palliation as per GP', does not qualify as an adequate assessment of Ms Dowson's pain. He though states,

        However as per the respondent's affidavit, it is clear that the respondent had applied clinical reasoning to her assessment of Ms Dowson's condition and symptoms at the time, but unfortunately this was not documented due to other demands on the respondent on the day, as well as the iCare record (documentation system) of Ms Dowson being closed within 24 hours after her death, prohibiting a retrospective entry. This in my opinion, could certainly be considered a reasonable mitigating factor in this situation.

154. 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.*

155. Concerning Ms Dowson, she advised,

a. She agrees with the CNC that there is no correct dose for 'as required' Morphine and that a clinical decision is made following consideration of a number of factors eg. level of distress, ability to give repeat doses, expected drug absorption considering lack of subcutaneous tissue. She states,

Although, ideally, it might have been preferrable to deliver a lower dose initially (eg 5mg) and review and repeat if necessary, in the circumstances of end stage respiratory disease, severe respiratory distress plus pain, the difficulty in delivering the drug subcutaneously in the absence of subcutaneous fat, lack of renal impairment, the lack of orders for a continuous morphine infusion and the inability to give a repeat dose within 2 hours, the dose given was in accordance with a reasonable, considered treatment plan.

b. The GP did not give guidance as to the starting dose when approving the commencement of End of Life medications on 10 April 2017.

c. Concerning the opinion expressed by Professor Good, she states,

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

Professor Good states that [the CNC] *"did not appropriately detail the reasons for providing the highest dose of morphine in the range". These reasons have subsequently been provided by* [the CNC] *both in her general statement and when discussing each of the cases.* [The CNC] *also states that on many occasions, she had delivered Morphine at the lower end of the range consistent with the patients symptoms…*

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

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

Explanation from OHO

156. 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 former Coroner confirmed an inquest was not scheduled and the 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 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.

157. 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

158. 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.

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

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

161. I accept based on the clinical contemporaneous records that there had been a deterioration in Ms Dowson's condition. A decision was made to commence Ms Dowson on End of Life treatment. According to the preponderance of expert evidence, this was reasonable.

162. Despite encouragement by staff and her family Ms Dowson was reluctant to eat and drink. I accept Ms Dowson had reached the end stage of her life. That is, it was appropriate to treat Ms Dowson's symptoms to ensure she was kept comfortable as she continued to deteriorate.

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

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

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

    a. Professor Good opined a way to balance the risk of anticipatory prescribing is that medications are written up in safe dose, compliant with guidelines and administered by nurses 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.

166. 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.

167. I am of the opinion the GP erred in his clinical judgement in prescribing anticipatory End of Life medications in such a broad range. The GP would understand there are levels of experience of registered nurses who work in aged care, and he did not mitigate the risk of a nurse not commencing at the lowest end of the range he had prescribed.

168. The GP had a good working relationship with the CNC. He believes he discussed a starting dose of 2.5mg of Morphine for Ms Dowson. There is no contemporaneous record of this. I do not accept the CNC purposively disregarded such an order. In her relatively detailed note on the day, there is no indication that the GP specified a starting dose. On balance, I am of the view the GP did not provide a starting dose of the medication that was to be given to Ms Dowson.

169. The CNC says it was her usual practice to commence administration at the lowest dose on the sliding scale unless there was a reason not to. She has provided her rationale for starting at the highest end of the range. Professor Good and the Executive Manager of the RACF do not accept the rationale provided by the CNC. Mr Ruzicka is critical of the CNC's assessment and documentation regarding starting with the highest dose of the medication. Professor Hardy says ideally it might have been preferrable to deliver a lower dose initially but accepts the reasoning of the CNC.

170. I accept Ms Dowson was likely distressed and showing signs of discomfort, however taking into consideration her low body weight and the balance of the expert opinions, I do not accept the highest dose of End of Life medications was appropriate. I am of the opinion the CNC erred in her clinical judgement in the commencement of End of Life medications at the highest end of the dose range for Ms Dowson.

171. 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 materially relevant in this case. The CNC was an experienced nurse and had experience in palliative care. In my view on 10 April 2017, she made a poor clinical decision.

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

173. 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***".

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

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

176. Ms Dowson seemed to be deteriorating rapidly and had a short prognosis from her underlying conditions including her severe COPD.

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

178. While I suspect commencing with the highest dose of the End of Life medications, particularly given Ms Dowson's low body weight, hastened her death, given there are so many variables I accept it is not possible to determine this with the sufficient degree of evidence to make that finding.

179. There was no autopsy in this case as the death was not identified in the first instance as a reportable death. Based on Dr Ulcoq's opinion that Ms Dowson was terminally ill from COPD and her final illness was in keeping with respiratory failure, I accept the cause of death was Chronic obstructive pulmonary disease.

180. It has been close to seven years since the concerns regarding Ms Dowson 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 Ms Dowson's daughters to publish these findings so other clinicians and other RACFs are able to consider and reflect on the events which occurred in this case. Further, that this case may result in the implementation of certain safeguards when considering the prescription and administration of End of Life treatment in a RACF.

181. I acknowledge how long it has taken to finalise this investigation. I extend my condolences to Ms Dowson's family and friends for their loss.

I close the investigation.

Melinda Zerner
Coroner

22 August 2024