QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INVESTIGATION

CITATION:	**Non-inquest findings into the death of Mr G**
TITLE OF COURT:	Coroners Court
JURISDICTION:	BRISBANE
DATE:	17/02/2026
FILE NO(s):	2024/4177
FINDINGS OF:	Melinda Zerner, Coroner
CATCHWORDS:	Coroner; Alzheimer's; Registered Aged Care Facility (RACF); Delirium; Failure to Recognise; Emergency Department; and Appropriateness to return to RACF.

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Introduction

1. Mr G was born on 25 November 1939 and died on 24 August 2024 at the Nambour Hospital. He was 84 years old.

2. Mr G's death was reported to the Coroner because his death was identified as a potential healthcare related death within the definition of a reportable death in the *Coroners Act 2003*.

3. I have received correspondence from Mr G's daughter raising several concerns about the care provided to Mr G's by both the Nambour Hospital and the Residential Aged Care Facility (RACF) at which he was residing. His family have advised Mr G suffered falls after progressive medication changes. Preceding his death, he had seven falls at the RACF and three hospital admissions over a period of four days.

4. Mr G's family prepared a timeline of events, copies of correspondence, and their own personal observations of what took place in the lead up to, and following Mr G's death. I have reviewed that material.

5. 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.

6. In making my findings, they are based on proof of relevant facts on the balance of probabilities. I am not able to make adverse findings against, or comments about individuals, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

7. Mr G had been an academic working in the veterinary field in his working days and unfortunately developed Alzheimer's disease, and behaviours and psychological symptoms of dementia (BPSD) five years prior to his admission to the RACF on 13 June 2024. He had resided in another RACF prior to that.

Circumstances of the Death

8. Mr G was an 84-year-old man with a background history of Alzheimer's disease, osteoporosis, arthritis, Meniere's disease (dizziness due to middle ear issues), depression, atrial fibrillation (AF) and prostate cancer. He resided in a Residential Aged Care Facility (RACF).

9. Mr G's daughter says at the time of entering the RACF Mr G was reasonably lucid, mobile, and healthy. It is evident through the email correspondence with the RACF that Mr G's daughters were heavily involved in his care and were working with the RACF in his management, making several recommendations to assist staff in caring for Mr G. He was clearly very loved and supported by his daughters.

10. According to the clinical records, Mr G had complex behaviours with disinhibition causing him to wander, be intrusive (invading other residents' rooms), disrobing, walking around naked (often into female residents' rooms), urinating in inappropriate areas, etc. He also called out loudly, swore in general and at others, threw things, was aggressive in tone and manner but not in action (he was not violent). His wandering was an issue as he had unsteadiness on his feet (assumed to be related to his Meniere's disease) with high falls risk. The documentation though seemed to show he could walk at a brisk pace and stoop to pick things up.

11. The RACF records document a gradual increase in Mr G's behaviours over the three months from June to August 2024. He was initially able to be re-directed with his wanderings, language, and aggression/sexualised behaviours but with time he became more resistant. He resisted cares including (especially) hygiene such as regular showering.

12. There were some falls recorded. On 6 July 2024, Mr G was found sitting on the floor of his room with no apparent injury. He denied falling.

13. Mr G was under the care of a geriatrician, who reviewed him on 13 August 2024 noting progressive cognitive decline despite donepezil (without any interval improvements since it was commenced 4 years previously) [treatment for Alzheimer's disease]. She suggested a gradual wean off donepezil and a trial of mirtazapine for depression, and quetiapine (antipsychotic) for the behaviours, commencing an *"as required*" dose, rather than as a regular medication in the afternoon/evening. The Geriatrician stated in correspondence to Mr G's General Practitioner,

> *The role of ongoing therapy with donepezil is debatable. It has been more than four years since [redacted] has been on donepezil. Based on discussions with Alyshia, there has been no significant improvement in his overall cognitive capabilities; on the contrary, there has only been a decline. To help with polypharmacy, we could certainly consider stopping donepezil. We shall look at reducing the dose to 5 mg daily for three weeks and then gradually wean him off it. It is now time that we trialled an antipsychotic to help with these behavioural and psychological symptoms. I discussed this with Alyshia. To begin with, we should be trialling quetiapine 12.5 Mg as needed, a maximum of 50 Mg per day. We could begin with trialling this at 3 PM every day. Based on his daily requirements, we can consider making it regular or increasing the dose further. It is ideal if the team monitors his behaviours closely. We shall monitor for visual hallucinations. Non-pharmacological interventions, such as having a phone number saved on his phone as his daughter Alyshia's but a call goes to a message bank with Alyshia's voice calming him and suggesting she is busy at work and also having a system where Alyshia calls [redacted] on a fixed routine, should help for now. This is only a trial. Obviously, as things get dynamic, we should look at options such as having a recorded video of Alyshia reassuring her dad on an iPad. [redacted] has been appropriately vaccinated for COVID and influenza. [redacted] has an advanced health directive. I am hoping to review [redacted] again in 3 months to monitor his progress. In the meantime, if you have any concerns, please feel free to contact me.*

14. On 13 August 2024, Mr G's General Practitioner (GP) spoke with the Clinical Care Coordinator at the RACF about her consultation with the Geriatrician. It was noted Mr G was for a trial of quetiapine and for a trial in a different unit (Cartwright), so he was able to move around more freely.

15. On 14 August 2024, Mr G's daughter advised she was happy for Mr G to move to Hay lodge but was not keen on the idea of moving him to Cartwright just yet. She was happy for her father to trial quetiapine.

16. The new medication was commenced on 15 August 2024.

17. On 17 August 2024, there was a '*near miss'* as Mr G went to sit on a chair without it being fully beneath him with no fall. There were two falls recorded that evening at 6:00pm. They were unwitnessed, with Mr G being found on the floor with no injury. He was rubbing his face saying there were *"too many things going on in his head*." His daughter had reported Mr G's spatial judgment was getting worse. He was requiring a lot of prompting and redirection on basic tasks. Mr G was given a dose of quetiapine

after this.[1] At 10:00pm there was a second unwitnessed fall which resulted in Mr G complaining of shoulder and hip pain. He was transferred to the Nambour Hospital for review.

18. Mr G arrived at the Emergency Department (ED) at 10.30pm. The presentation recorded behavioural issues with Mr G trying to crawl out of bed continually. He had apparently been out and mobilising in the department "effectively" with no ataxia (unsteady gait). He was given several CNS-active agents to settle his activity including quetiapine, lorazepam (benzodiazepine), and intramuscular olanzapine (another antipsychotic). After the latter agent, Mr G went into rapid Atrial Fibrillation (AF) requiring digoxin to slow his heart rate down. A urine sample taken suggested Mr G had a urinary tract infection (modest number of white cells) and he was commenced on an antibiotic, trimethoprim.

19. On 18 August 2024, it was documented at 8.39am in the hospital notes by the RaSS (Residential Aged Care Facility Support Service) Clinical Nurse that Mr G was a patient of the "dementia wing" of a RACF. He was asleep at the time of her assessment, so she did not examine him noting some collateral history from the RACF staff. She did not assess his cognition, behaviour, or mobility. She documented that carer told her that Mr G appeared to hallucinate which included, picking at things and that he was not at his "baseline". She listed some generic strategies for managing dementia noting that emergency staff deemed him "safe and stable" for discharge to the nursing home.

20. The RaSS nurse recorded under the heading, 'Relevant background to presentation':

> *Collateral history on presentation from RACF, [redacted] had 3 x falls yesterday from 1700hrs, all within his room. After his last fall c/o L) should and hip pain. RN also states she noted increased confusions yesterday, could not recognise table, and had difficulty sitting on a chair. [redacted] was also seen hitting head'.*

21. Under the heading Geriatric Nursing Assessment she states,

> *RN states pt has been grabbing at things that are not there, stating needing to leave and go to work. This is not baseline for [redacted] evidence of current active delirium.*

22. At 8.40am, it was noted 'AIN now specialling pt', and at 7.15am, it was noted Mr G was requiring 1 to 1 nursing as he was 'attempting to get out of bed ++'. He was also noted to be 'reaching for objects in air that aren't there'.

23. The RaSS Clinical Nurse returned and completed the discharge summary at or around 1.07pm. She provided several recommendations to the RACF for 'delirium risk' and stated,

> [redacted] *was showing signs of visual hallucinations overnight. Please continue non-pharmacological strategies for de-escalation and hallucinations. Maintain a low stimulus environment, ensure regular rounding, orientation and reassurance, anticipate patients cares needs eg. toileting, pain diet and fluids*.

24. The nurse identified Mr G was a 'High Falls Risk' and suggested the following interventions in the discharge plan:

    a. High visible room, keep curtain open for frequent visual checks

[1] According to the medication chart this was the only dose of Quetiapine Mr G received after being prescribed it by the Geriatrician

b. Bed at lowest point

c. 1 x assist with all mobilisation

d. Call bell within reach

e. Bed alarms to be used when available

f. Safety socks are to be worn for mobility

g. Restrict fluid after 4pm to help reduce nocturnal frequency (avoid caffeine after 3pm).

25. Under the heading 'Discharge', she states,

> *The medical team have deemed the patient medically stable and safe for discharge. Clinical Handover advising of care and management during this presentation given to RACF RN at 1230 with thanks. Nil barriers to discharge identified. Happy for transfer back to RACF today.*

26. Mr G was returned to the RACF from the hospital on 18 August 2024. On his return to the RACF, he was noted to be *"bright and alert*". At 10:00pm on 18 August 2024, there was another fall with no apparent injury, but Mr G had confused speech. There were another two falls on 19 August 2024. After midnight there was an unwitnessed fall with bruising to his left forehead, a lip laceration and skin tears to his right knee and elbow. At 6:00pm there was an unwitnessed fall in the bathroom with no apparent injury. Mr G was assisted to his feet, and he began pacing without apparent symptoms. Another unwitnessed fall occurred at 11:00pm, with a possible head strike and painful left shoulder.

27. On 20 August 2024 at 2.20am, Mr G was taken to Nambour Hospital post fall with a painful left shoulder. The history recorded was unwitnessed fall, that he was "baseline confused", had a haematoma on his head, and that he had shoulder pain. Noting "*falls past few weeks*", and likely urinary tract infection. A CT brain scan found no intracranial injury. A shoulder X-ray confirmed Mr G had sustained a fractured neck of humerus (upper arm bone). Review of the urine test from 18 August 2024, showed enterococcus species which resulted in his antibiotic being changed to cephalexin. He was placed in a collar-and-cuff sling (which he did not tolerate), was given oxycodone for pain and was discharged back to the RACF with a fracture clinic referral. There was no documented discussion by doctors from the ED with Mr G's GP or nursing staff from the RACF.

28. On his return to the RACF, Mr G's falls risk was reviewed, and a plan was put in place by the physiotherapist. He was assessed as a high falls risk (score 18/20) due to reduced static and dynamic balance, unsteady gait, no insight, and poor posture. Falls mitigation strategies included non-slip socks, clutter-free room, call bell (though it was noted that he had no understanding of its use), drinks and phone within reach, low bed, sensor mat and hip protector pads.

29. On 20 August 2024 at 1.14pm, a Registered Nurse wrote to Mr G's daughter. She stated,

> *I tried to call, you are probably busy, no worries.*
> *I've spoken with [the GP]; she believes* [redacted] *balance and delirium are probably related to AF and the UTI.*
> *She has made an urgent review to [the Geriatrician], we are waiting on his response. He's quick to respond generally.*

Also, [redacted] the physio has reviewed your dad, he believes he should be on a low low bed, believes this is the safest option for the time being. There will be a sensor mat on the floor.
This is classed as a restrictive practice, if you agree to this, please let us know so I can add that to this restrictive practice sign sheet.
If you have any concerns, please call the RN on duty. I have finished my shift for today as I started early.

30. On 20 August 2024 at 7.50pm, Mr G had a third presentation to the ED, noting his earlier presentation that day. The RACF reportedly had difficulty managing his behaviours which required two staff to supervise, monitor, and redirect him. It was noted Mr G had worsening delirium and was difficult to manage in the RACF. He was constantly moving, trying to get out of bed and clutching at his arm.

31. Mr G was admitted to the geriatric unit with increased confusion, not at normal baseline, often having increased agitation in the evening. It was noted he was on quetiapine and temazepam as required to manage these behaviours. His quetiapine was ceased on admission and his antibiotics were continued with a plan to discuss his case with his usual geriatrician. It was noted that whilst in the ED, Mr G had been given a combination of oxycodone 15mg, quetiapine 12.5mg, and lorazepam 1mg. A diagnosis of hyperactive delirium was made and felt to be triggered by his pain. He was placed on a buprenorphine patch for pain with the following to be given (in order of priority) to manage behaviour: quetiapine 12.5-25 mg to a max of 100mg daily; oxazepam (benzodiazepine) 7.5-15mg to a max of 30mg daily; and midazolam (intramuscular benzodiazepine) 1mg to a max of 2mg daily.

32. On 22 August 2024, Mr G was observed to be incoherently mumbling but denied pain. He had been striking out at nurses and had been verbally abusive. He had been given oxycodone, quetiapine, and oxazepam overnight. That night he was observed to be groaning and attempting to swing his legs out of the bed. Nurses gave oxazepam 15mg in the evening, five doses of oxycodone throughout the day and quetiapine 25mg at 07.25am and 2.29 pm. Doctors noted Mr G to be lying in bed with gurgling breathing. Opining the analgesia was inadequate, Mr G was commenced on subcutaneous morphine.

33. On discussion with Mr G's daughter, she requested transitioning Mr G to comfort cares (agreed to by her sister and other EPOA), stating that this was not her father. A syringe driver containing morphine, midazolam, hyoscine, and haloperidol was commenced.

34. On the morning of 24 August 2024, Mr G was noted to be more settled but with laboured breathing indicating he was entering the terminal phase. He was declared deceased at 2:42 pm.

35. Mr G's daughter raised several questions with the RACF following his death. I have been provided with a copy of the response by the RACF addressing those questions. I do not repeat those herein. I have been provided a copy of an audio recording of a meeting held on 27 August 2024 with Mr G's daughter, his GP, and staff from the RACF. I have listened to the recording.

Forensic Physician and Cause of Death

36. Dr Gary Hall, Senior Forensic Physician was asked to provide a preliminary review of the case. He raised some concerns with Mr G which assisted in informing my investigation strategy. He was asked to confirm the cause of Mr G's death. He concluded the cause of death was:

Complications of fracture left humerus neck due to fall due to hyperactive delirium due to antipsychotic medication due to dementia of Alzheimer's' type.

Clinical Review by Nambour Hospital

37. The Nambour Hospital undertook a Concise Review into the circumstances regarding Mr G's death.

38. The review team noted Mr G was a highly vulnerable patient, requiring intensive nursing care due to his worsening cognitive impairment, aggression, and hallucinations. The author of the review states,

> *The team recognise that delirium is complex, and balancing return to familiar environment does need to be carefully assessed against benefit of remaining in hospital. The review team note that the discharge on the first presentation (18 August 2024), occurred with support of the RaSS team and discussion with the RACF. On review, the subsequent presentation, with new diagnosis of fracture of the humerus, the team agree that while further deterioration may not have been preventable, active treatment of the UTI, monitoring of digoxin/AF therapies, management of delirium, and pain management for his acute fracture would have been supported in the inpatient setting.*
>
> *Assessment and decision making around disposition planning was reviewed and the review team note there may be an underappreciation of the limited capacity of the RACF to provide intensive nursing care as well as the access issues to General Practitioners at short notice within this environment. It is noted that the discharge summaries request urgent GP follow up, and this was unlikely to be able to be achieved by the RACF in a timely manner.*
>
> *The second presentation (20 August 2024) and subsequent discharge occurred in the afterhours setting, with the patient presentation at 0230hrs and discharging home at 0740hrs. The team agree that further education is required to ensure that medical staff are sensitive to the risk of discharge in this patient population and that contact is made with the facility to discuss any concerns or limitations that may exist prior to discharge. Had this occurred the opportunity to recognise the risk of discharge would have been increased.*

Geriatrician Expert Opinion

39. I requested an independent expert opinion from a Geriatrician concerning the care Mr G was provided. Dr Gill is a specialist geriatrician employed as a senior medical officer in Metro North Health Service. She manages acute geriatric inpatients and manages a behavioural and falls unit. She is also the geriatrician in charge of the RADAR[2] outreach team at the Redcliffe Hospital and has extensive knowledge about nursing homes.

40. Dr Gill is of the opinion the review by Mr G's Geriatrician on 13 August 2024 was appropriate. She notes Mr G had had a progressive decline in cognition and behaviour. She considered the suggested addition of prn quetiapine was suitable, and states,

> [redacted] *was displaying significant behaviours which were impacting on his dignity and the ability of staff to take care of him (he was resistive to showers, etc), so a trial of a low dose of antipsychotic was reasonable*.

[2] Residential Aged Care District Assessment team (specific to Metro North Hospital Health Service)

41. Dr Gill opines it would be highly unlikely that the introduction of such a small dose of a fairly weak antipsychotic such a quetiapine would be the primary cause of Mr G's falls. She states,

> *Rather, this is a patient who is slowly deteriorating in function and cognition already, the medication is for symptoms of that deterioration. The escalation in falls appears to be in the context of a new delirium, thought to be due to development of a urinary tract infection.*

42. Dr Gill reviewed the care provided at the Nambour Hospital. She made the following observations:

    a) There was poor recognition that Mr G had a delirium during Mr G's initial presentation to the ED. She notes the discharge summary incorrectly reported Mr G was at his 'cognitive baseline'.

    b) Mr G was noted by the RaSS nurse to be delirious and have constipation in addition to rapid AF. This was not communicated in the discharge letter and no treatment was given for constipation.

    c) Mr G was so agitated during this presentation he required one on one nursing. This is not possible in a nursing home and there appears to have been no recognition of this.

    d) Mr G was given olanzapine due to his agitation. This was later thought to be the cause of his AF. This though is very unlikely. AF was more likely a marker of acute illness. This resulted in Mr G not being given olanzapine again, a very effective agent for extreme agitation and appropriate in Mr G's presentation. He was instead given more inferior agents such as quetiapine and lorazepam.

    e) During Mr G's second presentation to the Nambour Hospital, there again was no recognition of delirium and he was discharged back to the RACF without discussion with his EPOA or the RACF.

    f) On the evening of 20 August 2024, Mr G was again brought to the ED with worsening delirium, hallucinations, and escalating behaviours. Mr G was very distressed on this presentation, kicking and punching and attempting to bite staff. She questions the use of security staff and the administration of 1mg of Lorazepam. On this admission Mr G was diagnosed with delirium with a 4AT score of 8 (a delirium screening tool) which was thought to be due to pain and the UTI.

    g) The care by the Geriatrician at the hospital after Mr G's admission was appropriate. She says it is common and accepted practice that opioids for pain, anti-psychotics for paranoia/hallucinations and benzodiazepines for agitation and anxiety be used in this setting. The doses were relatively small, and the geriatrician team is experienced in prescribing these drugs in such circumstances. She does not think the acute pain team would have been helpful. She notes it is a delicate balance as pain can cause delirium, as can the use of opioid analgesia. This is why there is a reliance on lower regular doses and prn (as needed medication) as different people need different doses of medication to treat the pain and the delirium.

    h) The decision to switch to comfort cares was appropriate as Mr G was in a terminal delirium.

43. As to the care provided by the RACF, she opines the care provided to Mr G appears to have been appropriate. They instituted appropriate and standard falls management strategies, which included physiotherapy review, mobility aids, non-slip socks, bed

sensors, etc. All the falls were managed expediently, and Mr G was not left lying on the floor for a prolonged period of time. She states,

> *It would not be usual for nursing homes to 'special' (provide one on one nursing) to patients. All of the initiated transfers to hospital were appropriate and from the ambulance reports it would appear that the information provided by the nursing home was standard. It is worthwhile emphasising that nursing homes are not hospitals and most of the care workers in nursing homes have minimal training to recognise and respond to medical issues. The registered nurses appear to have appropriately followed protocol and managed [redacted] as best as they could. Nursing homes in general feel very disempowered and will very rarely refuse a transfer back from an acute hospital, although in this case it looks as though they were not even asked.*

44. In conclusion Dr Gill states,

> *I think the main problems with [redacted] management in Nambour hospital is* ***the failure to recognise delirium as the primary diagnosis in the emergency department*** *and thus failure to realise how unwell [redacted] was. There also appear to be a* ***failure to understand the capabilities of the nursing home*** *(i.e. in terms of staffing and supervision) and a breakdown in communication between the hospital and the nursing home. I don't think this would have changed the patient's ultimate outcome, but it perhaps would have been better managed and less traumatic for the family if he had been admitted earlier to hospital. There is a reluctance to admit and a rush to try and push management back out into the community. The problem is that the community does not have the support these frail, unwell patients need.*

Response from the Hospital

45. I sought statements from the relevant clinicians who reviewed Mr G in the ED.

46. The doctor who assessed Mr G during his presentation on 20 August 2024 has returned to the United Kingdom and is no longer a registered doctor in Australia. I have no jurisdiction outside of Australia to seek further information from this doctor.

47. The doctor who reviewed Mr G on 18 August 2024 was an Emergency Registrar. He was in his second year of his five year training program. He saw Mr G in the morning following a handover from the night staff. He reviewed Mr G and noted his urine had leukocytes of 50 and that cultures were pending. His other bloods were normal, but a repeat ECG showed Mr G was still in rapid AF with a heart rate of 160. His impression was Mr G had rapid AF secondary to olanzapine and/or a UTI. He did not consider Mr G was delirious.

48. The doctor says he discussed his findings and proposed plan with the Senior Medical Officer. That was to commence Mr G on digoxin for the AF, trimethoprim for his UTI, and PRN lorazepam to relieve Mr G's situational stress. He discussed Mr G care with his daughter who was not keen on Mr G commencing an anticoagulant due to his recent multiple falls.

49. The doctor completed the discharge letter and handover to the GP to follow up Mr G's newly diagnosed AF and to review his PRN medications for agitation. The Virtual Acute Care Service was to follow up on the urine result.

50. The registrar says his assessment was that Mr G's UTI had contributed to his presenting condition, and that this could be managed in the community with oral antibiotics. He did recognise that the cognitive state of Mr G after he had been treated with sedative and

antipsychotic medications including olanzapine and lorazepam may have masked his presentation. He acknowledges treatment for constipation was not offered and that he considered this should have been known by his RACF and appropriately treated in the primary care setting.

51. In response to Dr Gill's finding that there was no recognition of Mr G agitation and that he could not be managed at the nursing home, he states, '*Considering my review and discussion with the SMO, I considered Mr G could be managed back at the RACF. Mr G did not present in a highly agitated state that was not manageable at time of my review*'.

52. The doctor has since acknowledged Mr G had delirium and accepts; he did not include it in his diagnosis on the discharge summary. He says this was though documented by the RaSS nurse. He accepts he did not contact the RACF to see if they had the appropriate staff to manage Mr G but says he has noted this as a change to his clinical practice in moving forward. He is of the view Mr G's urinary tract infection was causing his delirium and that with the commencement of treatment Mr G's risk of having falls had been mitigated. He states,

> *Nil barriers were identified for Mr G to return to the RACF as he was medically stable, commenced on treatment for his UTI and it very often with patients with delirium that being in an unfamiliar environment contributes to worsening of their delirium.*
>
> *The option of admission to hospital was not explored for Mr G and in hindsight I recognise this may have beneficial* (sic) *for Mr G.*

53. The Clinical Nurse for RaSS who reviewed Mr G on 18 August 2024 has advised the term 'Nil barriers identified to patient to return to RACF once deemed medically stable' is a common phrase used in nursing discharge summaries meaning that the RACF can provide ongoing cares for the resident upon discharge once the medical team deem that the patient is medically stable for discharge back to the RACF.

54. The Clinical Nurse noted (which I accept) that the ED environment exacerbates or causes delirium in vulnerable patients, due to unnatural lighting, increased sounds, increased staff and inability for patient to move around freely. Further, that a nursing special is often arranged to mitigate the risk. She states,

> *The risks of worsening delirium in the hospital environment needs to be strictly weighed against the interventions that can be provided in a hospital environment. The ultimate decision regarding the risk benefit outcome and inpatient admission lies with the treating doctors caring for the patient.*

55. The Hospital says, the Review team considered the first presentation on 17 August 2024 followed by discharge on 18 August 2024 was reasonable. There was input and support from the RaSS team and discussion with the RACF.

56. With the second presentation on 20 August 2024, it is acknowledged Mr G could have benefited from an admission to support treatment for his UTI, monitoring digoxin and AF therapy, delirium, and pain management. Further, it is accepted there may have been an underappreciation of the level of acuity of nursing available at a RACF to attend to Mr G and difficult with access at short notice of general practitioners to attend the RACF.

57. The Medical Director of Emergency at the Nambour Hospital states,

> *The Review team acknowledge that further education is required to educate staff about the limitations of nursing teams at RACF to provided intensive nursing care. I have been in contact with clinicians from our Residential and aged care facility Support Services (RaSS) team, who are providing regular education to our trainees around the management of patients from residential aged care facilities. We are also providing feedback to individual clinicians when any clinical issues are identified. In particular, there is emphasis on the need to contact a patient's care facility and/or next of kin prior to discharge.*
>
> *The Concise Review recommended the case was to be shared with relevant staff to provide a learning opportunity. I have made arrangements for this case to be presented to our trainees at an upcoming 'learning from cases' education session.*

Conclusions

58. After considering the material obtained during the coronial investigation, I consider I have sufficient information to make the necessary findings required by s45(2) of the *Coroners Act 2003* in relation to Mr G's death. I accept the forensic physician's opinion as to the cause of Mr G's death.

59. Mr G, a former professional was inflicted with the terrible condition of Alzheimer's which changed his demeanour considerably, including causing him to have several challenging behaviours. He continued to be loved and supported by his family during this difficult time. There is evidence the staff from the RACF were working with Mr G's family to try and support him.

60. On developing a urinary tract infection, Mr G's condition deteriorated causing him to experience AF, delirium and to be increasingly unsteady on his feet. While the medical officer who reviewed Mr G on 18 August 2024 did not identify delirium in the discharge summary, there is documented evidence this was identified by the RaSS Clinical Nurse and communicated to the RACF, including her suggesting some strategies to the RACF as to how to attempt to manage Mr G in the RACF. He was commenced on an antibiotic for his UTI which it was hoped would also lessen his confused state.

61. The RaSS Clinical Nurse contacted the RACF personally to discuss Mr G prior to his discharge. I acknowledge she had appropriately identified Mr G was suffering a delirium and had attempted to mitigate the risks associated with this.

62. I accept Dr Gill's opinion that there was an under appreciation by the medical staff of how unwell Mr G was on his presentation to the hospital on 18 August 2024 and that he was suffering an acute delirium.

63. I accept Dr Gill's opinion that the RACF provided appropriate care to Mr G in what were difficult circumstances. The staff at the RACF would have been guided by the advice they had received from the hospital.

64. I acknowledge admission to a hospital can be a fine balance in an elderly person from a RACF. That is, is it better that they are at 'home' in a familiar environment, or admitted to an acute unfamiliar environment which can be overwhelming leading to a further increase in confusion.

65. Given Mr G required specialling (one on one care) in the ED because he was 'continually trying to get out of bed'; had had three recent falls; had a suspected infection; and was acutely confused (beyond his baseline), I am of the opinion the

prudent approach was for him to have been admitted to hospital on 18 August 2024 so that he could be further assessed by his regular geriatrician and provided with acute supportive care.

66. I am particularly concerned about Mr G's subsequent presentation to the hospital on 20 August 2024 and am of the opinion there was a further missed opportunity by the hospital to admit Mr G to the geriatric ward. This to treat his persistent delirium, to have him reviewed by his geriatrician, to provide him with supportive and safe care during his acute episode of delirium, and importantly to provide him with adequate pain relief for his fractured humerus.

67. I acknowledge Dr Gill says the admission of Mr Gill may not have altered his outcome as he was in the terminal phase of his illness. It would though have provided Mr G the opportunity to be appropriately assessed by his geriatrician, and in consultation with his family, to have a supportive plan in place to manage the terminal phase of his illness.

68. While I consider there have been missed opportunities by the hospital in this case, I do not consider an inquest (formal court hearing) is required. I do consider it would be appropriate to publish these findings so that other clinicians and health services can learn from the oversights which occurred in the care provided to Mr G. I have sought the permission of Mr G's family to publish these findings. I will also provide a copy of my findings to the Office of the Health Ombudsman, Clinical Excellence Queensland, and the Aged Care Quality and Safety Commission.

69. I extend my condolences to Mr G's family and friends for their loss. To lose someone in such traumatic and distressing circumstances is always difficult. I recognise there are no words which can adequately express your sorrow, or the profound impact Mr G's loss has had on you all.

Findings required by s.45

Identity of the deceased – [redacted]

Place of death – Nambour General Hospital NAMBOUR QLD 4560 AUSTRALIA

Date of death– 24/08/2024

Cause of death – Complications of fracture left humerus neck due to fall due to hyperactive delirium due to antipsychotic medication due to dementia of Alzheimer's' type.

I close the investigations.

Melinda Zerner
Coroner
CORONERS COURT OF QUEENSLAND - BRISBANE OFFICE
17/02/2026