2Coroners Act 1996
[Section 26(1)]

Western *Australia*

RECORD OF INVESTIGATION INTO DEATH

Ref No: 21/16

I, Barry Paul King, Coroner, having investigated the death of ***Maria Carmel Niceforo*** *with an inquest held at* ***Perth Coroner's Court*** *on* ***30 June 2016; 4, 5, 6, 7 and 11 July 2016; and 14 September 2016*** *find that the identity of the deceased person was* ***Maria Carmel Niceforo*** *and that death occurred on* ***7 February 2014*** *at* ***Armadale Kelmscott Memorial Hospital*** *from* ***organ failure due to sepsis*** *in the following circumstances:*

Counsel Appearing:

Ms K E Ellson assisting the Coroner
Ms B E Burke (ANF) appearing for Ms A Thungmun RN and Ms M Warner-Groves RN
Mr A P Hershowitz instructed by Maddocks appearing for KinCare Community Services Limited
Mr D V Brand (MDA National Insurance) appearing for Dr P C Lim

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INTRODUCTION

1. Maria Carmel Niceforo (**the deceased**) was 75 years old when she died in Armadale Kelmscott Memorial Hospital (**AKMH**) on 7 February 2014. She lived in Kelmscott with her son, Nicola Cosimo Niceforo (**Mr Niceforo**).

2. The deceased had a number of age-related illnesses, including type II diabetes and ischaemic heart disease with severely impaired right ventricular function. She self-administered insulin with the help of her children.

3. In April 2010 the deceased fractured her right hip, after which she was admitted to Royal Perth Hospital's Shenton Park campus (**Shenton Park Hospital**) for two months for rehabilitation. She developed bed sores, or pressure sores, during that admission.

4. From at least July 2010 the deceased received medical attention from her general practitioner, Dr Peter Lim, for pressure sores on her legs and heels.

5. In about August 2012 the deceased began to receive nursing care at home from Silver Chain Nursing

Association (**Silver Chain**) for wounds on her lower legs and a gluteal pressure sore.

6. In December 2012 the deceased was admitted to AKMH for over two weeks with congestive heart failure. Following that admission, steps were put in place for her to be assessed for a home-care funding package. In early March 2013 she was granted an Extended Aged Care at Home (**EACH**) package and was referred to KinCare Community Health Pty Ltd (**KinCare**), a home care agency which provided in-home care and nursing services, to provide the services.

7. On 5 April 2013 the deceased began to receive home-care and wound care from Kincare while also receiving assistance with meals and shopping from her two daughters, Christine Nigrone (**Ms Nigrone**) and Cecilia Antoinetta Niceforo (**Ms Niceforo**). At that stage the deceased was relatively mobile and was able to look after her own grooming and toileting, but as time went on she became increasing less mobile and less independent.

8. KinCare personal care workers attended to the deceased five times a week and registered nurses attended three times a week to change dressings on her wounds. On weekends and public holidays, no care was provided by KinCare. The deceased became doubly incontinent, which led to difficulties with wound care. Personal care workers would wash her before nurses attended to change dressings. Regular problems occurred with the supply of dressings, thereby requiring the deceased's children to purchase dressings from their local chemist.

9. The deceased's pressure sores fluctuated in severity over the next eight or nine months. In November 2013 her sacral sores appeared to be improving, but in early December 2013 she became unwell, with vomiting and a suspected urinary tract infection. At that time a sacral pressure sore deteriorated, becoming raw and painful.

10. The condition of the deceased's sacral sores did not change markedly over the next month or so, though there were days when they appeared to have improved slightly.

11. On Thursday 30 January 2014 Michelle Peel, the personal care worker attending to the deceased thought that the deceased had a urinary tract infection and suggested that she see a doctor. A doctor did not attend that day for reasons that are not apparent.

12. On Friday 31 January 2014, the skin on the deceased's sacrum had broken down, leading to the nurse who attended to her dressing also to suggest that she be taken to her doctor. That night, a doctor attended, and the deceased complained of constipation, nausea and vomiting once. She told the doctor that she had sores on her bottom that were already being dressed by nurses. The doctor prescribed a laxative for constipation and may have prescribed antibiotics for a urinary tract infection.

13. On Monday 3 February 2014, Ms Peel, was unable to shower the deceased because the deceased had difficulty standing. Ms Peel cleaned apparently fresh faecal matter from the deceased's sacral region as best as she could, but she could not remove it all. She assumed that the nurse who would attend after her would notify the KinCare office if she thought that it was necessary.

14. On that morning, Ms Peel was concerned because the deceased appeared weak, lethargic and less mentally aware than usual. Ms Peel suggested that the deceased go to hospital, but the deceased refused.

15. The nurse who attended after Ms Peel that morning, Tracey Myhill RN, had not treated the deceased's wounds previously. She was unaware that part of her duties was to change the dressing on the deceased's sacral sores. She changed only the dressings on the deceased's legs.

16. On the next morning, 4 February 2014, the deceased was drowsy and difficult to rouse. Ambulance officers took her to AKMH where she was found to have an extensive sacral pressure wound down to the bone, with deep necrotic tissue. She was diagnosed with an infected stage four pressure area, acute renal failure, hyperkalaemia and hyperglycaemia. She was admitted to a ward and was given intravenous antibiotics.

17. The deceased's condition in hospital appeared to improve slightly until the afternoon of 6 February 2014 when it began to deteriorate. She died on the morning of 7 February 2014. A medical practitioner completed a *Medical Certificate of Cause of Death* (**death certificate**) in which the disease or condition leading to death was stated to be septic shock, with the antecedent condition being poorly controlled diabetes mellitus. Other significant conditions were noted to be a 10cm x 10cm chronic sacral wound and congestive heart failure.

18. Following the certification, the deceased was cremated.

19. Where a death certificate is completed in relation to a person's death by natural causes, a coroner is not usually notified of the death. However, in the deceased's case, on 21 February 2014 the Health Director at Armadale Health Service reported her death to the State Coroner due to concerns expressed by staff at AKMH that the deceased had been neglected. Those concerns arose because of the state of the deceased's pressure sores when she attended the hospital on 4 February 2014.

20. The State Coroner began inquiring into the deceased's death and, on 25 July 2014, approved the holding of an inquest. The focus of the investigation was to be on the care provided to the deceased and whether her death could have been prevented.

21. On 30 June 2016 and 4, 5, 6, 7 and 11 July 2016, I held an inquest at the Perth Coroners Court. Following the hearing, I gave KinCare's representatives time to provide written submissions.

22. The documentary evidence adduced at the inquest comprised:

    a. the brief of evidence comprising six volumes;[1]

    b. an email dated 1/19/2014 (19 January 2014) from Geraldine Grove-Price, a personal care worker employed by KinCare;[2]

[1] Exhibit 1, Volumes 1 – 6

c. two bundles of hard copies of KinCare internal emails from and to Andera Thornton RN, a nurse employed by KinCare;[3]

d. two photos of the deceased;[4]

e. a bundle of hard copies of 'Client Feedback Forms', an internal medium of communication at KinCare;[5]

f. a Nursing Care Plan form and a Wound Assessment & Care Plan form from Sir Charles Gairdner Hospital;[6]

g. a statement, with attachments, by Rosa Hamann, the National Business Support Manager at KinCare;[7]

h. the witness statement of Michelle Peel with corrections;[8]

i. a KinCare gap analysis on clinical governance;[9]

j. a bundle of hard copies of KinCare internal emails from and to Monique Warner-Groves RN, a nurse employed by KinCare;[10] and

k. a copy of a letter dated 8 July 2016 from Mr Niceforo to the Court.[11]

23. Following the inquest, the following documents were received as evidence:

a. a bundle of copies of letters from Professor of Ophthalmology Ian L McAllister in relation to his treatment of the deceased;

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[2] Exhibit 2
[3] Exhibit 3
[4] Exhibits 4 and 5
[5] Exhibit 6
[6] Exhibits 7 and 8
[7] Exhibit 9
[8] Exhibit 10
[9] Exhibit 11
[10] Exhibit 12
[11] Exhibit 13

b. a bundle of hard copies of emails and file notes held by Advocare in relation to a complaint against KinCare by Mr Niceforo; and

c. a copy of a letter dated 20 August 2016 from Mr Niceforo to the Court.

24. The following witnesses (in order of appearance) provided oral evidence:

a. Karen Goodman RN, a nurse employed by KinCare as a program manager;[12]

b. Mr Niceforo, the deceased's son;[13]

c. Ms Nigrone, the deceased's daughter;[14]

d. Ms Niceforo, the deceased's daughter;[15]

e. Pamela Morey RN, nurse, PhD candidate and wounds care expert;[16]

f. Christina Taylor RN, a nurse employed by Silver Chain;[17]

g. Amy Tunnecliffe RN, a nurse employed by Silver Chain;[18]

h. Andera Thungmun RN (formerly Andera Thornton), a nurse employed by KinCare;[19]

i. Renee Hehir RN, a nurse employed by KinCare;[20]

j. Barry Morely, OAM, the Nursing Director for Medical Services at Armadale Health Services;[21]

[12] ts 3 – 54 per Goodman, K M
[13] ts 62 – 123 per Niceforo, N
[14] ts 124 – 154 per Nigrone, C
[15] ts 154 – 177 per Niceforo, C A
[16] ts 177 – 193, 197 – 257 per Morey, P
[17] ts 265 – 282 per Taylor, C
[18] ts 282 – 289 per Tunnecliffe, A M
[19] ts 289 – 315 per Thungmun, A P
[20] ts 319 – 357 per Hehir, R A
[21] ts 357 – 380 per Morely, B

k. Dr Christie De Silva, a consultant in general medicine at Armadale Kelmscott Memorial Hospital;[22]

l. Dr Clive Cooke, the Chief Forensic Pathologist in Western Australia;[23]

m. Dr Peter Lim, the deceased's general practitioner;[24]

n. Geraldine Grove-Price, a personal care worker employed by KinCare;[25]

o. Michelle Peel, a personal care worker employed by KinCare;[26]

p. Rosa Hamann, KinCare's national business support manager;[27]

q. Tracey Myhill RN, a nurse employed by KinCare;[28]

r. Monique Warner-Groves RN, a nurse employed by KinCare as a program manager;[29]

s. Michelle Jenkins, the state manager for KinCare from 2013 to 2015;[30] and

t. Mr Niceforo, who provided responsive evidence.[31]

25. On 23 August 2016 the Court received a letter from KinCare's solicitor, requesting a re-opening of the inquest to address, among other issues, his concerns that I had not clearly enunciated the possible adverse findings that I might make against KinCare.

26. On 14 September 2016 I held a directions hearing in order to address KinCare's concerns, after which I gave its representatives further time to provide submissions.

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[22] ts 381 – 400 per De Silva, C
[23] ts 400 – 410 per Cooke, C T
[24] ts 415 – 452 per Lim, P C
[25] ts 452 – 465 per Grove-Price, G
[26] ts 465 – 491 per Peel, M L
[27] ts 491 – 521 per Hamann, R
[28] ts 529 – 544 per Myhill, T L
[29] ts 544 – 580 per Warner-Groves, M
[30] ts 581 – 585 per Jenkins, M
[31] ts 588 – 596 per Niceforo, N

27. In the following finding I have described wounds on the deceased's buttocks and sacral area as pressure ulcers, pressure sores and pressure wounds interchangeably, usually depending on the source of the information. Likewise, at times I have imprecisely referred to those wounds as being on the deceased's sacrum, buttocks or bottom, again as a result of the source of the information, or out of convenience.

THE DECEASED

28. The deceased was born on 4 August 1938 in a small village in Calabria in Italy called Santa Nicola. She had to leave school in the third grade and worked on the family farm from then.[32]

29. When she was about 19 years old the deceased met the man she was to marry. He was 26 years older than she was. After they met, he came to Australia and established himself in Manjimup before returning to Italy to marry the deceased. After they were married, the deceased's husband returned to Manjimup to set up their house and the deceased followed him a short time later.[33]

30. In Manjimup the deceased had three children with her husband. She worked to supplement the income her husband received from working on farms and sawmills. In about 1970, the deceased developed type 2 diabetes.[34]

31. In about 1974 the deceased and her family moved to Perth where she worked for some time at an aged-care facility, washing dishes and cleaning. She was also occupied as a housewife and spent much of her time gardening, an activity she loved.[35]

32. In about 1980 the deceased's husband retired from work with the Water Board, and in 1983 he died. The deceased

[32] ts 62-63 per Niceforo, N
[33] ts 62 per Niceforo, N
[34] ts 63-64 per Niceforo, N; Exhibit 1, Volume 3, Tab 40.C, Kelvale Medical Group patient health summary
[35] ts 63 and 590 per Niceforo, N

remained in the family home with her son, Mr Niceforo, while her daughters moved out but remained nearby.

33. The deceased could understand spoken English but had difficulty speaking it. Her mental faculties remained undiminished until her final days.[36]

THE DECEASED'S MEDICAL HISTORY

34. The available evidence of the deceased's early medical history is somewhat limited. It is clear that she had diabetes for several years and that in 1992 she experienced chest pain of an unknown aetiology.[37]

35. In December 2003 the deceased underwent a laminectomy in Mount Hospital in Perth,[38] but the details of that operation are not available.

36. On 1 January 2006 the deceased was at home in the laundry when she experienced cardiovascular chest pain and collapsed onto the floor for two or three minutes. She attended the emergency department at AKMH, but no clear cause of her collapse was identified. The medical officer who examined her advised her that she should be admitted for 12 hours to exclude an acute myocardial infarction, but she discharged herself against medical advice. Her children were present but were unable to convince her to stay, despite being aware that the cause of the collapse was potentially lethal.[39]

37. The deceased developed eye problems as a result of diabetic retinopathy. By 2007 her right eye acuity was 6/30 and she had no sight in her left eye. Ophthalmologist Professor Ian McAllister had encouraged her to have vitrectomy surgery on the left eye some years earlier, but she was very resistant to surgical intervention. In 2008 and 2009 the

[36] ts 354 per Hehir, R A; ts 418 per Lim, P C; ts 551 per Warner-Groves, M
[37] Exhibit 1, Volume 3, Tab 40.B, Armadale Kelmscott Hospital Accident and Emergency notes 12/4/1992
[38] Exhibit 1, Volume 3, Tab 40.B, Armadale Health Service Emergency Department nursing triage assessment 25/01/2004
[39] Exhibit 1, Volume 3, Tab 40.B, Armadale Kelmscott Hospital Department of Emergency Medicine medical notes 1/1/2005

vision in her right eye was stable at 6/18 and the diabetic retinopathy was quiescent.[40]

38. The deceased last saw Professor McAllister on 6 June 2012. By then she was legally blind with acuity of 6/7.5 in her right eye and no perception of light in her left eye. Professor McAllister noted that the reduction of her vision was due to severe diabetic retinopathy.[41]

39. On 6 December 2008 the deceased was sent by her doctor to the emergency department at AKMH with possible cellulitis of both lower legs. She had a history at that time of congestive heart failure. She refused admission and was discharged at her own risk.[42]

40. Despite her medical history, the deceased had been strong physically until late April 2010 when she fell at night and fractured her right neck of femur.[43] After undergoing open reduction internal fixation of the fracture, she spent two months in Shenton Park Hospital for rehabilitation. For the first four weeks she was unable to bear weight, but for the next four weeks her mobility improved and she was highly motivated to work with the physiotherapist. She mobilised with a walking frame and could navigate stairs if there was a rail.[44]

41. During the admission in Shenton Park Hospital the deceased developed a sacral pressure wound,[45] cellulitis of the legs and a pressure ulcer on her right heel.[46] The cellulitis resolved with an antibiotic.[47]

42. It is also notable that the discharge letter issued by Shenton Park Hospital for the deceased's admission indicates that she was 'a challenging patient'. It records how she refused to have an in-dwelling catheter removed despite the risk of infection, and that four 'code blacks',

[40] Lions Eye Institute reports, 3/4/2007 and 20/3/2008
[41] Lions Eye Institute reports, 7/7/2016
[42] Exhibit 1, Volume 3, Tab 40.B
[43] ts 66 per Niceforo, N; Exhibit 1 Volume 3, Tab 40.B, Armadale Health Service musculoskeletal assessment 28/8/2010
[44] Exhibit 1, Volume 3, Tab 40.B, Royal Perth Hospital inpatient discharge letter 29/6/2010
[45] Exhibit 1, Volume 3, Tab 40.B, Royal Perth Hospital physiotherapy orthogeriatric patient summary 28/6/10
[46] Exhibit 1, Volume 3, Tab 40.C, Kelvale Medical Group patient health summary
[47] Exhibit 1, Volume 3, Tab 40.B, Royal Perth Hospital inpatient discharge letter 29/6/2010

where hospital staff call for assistance because of a patient's behaviour, were called regarding the deceased's distress about her insulin dose. The discharge letter notes that the deceased was very fixed in her belief that she required insulin prior to every meal, even when her blood sugar levels were very low, and that if she was not given insulin she became distressed and was inconsolable by staff or family.[48]

43. On 3 July 2010 the deceased was taken by her daughters to the emergency department at AKMH with pain in her right leg. The history provided to medical staff included sacral pressure sores on discharge from Shenton Park Hospital, which Silver Chain nurses were treating. On examination, a pressure sore was noted under the right heel. The medical officer who saw the deceased diagnosed peripheral oedema and stressed to her and her daughters the importance of attending to the pressure sore because diabetics risk serious infection that can enter the bone. No mention is made in the discharge summary of sacral pressure sores, possibly because they were covered with dressings.[49]

44. An Armadale Health Service musculoskeletal assessment form dated 28 August 2010 lists the deceased's general history as including diabetes, ischaemic heart disease, hypertension, acute myocardial infarction with one stent, and osteoarthritis in her knee and fingers.[50]

45. After discharge from hospital, the deceased began to see Dr Lim of Kelvale Medical Group in Kelmscott about the pressure ulcer on her heel. Dr Lim recorded that the deceased's medical history included diabetes, osteoarthritis of the spine, constipation and hypertension.

46. Dr Lim debrided the ulcer on the deceased's heel and referred her to Silver Chain for wound care at home. By December 2010 the heel ulcer was healing well and by 24 March 2011 it had healed. By that time, Dr Lim noted

[48] Exhibit 1, Volume 3, Tab 40.B, Royal Perth Hospital inpatient discharge letter 29/6/2010
[49] Exhibit 1, Volume 3, Tab 40.B, Armadale Kelmscott Hospital Department of Emergency Medicine discharge summary 3/7/10
[50] Exhibit 1, Volume 3, Tab 40.B, Armadale Health Service musculoskeletal assessment 28/08/2010

that the deceased was ambulating well but that she had 'put on much weight'.[51]

47. In July 2011 the deceased developed an infected ulcer on her lower right leg. Dr Lim again referred the deceased to Silver Chain and the ulcer healed in a month's time, but the deceased began to develop oedema in her lower legs, requiring pressure stockings.[52]

48. On 25 October 2011 Dr Lim paid the deceased a home visit, as was common practice for him, and noted that she had gained weight from inactivity and that her leg skin was thickened and fibrotic, but that she had no ulcers. During a home visit on 19 December 2011 he noted that she had lower leg oedema and a small left leg ulcer.[53]

49. On 12 April 2012 Dr Lim made another home visit to the deceased to examine a small left gluteal pressure sore. This was the first instance recorded by Dr Lim of the deceased developing a sacral pressure sore. He referred the deceased to Silver Chain, whose nurses then visited the deceased twice a week. Within a few weeks the sore was almost healed, but by 12 July 2012 the deceased had recurrent skin breakdown on her buttock.[54]

50. On 31 July 2012 Dr Lim visited the deceased at home in relation to a right lower leg bullous eruption. The wound resolved in a week or so with treatment, but by late September 2012 the deceased had developed lower leg cellulitis. Dr Lim prescribed antibiotics, though it is not clear whether the deceased was compliant with the prescriptions because, on 13 November 2012, Dr Lim found other undispensed prescriptions for antibiotics on a table at the deceased's home.[55]

[51] Exhibit 1, Volume 3, Tab 40.C, Kelvale Medical Group patient health summary
[52] Exhibit 1, Volume 3, Tab 40.C, Kelvale Medical Group patient health summary
[53] Exhibit 1, Volume 3, Tab 40.C, Kelvale Medical Group patient health summary
[54] Exhibit 1, Volume 3, Tab 40.C, Kelvale Medical Group patient health summary
[55] Exhibit 1, Volume 3, Tab 40.C, Kelvale Medical Group patient health summary

SILVER CHAIN

51. On 23 August 2012 the deceased was admitted to Silver Chain's care for wound care of her lower legs after Dr Lim had referred her the previous day.[56] Prior to then, it seems that Dr Lim had referred the deceased to Silver Chain on an ad hoc basis.

52. Silver Chain nurses attended the deceased's home almost daily to dress blisters associated with her cellulitis. The deceased initially required a great deal of encouragement to elevate her legs. She usually sat in the kitchen on a high back chair and was resistant to placing her legs onto a stool that Mr Niceforo had bought for that purpose. She began to use a recliner chair, but could not get out of it unassisted, so stopped using it.[57]

53. On 5 October 2012 Silver Chain nurse Christina Taylor RN noticed that the deceased was incontinent of urine.[58] Later that month, Ms Taylor noted that the deceased was still not elevating her legs enough and that the deceased's family were looking for a new recliner chair that would allow the deceased to get out of it on her own. Daily dressings were still required and the deceased was recommenced on antibiotics.[59]

54. On 25 October 2012, another Silver Chain nurse, Ms Wade RN, reviewed the deceased and updated the care plan. She noted that Dr Lim was to visit the deceased weekly.[60]

55. On 29 October 2012 Ms Taylor recorded that there was still no progress with the deceased's lower legs and that the deceased's family was still not able to get the deceased's compliance to use the recliner chair. Ms Taylor noted that she had again requested the deceased to try compression bandaging, but the deceased had refused. Ms Taylor noted that the deceased needed strict bed rest and that Dr Lim had suggested that the deceased be admitted to hospital.[61]

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[56] Exhibit 1, Volume 2, Tab 38 and 38.A, progress notes
[57] Exhibit 1, Volume 2, Tab 38.A, progress notes
[58] Exhibit 1, Volume 2, Tab 38.A, progress notes
[59] Exhibit 1, Volume 2, Tab 38.A, progress notes
[60] Exhibit 1, Volume 2, Tab 38.A, progress notes
[61] Exhibit 1, Volume 2, Tab 38.A, progress notes

56. By 7 November 2012 the deceased's leg wounds appeared to be improving somewhat, thought by Ms Taylor and Dr Lim to be partly a result of the deceased elevating her legs more, but by 15 November 2012 swab results showed pseudomonas and streptococcus bacteria.[62]

57. On 26 November 2012 Dr Lim noted that the deceased had bleeding ulcers on her inner thigh and buttock. From that time, Silver Chain nurses dressed them as well as the wounds on the deceased's lower legs and, from 5 December 2012, they dressed a wound on her right heel. The need for a cushion for her chair was noted.[63]

58. It seems that by 12 December 2012 the deceased's lower leg wounds had been improving to the stage where they could be dressed every second day, but within two days they again required daily dressing. On that date, the sacral wound was dry.[64]

FIRST ADMISSION TO AKMH

59. On 22 December 2012 the deceased was taken by ambulance to the emergency department at AKMH, complaining of weakness to both lower legs after she became unable to stand, even with assistance.[65] She was diagnosed with congestive heart failure and generalised weakness and was admitted into a ward. Mr Niceforo stayed at the hospital as a boarder.[66]

60. On the ward, nurses soon identified the need for the deceased to be seen by a wound care specialist in relation to the wounds on her legs and buttocks. A nurse told the deceased and Mr Niceforo of the importance of pressure area care and the need for the deceased 'to stay off bottom'. The deceased refused pressure area care.[67]

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[62] Exhibit 1, Volume 2, Tab 38.A, progress notes
[63] Exhibit 1, Volume 2, Tab 38.A, progress notes
[64] Exhibit 1, Volume 2, Tab 38.A, progress notes
[65] Exhibit 1, Volume 3, Exhibit 1 Volume 3, Tab 40.V, Armadale Health Service Emergency Department nursing triage assessment 22/12/2012; St John Ambulance patient care record 12143131
[66] Exhibit 1, Volume 3, Exhibit 1 Volume 3, Tab 40.V, Armadale Health Service integrated progress notes 22/12/2012
[67] Exhibit 1, Volume 3, Exhibit 1 Volume 3, Tab 40.V, Armadale Health Service boarder registration form

61. AKMH's initial management plan was for the deceased to return home on 25 December 2012 if she was clinically stable, but on that morning she became drowsy and her responsiveness decreased. She was reviewed by intensive care clinicians and a meeting was held with the deceased and her family about the possibility of admitting the deceased into the intensive care unit (**ICU**). Given the deceased's poor baseline function and significant decline in her function in the previous month, together with her significant co-morbidities, the clinicians considered that she was not appropriate for admission to the ICU.[68]

62. However, within a day or two the deceased's condition began to improve. By 27 December 2012 the deceased's discharge was being considered, with the social work team reviewing the deceased's need for services at home. By 28 December 2012 the deceased was able to stand with assistance. The pressure sore on her buttocks continued to be treated. She remained alert and oriented. She began to be weaned from oxygen. She wanted to go home, and that desire remained until she was finally discharged.[69]

63. On 31 December 2012 the deceased was seen by an occupational therapist about seating and the use of a pressure cushion. She was provided with a ROHO cushion and she used it for two hours. It was noted that she needed encouragement to maintain her own pressure relief.[70]

64. On 2 January 2013 a nurse who carried out wound care on the deceased noted that there was skin broken on the buttock with slight bleeding. The deceased's strength had returned sufficiently to allow her to walk with her walking frame while assisted, which she was motivated to do, but she declined intervention from the rehabilitation team.[71] An occupational therapist attended the deceased's home to assess its suitability for the deceased upon discharge. She noted that the deceased 'sits at home mostly', and

[68] Exhibit 1, Volume 3, Exhibit 1 Volume 3, Tab 40.V, Armadale Health Service integrated progress notes 25/12/2012
[69] Exhibit 1, Volume 3, Exhibit 1 Volume 3, Tab 40.V, Armadale Health Service integrated progress notes 27-28/12/2012
[70] Exhibit 1, Volume 3, Tab 40.V, Armadale Health Service integrated progress notes 31/12/2012
[71] Exhibit 1, Volume 3, Exhibit 1 Volume 3, Tab 40.V, Armadale Health Service integrated progress notes 2/1/2013

recommended a ramp at the front entrance, a bedrail and a bedside commode.[72]

65. The deceased continued to improve over the next three days. On 5 January 2013 the pressure area to her buttock was still broken. She desaturated oxygen on exertion though her lungs were clear. She refused to have an in-dwelling catheter removed despite the fact that it had been in place for at least 10 days.[73]

66. By 7 January 2013 the deceased was feeling well. The catheter was removed and a pressure sore on her left buttock was noted to be small. She sat out of bed for much of the day and was able to walk short distances with her walking frame.[74]

67. On 9 January 2013 the deceased was discharged home. The social work team had arranged for an aged-care assessment team to assess the deceased for ongoing services. The occupational therapist provided a ROHO cushion and instructions on its use to one of the deceased's daughters.[75]

SILVER CHAIN RESUMES CARE

68. On 14 January 2013 Silver Chain nurses recommenced their care of the deceased's wounds, namely a grade 2 pressure wound on the left buttock and a grade 3 pressure wound on the right heel, by attending three days a week. The wounds initially appeared to be healing well, but the skin on the buttock began to break down by 20 February 2013, and by 13 March 2013 the deceased's lower legs were 'weepy'.[76]

69. On 21 March 2013 the deceased went by ambulance to the emergency department of AKMH with a six-day history of

[72] Exhibit 1, Volume 3, Exhibit 1 Volume 3, Tab 40.V, Armadale Health Service occupational therapy home assessment 2/1/2013
[73] Exhibit 1, Volume 3, Exhibit 1 Volume 3, Tab 40.V, Armadale Health Service integrated progress notes 5/1/2013
[74] Exhibit 1, Volume 3, Exhibit 1 Volume 3, Tab 40.V, Armadale Health Service integrated progress notes 7/1/2013
[75] Exhibit 1, Volume 3, Tab 40.V, Armadale Health Service integrated progress notes 9/1/2013
[76] Exhibit 1, Volume 2, Tab 38.A, progress notes

coughing and wheezing. Following an X-ray, the deceased was diagnosed with pneumonia and was prescribed antibiotics. She was discharged home that evening.[77]

70. On 22 March 2013 Ms Taylor recorded that she had promoted the use of the deceased's ROHO cushion and put it on the deceased's chair, but the deceased had started screaming, presumably when she attempted to sit on it. Ms Nigrone told Ms Taylor that she would ask Mr Niceforo to lower the chair before putting the cushion in place.[78]

71. On 29 March 2013 Ms Taylor recorded that there had been no progress with the ROHO cushion. She reinforced the use of it with Mr Niceforo. She also noted that the deceased was not wearing incontinence knickers and that she had excoriation/maceration under her right buttock.[79]

72. On 1 April 2013 Silver Chain nurse Amy Tunnecliffe RN noted problems with the deceased's wounds on her buttocks and the wound on her right heel and that both legs were in poor condition. Two days later, Ms Tunnecliffe noted faecal exudate in the deceased's buttock wounds due to the deceased's incontinence. The deceased refused all of Ms Tunnecliffe's treatment. Ms Tunnecliffe encouraged her to ask Dr Lim for a review, but the deceased refused.[80]

73. On 5 April 2013 Ms Tunnecliffe recorded that there had been no changes to the deceased's health and that the wounds remained the same, with faecal contamination from incontinence. The deceased loudly refused leg wound care. The situation remained much the same until Ms Tunnecliffe's last attendance on 22 April 2013.[81]

KINCARE

74. On 6 March 2013 an aged-care assessment team (**ACAT**) from Armadale Health Service visited the deceased at her

[77] Exhibit 1, Volume 3, Tab 40.V, Armadale Health Service nursing triage assessment and discharge summary 21/3/2013
[78] Exhibit 1, Volume 2, Tab 38.A, progress notes
[79] Exhibit 1, Volume 2, Tab 38.A, progress notes
[80] Exhibit 1, Volume 2, Tab 38.A, progress notes
[81] Exhibit 1, Volume 2, Tab 38.A, progress notes

home to assess her for a home care package.[82] Following that assessment, the deceased was granted an Extended Aged Care in the Home (**EACH**) package and was referred to KinCare, who would deliver the package.

75. An EACH package was the highest level of aged-care assistance available short of residential care in an aged-care facility. The ACAT had recommended residential care for the deceased but the deceased and her children would not consider it.[83]

76. KinCare is based in New South Wales, where it has a relatively large geographical spread, and has operations in each State and the Australian Capital Territory. According to its website, in 2010 it became the largest private in-home care and nursing service in Australia. KinCare's national business support manager, Rosa Hamann, said that KinCare had approximately 10,000 clients. She said that its presence in Western Australia is moderate compared to its presence in New South Wales.[84]

77. The deceased met with a KinCare program manager and entered into an EACH client service agreement to receive personal and domestic care and equipment from 22 April 2013.[85] A client service plan was created on 11 April 2013 by the program manager to identify the activities in which the deceased required assistance and to describe the nature of the assistance. It seems that this client service plan was misconceived since no mention was made of the frequency of wound care, and reference to domestic assistance was unnecessarily included. The deceased was noted to be independent with most activities of daily living, though she may have needed assistance with bathing and dressing, and she required assistance to apply moisturising cream and to report on skin conditions.[86] As I understand it, the reference to the deceased being independent included situations where assistance was provided by her daughters.[87]

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[82] Exhibit 1, Volume 3, Tab 40.B, Armadale Health Service aged care assessment team community assessment
[83] Exhibit 1, Volume 3, Tab 40.B, aged care client record
[84] ts 492 per Hamann, R
[85] Exhibit 1, Volume 2, Tab 39.F
[86] Exhibit 1, Volume 2, Tab 39.D
[87] Exhibit 1, Volume 3, Tab 40.B, aged care client record

78. Another client service plan was created by the same program manager on 24 April 2013. On this plan, reference is made to the deceased having wound dressings to her heel and sacrum two days per week and to monitoring of her lower legs for oedema and skin integrity.[88] Despite that plan and its successor in July 2013, an attendance record at the deceased's home shows that the deceased received wound care three times a week from registered nurses employed by KinCare.[89]

79. Other KinCare documents kept at the deceased's home were service variation reports, ostensibly to be used when there was a variation to the regular service, and wound assessment forms comprising charts and spaces where attending nurses could add information about the wound management.[90]

80. There was no document in the nature of integrated progress notes as used in hospitals, aged-care facilities and by Silver Chain. Because of that, some KinCare nurses used the service variation reports as a record which could be viewed by subsequently attending nurses.[91] There were also wound assessment forms which included lined pages that could be used as progress notes.[92]

81. Another means of communication available to KinCare staff was known as 'myKinCare', a smartphone app which, among other things, allowed field staff to make entries into a client's electronic record by creating a text-based comment known as a 'Client Feedback Form'. The information in client feedback forms was available to program managers to review, but was not available to other field staff.[93]

82. Field staff could also email office staff with information about clients, but the emails were not accessible to other field staff.

[88] Exhibit 1, Volume 2, Tab 39.E
[89] Exhibit 1, Volume 2, Tab 39.B
[90] Exhibit 1, Volume 3, Tab 40.E and .F
[91] Exhibit 1, Volume 2, Tab 39.H
[92] Exhibit 1 Volume 3, Tab 40.F
[93] Exhibit 9, Statement of Rosa Hamann, paragraphs 44 – 52

ANDERA THORNTON RN

83. From 26 April 2013 until 9 October 2013, Andera Thornton RN was the only nurse to provide wound care to the deceased on behalf of KinCare, apart from four consecutive occasions in August 2013 when another nurse attended. Regular personal care workers for the entirety of KinCare's involvement with the deceased included Michelle Peel and Alexandra Mayor, with Ms Peel attending about 125 times in those nine months.[94]

84. In April 2013 Ms Thornton (now Ms Thungmun) had recently graduated as a nurse, and KinCare was her first job as a graduate. When she began, she noted that there was nothing in the client service plan about wound care and there was no wound care plan with the KinCare documents at the deceased's home. She contacted the case manager to clarify what she had to do.[95]

85. Ms Thornton completed her own wound assessment forms and gave the forms to KinCare office staff.[96] She also filed client feedback forms on each day she attended the deceased.[97] In those forms she set out details of the treatment she provided to the deceased, and she identified several recurrent issues of importance to the deceased's care.

86. The first recurrent issue noted by Ms Thornton was the deceased's refusal to comply with Ms Thornton's continuing exhortations to relieve pressure on her sacral sores. For example, on 13 May 2013 Ms Thornton wrote:

> Wounds on sacrum are bleeding and deteriorating. I have educated client and daughter of pressure sores. Client still refuses to move from kitchen chair. She on there all day (*sic*). This is a major concern.[98]

[94] Exhibit 1, Volume 2, Tab 39.B
[95] ts 293 per Thungmun, A P
[96] ts 305 per Thungmun, A P
[97] Exhibit 3
[98] Exhibit 3

87. Ms Thornton arranged for KinCare to provide the deceased with a pressure cushion but, once it arrived, the deceased refused to sit on it, claiming it was too high and uncomfortable while refusing to lower her chair. Ms Thornton wrote:

> Client is in 7/10 pain on the right thigh under her sacral. She is non compliant when asked to sit on a pressure cushion. She states it is too high and uncomfortable. She also refuses to get up and moving. She sits on the kitchen table 24 hours a day, unless her daughter Toni forces her to get up and go for a walk together.[99]

88. By 30 July 2013 Ms Thornton noted that the deceased's sacral area was slightly heated but that her daughters were walking her every day to help prevent pressure sores.[100]

89. The second recurrent issue noted by Ms Thornton was the shortage of dressings and other stock provided by KinCare to the deceased's home. On 20 May 2013 Ms Thornton was instructed to tell the deceased's family that they had to buy dressings for which they would be reimbursed. On 13 June 2013 Ms Thornton noted that Ms Nigrone remembered washing a pair of tubular stockings so that they could be re-used. Ms Thornton told her to ask carers to save dressings so that they could be washed and re-used.[101]

90. Regular problems with stock supply arose at almost the commencement of the deceased's care and continued, albeit with some improvement, until 9 September 2013 at the latest, when Ms Thornton noted that she had not had gauze for two weeks.[102] On occasions, Ms Thornton had to use incontinence pads as dressing on the deceased's legs. It is clear that she became increasingly frustrated. On 9 July 2013 she wrote in a client feedback form:

> I have waited a few weeks in regards to Maria Niceforo's Tubifast order. It came in one piece and I spoke to Mechy and she said she will order

[99] Exhibit 3
[100] Exhibit 3
[101] Exhibit 3
[102] Exhibit 3, 15, 20 and 22 July 2013

> another one. It was meant to come in a box. I have emailed WA kincare and Liz and I stated about the tubifast but no response has been given. As a field staff we need to notified if stock has been ordered or not. This is not the first time with this client. We have had stock issues about 3 times now and the client had to wait a month or more before stock arrived. I m also waiting for more stock that Liz said she would order Mepilex, combine. I have run out of combine and am waiting on order. Can you please check if order has been completed or if it has been ordered. The client is frustrated and I feel unprofessional to not be able to complete my care. Client had to be reimbursed last time but this cannot happen again. I have stated to the client that she can not go to the pharmacy and get stock and expect to be reimbursed, this was only a special occasion. I have ordered stock to month a head but the issue is I do not know if it has been ordered or not. (typographical errors not corrected)[103]

91. Another recurrent issue identified by Ms Thornton was the inadequacy of the care she was able to provide the deceased by attending three times a week. The sacral wounds, in particular, deteriorated even after they had improved in early July following the prescription by Dr Lim of antibiotics.[104] One of the causes identified by Ms Thornton was the fact that the dressings were not staying on.[105]

92. Around this time, Ms Thornton spoke to a case manager and suggested that the deceased's dressings should be changed twice a day, three times a week.[106]

93. On 23 July 2013 Ms Thornton notified KinCare's state services manager that the deceased needed full assistance with bathing, so the client service plan needed to be changed accordingly.[107] That change was done on 30 July 2013 to indicate that the deceased required assistance with

[103] Exhibit 3 p.29
[104] Exhibit 3 p. 31, 10 July 2013
[105] Exhibit 3 p. 27, 8 July 2013
[106] Exhibit 1, Volume 6, Tab 43, paragraph 62
[107] Exhibit 3 p. 45, 23 July 2013

all activities except managing continence aid pads for faeces, selecting clothing and grooming. For those three latter activities she was to be observed and assisted if necessary.[108]

94. On 19 August 2013 Ms Thornton sent her program manager a client feedback form in which she stated that the deceased's sacral wounds were deteriorated and bleeding, and that the dressing on the wounds needed to be changed every day due to faecal contamination.[109]

95. On 23 August 2013 Ms Thornton sent her program manager a client feedback form to inform her that the deceased refused to go to hospital. She spoke to the deceased's daughters, who said that they would try to persuade the deceased.[110]

96. On 29 August 2013 Ms Thornton wrote in a client feedback form that she needed to discuss whether the deceased could get care on weekends from Silver Chain. On 3 September she wrote that, due to the area in which the sacral wounds were situated, the dressings would get soiled with faecal matter and would not last a day.[111]

97. Ms Peel also noted in oral evidence that dressings on the deceased's sacral area would often come off within one day.[112]

98. On 9 September 2013, Ms Thornton attached photos of the deceased's open sacral wounds to a client feedback form and stated that the deceased's bottom had deteriorated. She said that she had lowered the deceased's chair, placed a pressure cushion on it and sheepskin on top of that, but that the deceased was in 10/10 pain and required a prescription for pain patches.[113]

99. On the same day, Ms Thornton wrote to KinCare's state manager, Riana Warner, and queried whether KinCare

[108] Exhibit 1, Volume 2, Tab 39.G
[109] Exhibit 6 p. 128
[110] Exhibit 6 p. 126
[111] Exhibit 3 p. 61, 3 September 2013
[112] ts 469 and 486-487 per Peel, M L
[113] Exhibit 3 p. 64, 9 September 2013

could provide transport for the deceased to attend a wound care clinic.[114] Ms Warner replied that it was a good idea and that she would see if the deceased could afford it. There is no evidence of whether anything came of that idea.

100. The service variation reports indicate that on 25 September 2013 a relief nurse, Rachela Bodace RN, attended the deceased. Ms Bodace recorded that she arrived at 8.38 am and was told by the deceased that it was the wrong appointment. She returned at 12.15 pm that afternoon and treated all the deceased's wounds, but she noted that there was no nursing and wound management plan. She also appeared to note that the personal care worker had done the dressings on the deceased's legs.[115]

101. On 3 October 2013, in the last client feedback form sent by Ms Thornton before she resigned from KinCare,[116] she asked whether the deceased could be provided personal care by Ms Mayor and Ms Peel for showers on Saturday and Sundays. This, she said, was essential.[117]

102. On 18 October 2013 Ms Warner visited the deceased and Ms Niceforo to discuss weekend showers, among other things, and explained that the deceased was exceeding her budget, so weekend services were not available at that time.[118]

MONIQUE WARNER-GROVES RN

103. Monique Warner-Groves was a nurse with KinCare in 2012 and went on to become a program manager. She began attending the deceased to provide wound care on 11 October 2013, though she was unable to do the dressing at the time as the personal care worker had not arrived by then to wash the deceased. KinCare State Manager Ms Riana Warner attended later that afternoon to do the dressing.[119]

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[114] Exhibit 3 p.69, 8 July 2013
[115] Exhibit 1, Volume 2, Tab 39.M
[116] ts 314 per Thungmun, A P
[117] Exhibit 3 p. 73, 3 October 2013
[118] Exhibit 6 p. 69
[119] Exhibit 3 p. 81

104. Ms Warner-Grove remained the deceased's primary wound care nurse until early January 2014.[120] When asked in oral evidence about the deceased, she said that the deceased liked her care to be done in specific ways and would get upset if Ms Warner-Groves tried to initiate different products or methods. She said that the deceased was *compos mentis* and was able to make her own decisions.[121]

105. By way of notemaking, it appears that Ms Warner-Groves used both the service variation report forms and the wound assessment form as a means of recording progress notes.[122]

106. Those records indicate that the deceased's sacral wounds improved gradually until about 9 December 2013 when they deteriorated. After that, the condition of those wounds fluctuated, possibly as a result of changes to the deceased's general condition.

107. For example, on 2 December 2013 the deceased was unwell, with vomiting and an apparent urinary tract infection. Dr Lim attended and prescribed trimethoprim and malaxon, but on 3 December 2013 the deceased's blood sugar level was very low.

108. On 12 December 2013 the deceased saw another doctor, Dr Jaspreet Mudhar, complaining of vomiting after meals. Dr Mudhar conducted a limited examination because the deceased could not get onto the examination bed. He made reasonably comprehensive notes of the consultation and recorded that the deceased spent most of the time sitting. He made no mention of sacral wounds, but did note pain above the left hip and cellulitic legs. He prescribed hyoscine butylbromide for abdominal pain, and simple analgesia, massage and heat for the left midaxilla pain.[123]

109. On 13 December 2013, a nurse filling in for Ms Warner-Groves recorded that there were no dressings available at

[120] Exhibit 1, Volume 2, Tab 39.B and Tab 39.H
[121] ts 551 per Warner-Groves, M
[122] Exhibit 1, Volume 2, Tab 39.H; Exhibit 1, Volume 3, Tab 40.F
[123] Exhibit 1, Volume 3, Tab 40

the deceased's home and that the deceased was vomiting and complaining of nausea.[124]

110. The next day at about noon the deceased went by ambulance to the emergency department at AKMH with left lumbar/flank pain. The medical officer who examined her found tense, spasming back and paraspinal muscles, and noted bilateral chronic leg ulcers, though he did not specifically note sacral wounds. He prescribed antibiotics and paracetamol with codeine. He discharged the deceased to her doctor for review after completing the antibiotics, and to home nursing for her leg ulcers.[125]

111. From 16 December 2013 to 3 January 2014, Ms Warner-Groves recorded that the deceased's bottom was much unchanged, with some raw and painful areas.

112. On 6 January 2014 Ms Warner-Groves sent to program manager Karen Goodman RN an email in which she stated that the deceased's legs were unchanged but that the wounds on her bottom had deteriorated significantly, being very raw with some superficial wounds, and three very deep wounds. She said that the deceased was non-compliant with all suggestions regarding pressure management and remained in her chair all day. She said that she had spoken to the deceased's family about this in depth and advised of different strategies, but the deceased refused.[126]

113. In oral testimony Ms Warner-Groves said that relieving pressure on the deceased's bottom was a topic which she discussed almost every visit.[127] Ms Warner-Groves said that she was very honest with the deceased, telling her that she would be going to hospital if she continued to sit 'in incontinence product for quite some time during the day'.[128] She said that the deceased had all the information about the need to move around but chose not to follow that advice.[129]

[124] Exhibit 1, Volume 2, Tab 39.P
[125] Exhibit 1, Volume 3, Tab 40
[126] Exhibit 6 p.30
[127] ts 566 per Warner-Groves, M
[128] ts 574 per Warner-Groves, M
[129] ts 566-567 per Warner-Groves, M

114. It seems that on 6 January 2014 Ms Warner-Groves introduced to the deceased another nurse, Renee Hehir RN, who was to provide the deceased with wound care from then.[130] Ms Warner-Groves attended the deceased once more on 8 January 2014. On that day she reported that the wound on the deceased's bottom was slightly improved and the legs were looking well.[131]

RENEE HEHIR RN

115. Ms Hehir had experience in hospitals in Sydney and in country towns. She had not had much experience in wound care apart from four months during which she had worked on a surgical ward in Alice Springs. She was the deceased's primary wound care nurse from 6 January 2014 to 29 January 2014.

116. When Ms Hehir joined KinCare she received no specific training in wound care. She went through a brief orientation covering the basics of documentation and the KinCare app.[132] When dressing the deceased's wounds she found that she needed at least an hour to complete her duties rather than the 30 minutes she was allocated.[133]

117. Ms Hehir found difficulties with communication within the KinCare team because the written documentation was not used appropriately by all staff and because of the number of channels of communication.[134] She said that she was used to progress notes as used in hospitals, so she used the service variation report forms as a place to keep progress notes or she would send information by way of the KinCare app.[135]

118. Another difficulty faced by Ms Hehir was shortage of dressing supplies. Sometimes she would be able to use emergency supplies that she would take with her, and

[130] ts 327 per Hehir, R A
[131] Exhibit 1, Volume 2, Tab 39.R
[132] ts 320 per Hehir, R A
[133] Exhibit 1, Volume 6, Tab 44.J
[134] ts 324 and 343 per Hehir, R A
[135] ts 343 per Hehir, R A

sometimes the deceased's family would purchase supplies.[136]

119. When treating the deceased, Ms Hehir found her to be fairly cooperative while she was dressing wounds, but said that the deceased did not accept repeated suggestions to relieve the pressure on the wound. As with Ms Warner-Groves, Ms Hehir said that she raised this issue with the deceased and her family at least every second visit.[137]

120. Ms Goodman attended the deceased on 8 January 2014 with Ms Warner-Groves and on 15 January 2014, possibly on her own.[138] Ms Goodman was a clinical nurse with four years' experience with Silver Chain before she started work with KinCare in December 2013. She found that the sacral wound was clean and dry with no exudate of sign of infection and that there were small areas of stage 1 breaks to the buttocks region.[139]

121. On 24 January 2014 the personal care worker Ms Mayor left a note for Ms Hehir indicating that the deceased's right posterior thigh had swelling, was not tender to touch but had mild redness and moderate to severe pain at the site. On that day, another nurse attended instead of Ms Hehir. That nurse noted some bruising and that the deceased would go for a scan.

122. Ms Hehir left a note on 29 January 2014 to say that Ms Nigrone had told her that a scan had been booked in 'a week or so's time'.[140] That day, Ms Hehir noted that the wounds on the deceased's bottom were worse than they were a week previously, with the skin broken down more on the right leg inner buttock. The wound had not been washed in the shower and there were moderate amounts of ooze and blood.[141]

123. Ms Hehir spent one and a half hours dressing the wounds and carrying out related duties.[142] She was concerned that

[136] ts 322 per Hehir, R A; Exhibit 1, Volume 6, Tab 44.N
[137] ts 338 per Hehir, R A
[138] Exhibit 1, Volume 2, Tab 39.B; Exhibit 1, Volume 3, Tab 40.F; ts 35 per Goodman, K M
[139] Exhibit 1, Volume 6, Tab 44.C
[140] Exhibit 1, Volume 2, Tab 39.A
[141] Exhibit 1, Volume 2, Tab 39.T
[142] Exhibit 1, Volume 2, Tab 39.B; ts 347 per Hehir, R A

the wounds were getting worse and were going on for so long, so she took photographs of the wounds and sent them to Ms Goodman in order to ensure that she was providing the best possible treatment. She said that she did not recall receiving any feedback in relation to the photographs.[143]

124. The photographs taken by Ms Hehir show significant but demarcated[144] ulceration of the deceased's buttocks and sacral area. She said in oral evidence that there appeared to be no specific sign of infection, but there was a potential for it.[145]

125. The attendance on 29 January 2014 was the last time Ms Hehir saw the deceased.

126. On Thursday 30 January 2014 Ms Peel visited the deceased to shower her and put cream on her legs. It seems that by this stage the deceased usually had faeces on her bottom when Ms Peel showered her.[146] On that day Ms Peel made an entry into the service variation reports indicating that she felt that the deceased had a urinary tract infection and suggested that she go to the doctor.[147] The deceased did not go to the doctor, so her daughters called for a locum doctor to attend.[148] Dr Iqbal Hussain attended the next evening.[149]

127. On the morning of Friday 31 January 2014 Ms Mayor attended the deceased to shower her, but the deceased was not feeling well and complained of 'body malaise'. Ms Mayor sponged her and removed the old dressing on the deceased's bottom but was not able to clean the deceased well because the deceased could not stand for long in the shower. Ms Mayor noted that there was minimal bleeding on the bottom wound.[150]

[143] ts 341 per Hehir, R A
[144] ts 256 per Morey, P
[145] ts 356 per Hehir, R A
[146] ts 479 per Peel, M L
[147] Exhibit 1, Volume 2, Tab 39.T
[148] ts 153 per Nigrone, C
[149] Exhibit 1, Volume 1, Tab 10
[150] Exhibit 1, Volume 2, Tab 39.A

128. Later that day, a nurse that had not seen the deceased previously, Julie Williams RN, attended to provide wound care. She recorded in the wound assessment form that she dressed the wounds 'as per plan'. She queried whether the buttock wound was infected and noted that it looked bigger than stated.[151] In the service variation report she recorded: 'skin broken down on bottom very painful. Suggest for daughter to take Mum to Dr'.[152]

129. As mentioned above, Dr Hussain visited the deceased at home that evening. He reported that the deceased:

> … complained of nausea and said that she had vomited once. There was no diarrhoea present. In fact she complained of constipation. She was known diabetic patient and had sores on bottom which she told me were dressed regularly by nurses.

130. Dr Hussain examined the deceased and noted normal blood pressure, pulse and temperature. Her chest was clear and her ear, nose and throat examination was normal. He noted swelling and redness to the legs which, like the sores on the bottom, were already dressed by the nurses. He prescribed a laxative and advised her to continue with her regular medications.

131. Dr Hussain was not called as witness because he could not be located in order to be served a witness summons. On the evidence available to me, it seems clear that he did not examine the wounds on the deceased's bottom because the deceased did not complain of them and, instead, told him that the wounds had been dressed by nurses.

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132. On Monday 3 February 2014 Ms Peel attended the deceased to shower her, but she was lethargic and not as mentally aware as she was usually. She had had a very loose bowel movement which Ms Peel tried to clean quickly

[151] Exhibit 1, Volume 3, Tab 40.F
[152] Exhibit 1, Volume 2, Tab 39.T

as the deceased had trouble standing and could not have a shower. Ms Nigrone helped Ms Peel to stand the deceased up while Ms Peel washed her as well as she could.[153] Ms Peel stated that Ms Nigrone had checked the deceased's blood sugar level that morning and it was high.[154]

133. Ms Peel had not seen the deceased in a similar state before. She suggested to Ms Nigrone that the deceased needed to go to hospital. Ms Nigrone passed along Ms Peel's suggestion to the deceased, but she refused.[155]

134. Ms Peel thought that the faeces she cleaned on 3 February 2014 were very fresh and would not have been from a previous day.[156] However, she thought that the deceased was showered by her family on weekends,[157] which was not the case.[158] She was aware that a nurse would be attending after her and assumed that the nurse would notify the KinCare office if necessary.[159]

135. The nurse who arrived on 3 February 2014 after Ms Peel had finished washing the deceased was Tracy Myhill RN, who attended on her own. Ms Myhill was an experienced community care nurse who, prior to working with KinCare, had been working with Silver Chain for about two years.[160] This was her first and only visit with the deceased.

136. It appears that Ms Myhill obtained the information of the care she was to provide the deceased from the wound assessment form kept at the deceased's home with other documents.[161] On the top of the front page of that form were diagrams of the feet and of the sides, front and back of a human body. There was an instruction on the diagram to number each wound location on the diagram.[162]

137. On the diagram, the shins of the front of the body and been crossed and the number '1' was written beside the crosses.

[153] Exhibit 10; ts 474 and 408 per Peel, M L
[154] Exhibit 1, Volume 1, Tab 14
[155] ts 482 per Peel, M L
[156] 481 per Peel, M L
[157] 481 per Peel, M L
[158] ts 128, 136 , 137 and 141 per Nigrone, C; ts 159 and 165 per Niceforo, C A
[159] Exhibit 10
[160] Exhibit 1, Volume 3, Tab E
[161] Exhibit 1, Volume 3, Tab E
[162] Exhibit 1, Volume 3, Tab E

On the back of the body was an 'X on the sacral region with a circled '2' beside it. The form and the writing were both in black ink. Below the diagrams was a table where the date, wound number, site, duration, type, size and depth of the wounds, as well as whether the wound had been photographed or traced, was to be recorded.[163]

138. Beside the word 'Site' on the wound assessment form was hand-written 'Bilateral Lower Legs'. The sacral wounds were not mentioned, but there were columns marked with a circled '1' and a circled '2'.[164] On page 4 of the form was a heading 'Wound Treatment Plan' with columns for the date, current wound management plan with wound number, dressing frequency and signature of nurse. There were three entries, with the dates 23 October 2013, 6 December 2012 and 31 January 2014. No wound numbers were written and the wound treatment plans all appeared to be related to the leg wounds, since they included tubigrip, a tubular compression bandage which, I infer, could not be applied to the sacral area.[165]

139. In oral evidence, Ms Myhill said that she did not attend the deceased's sacral wound because she was not told about it, either by way of the KinCare app or as part of the wound assessment form.[166] She initially agreed that, though she did not have a specific recollection of looking at the wound assessment form, she had read it and it indicated that there was a wound on the deceased's bottom or sacral area.[167] She agreed further that the documents, including the service variation reports, in the deceased's file at her home directed her to treat the wounds on the deceased's bottom.[168]

140. When asked if she could explain how she missed the direction in the wound assessment form, she said that the app did not note the sacral wound and that the wound assessment form had two wounds on one plan, when wounds were meant to be kept separate.[169]

[163] Exhibit 1, Volume 3, Tab E
[164] Exhibit 1, Volume 3, Tab E
[165] ts 541 per Myhill, T L;
[166] ts 530 – 532 per Myhill, T L
[167] ts 536 – 537 per Myhill, T L
[168] ts 538 – 540 per Myhill, T L
[169] ts 541 – 542 per Myhill, T L

141. Unfortunately, a copy of the app page applicable at the time Ms Myhill attended the deceased was not available to take into evidence, so it is not possible to confirm Ms Myhill's recollection of what the app provided.[170]

142. However, it does appear that the cover page of the wound assessment form was, at best, less than clear. Importantly, when asked to look at that form, Ms Goodman also identified it as the wound care plan for the deceased's bilateral leg wounds and said that there would be a separate plan for the sacral wound as each wound had its own wound care assessment. When taken to the diagram at the top of the cover page, she said that she had not seen the '2'.

143. Ms Myhill's evidence about the need to have separate documentation for different wounds was also supported by Ms Morey.[171]

144. As a result of her understanding that she was only supposed to dress the deceased's leg wounds, Ms Myhill did not clean or dress her sacral wounds.[172] When shown photographs of wounds on the deceased's bottom on 4 February 2014, Ms Myhill said that if she had seen that kind of wound on 3 February 2014, she would have arranged for the deceased to go to hospital for probable debridement and surgical intervention.[173]

SECOND ADMISSION TO AKMH

145. On 4 February 2014 Mr Niceforo and Ms Nigrone became concerned about the deceased because she was becoming less responsive.[174] Ms Nigrone found the deceased's blood sugar level to be very high at over 22.[175]

146. Ms Peel attended to shower the deceased and also saw that she was very unwell. The deceased was difficult to rouse

[170] ts 542-543 per Atkin, T
[171] ts 208 per Morey, P
[172] ts 531 per Myhill, T
[173] ts 535 per Myhill, T
[174] ts 593 per Niceforo, N
[175] ts 483 per Peel, M L

and had unswallowed food in her mouth. About that time, Ms Nigrone called for an ambulance. There is some disagreement about whose idea it was to call for an ambulance,[176] but this is an irrelevant detail.

147. Ms Peel managed to get the deceased to stand, and she saw that the folded sheets on which the deceased had been sitting had a lot of blood and liquid faeces. It appeared that a blood-filled mass on the deceased's upper thigh had burst.[177]

148. Ambulance officers attended and took the deceased to the emergency department of AKMH, arriving at about 11.00 am. An emergency department nurse recorded that the deceased arrived with increased confusion and lethargy and that she had been incontinent of faeces en route. The nurse noted that the deceased had a large pressure ulcer on the sacral/buttocks/back of thighs that was infected and stage 2-3, with macerated areas of skin tears.[178]

149. An emergency department registrar examined the deceased and diagnosed contaminated pressure ulcers and acute renal failure.[179] The deceased was provided intravenous antibiotics, intravenous fluids and insulin.[180]

150. At 2.00 pm a wound care specialist nurse reviewed the deceased's wounds and took photos of the wounds with Ms Nigrone's consent. She recorded that the sacral wounds were down to the bone and deep tissue throughout, with black eschar and white necrotic tissue deep in the left buttock crease. The nurse assessed the wounds as being stage 4 and unstageable in parts and noted that the deceased was septic and for transfer to the ICU.[181]

151. At 3.45 pm, an emergency department registrar recorded[182] that nursing staff had identified evidence of possible negligence in the deceased's hygiene at home, with:

[176] Exhibit 1, Volume 1, Tab 14; ts 593 per Niceforo, N
[177] Exhibit 1, Volume 1, Tab 14
[178] Exhibit 1, Volume 3, Tab 40.H
[179] Exhibit 1, Volume 3, Tab 40.H
[180] Exhibit 1, Volume 3, Tab 40.H
[181] Exhibit 1, Volume 3, Tab 40.H
[182] Exhibit 1, Volume 3, Tab 40.O

a. stage 4 sacral pressure ulcer, not dressed on arrival to hospital with dry faeces in the wound;

b. bilateral oedema to lower limbs, excoriation to calves requiring dressing, with the legs appearing dry, crusty with old fluid leakage;

c. a large continence pad with faeces caked and dried around the bottom and sacral wound, and faeces in the vaginal and urethral areas; and

d. upper dentures black and discoloured with evidence of oral thrush. Photos of the dentures were taken.

152. An ICU consultant reviewed the deceased and determined that a poor outcome was likely and that the deceased was not appropriate for the ICU.[183] The deceased was transferred into the acute medical unit (**AMU**) under the care of consultant physicians Dr Rasiah Sureshkumar and Dr Christie De Silva.[184] Dr De Silva explained in oral evidence that the ICU consultant would have considered that the deceased's chance of survival was minimal.[185]

153. At 5.00 pm a medical registrar noted that the deceased had metabolic acidosis secondary to sepsis and prolonged elevated blood sugar levels. The registrar diagnosed her with sepsis, with a differential diagnosis of urinary tract infection, lower respiratory tract infection and osteomyelitis. The lower respiratory tract infection appears to have been based on crepitations heard in the mid-zone of the left lung on auscultation and a chest X-ray showing patchy shadowing of the left lung correlating with the crepitations.[186]

154. At 6.00 pm the medical registrar recorded the results of discussions with Ms Niceforo and Mr Niceforo, in which they said that the deceased and her daughters looked after the deceased's insulin but were not aware of how to adjust the level, that the deceased cleaned her dentures herself,

[183] Exhibit 1, Volume 3, Tab 40.H
[184] Exhibit 1, Volume 1, Tab 6.3
[185] ts 391 per De Silva, C
[186] Exhibit 1, Volume 3, Tab 40.J

and that the deceased spent most of the time in a chair because of a fear of falling.[187]

155. On the morning of 5 February 2014 Dr De Silva and the AMU team, including Dr Ajit Chaurasia, reviewed the deceased during a ward round and found her to be unwell with a low blood pressure (101/40) and in pain, but alert and responsive. The provisional diagnosis was confirmed to be sepsis with the possible source being the sacral wounds or bilateral leg cellulitis. A change was made to the antibiotics.[188]

156. On the next morning, Dr De Silva again reviewed the deceased during a ward round and found that her blood sugar levels were still high and her blood pressure was low, but that that sacral wound had improved from the day before. The deceased appeared to have resolving sepsis and poorly controlled diabetes mellitus. The integrated progress notes indicate that the deceased was chronically infected with *Pseudomonas* but was responding well to antibiotics.

157. At 2.35 pm on 6 February 2014 nursing staff noted that the deceased had eaten only two spoons of pudding for breakfast and refused to eat or drink thereafter. That evening she was rousable to voice but remained hypotensive and hypothermic.

158. By 9.00 am on 7 February 2014 the deceased's condition had deteriorated. She became unresponsive and, despite receiving further medical treatment, she died at about 10.10 am.

THE CAUSE OF DEATH

159. Dr Chaurasia was the medical practitioner who completed the death certificate mentioned in the introduction to this record of investigation into the deceased's death. Apart from identifying 'septic shock (sepsis)' as the condition leading directly to death and 'poorly controlled diabetes mellitus' as the antecedent cause, Dr Chaurasia listed

[187] Exhibit 1, Volume 3, Tab 40.P
[188] Exhibit 1, Volume 3, Tab 40.J

'10cm x 10cm stage IV chronic sacral wound' and 'congestive cardiac failure' as other significant conditions.[189]

160. Dr Sureshkumar and Dr De Silva sent the Court a letter dated 2 July 2014 in which they stated that they observed the deceased in sepsis leading to septic shock as a result of large necrotic infected sacral and thigh ulcers on a background of poor hygiene and poorly controlled diabetes, hypertension, ischaemic heart disease and heart failure. They considered that inadequate pre-hospital care could have contributed to her poor outcome.[190]

161. In a letter of 2 January 2015, Dr Sureshkumar stated that the main reason for the deceased's death was sepsis arising from large infected and necrotic sacral and thigh ulcers leading to septic shock.[191]

162. In oral evidence, Dr De Silva explained that the immediate cause of death was septic shock, which is part of multiple organ failure following sepsis. He said that the deceased's diabetes meant that her sugar levels were high, so the wounds would not heal and the infection would get worse, increasing the sepsis. Because the deceased had damaged kidneys, there were added complexities because the deceased could not be given diuretics or certain antibiotics, yet the deceased's cardiac failure would normally be treated with diuretics. In addition, a lot of intravenous fluids are required to treat septic shock, but (as I understand his evidence) that would have led to a worsening of the heart failure.[192]

163. Dr De Silva said that the main source of infection was identified as the sacral wound because there was no other source, including the urine, the blood, the lungs, the gall bladder and other places.[193] He said that microbiological examination of swabs of the sacral wound grew coliform organisms, which come from faecal contamination. So, he

[189] Exhibit 1, Volume 3, Tab 40.A
[190] Exhibit 1, Volume 3, Tab 6.3
[191] Exhibit 1, Volume 1, Tab 6.1
[192] ts 384-385 per De Silva, C
[193] ts 387 per De Silva, C

said, the infection started from there and spread rapidly due to the high blood sugar.[194]

164. Dr De Silva said that there was a history of urinary tract infection treated by a doctor earlier and that it was possible that the deceased's urinary tract infection contributed to her death.[195] However he went on to say that the deceased's uncontrolled diabetes was not likely to be caused by a urinary tract infection because urine analysis at the hospital found no evidence of urinary infection.[196]

165. I note that a urinary tract infection was not, on the evidence, ever definitively confirmed. It seems that the deceased was seen by Dr Hussain on 31 January 2014 because Ms Peel suspected a urinary tract infection, but Dr Hussain stated in his report that he treated the deceased for constipation and told her to keep taking her regular medications.[197] However, on 3 February 2014 Ms Peel recorded in the service variation report that the deceased had a 'UTI' and was 'taking amoxycillin',[198] and Mr Niceforo wrote that the 'locum doctor' prescribed antibiotics for a suspected bladder infection.[199] A history of urinary tract infection was provided to the emergency department on 4 February 2014. The medical assessment form for the medical acute unit includes a history of a urinary tract infection but states that there is no MSU (midstream urine test) on the system.[200] Dr De Silva said that the deceased's urine was tested at admission and no organism could be grown, although there was some nitrates indicating the presence of infection.[201] However, he was not taken to the test results, and the only ones I can find seem to indicate that nitrates were negative and leucocytes were small.[202]

166. Chief Forensic Pathologist Dr Clive Cooke was asked to review the deceased's medical file from AKMH and a file

[194] ts 385-386 per De Silva, C
[195] ts 386 per De Silva, C
[196] ts 393 per De Silva, C
[197] Exhibit 1, Volume 1, Tab 10
[198] Exhibit 1, Volume 2, Tab 39.T
[199] Exhibit 1, Volume 1, Tab 2
[200] Exhibit 1, Volume 3, Tab 40.J
[201] ts 386 per De Silva, C
[202] Exhibit 1, Volume 3, Tab 40.H, Nursing Triage Report

containing statements from the deceased's carers and opinion letters. Following that review, Dr Cooke provided a letter in which he stated that it seemed most likely that the deceased died as a consequence of organ failure due to sepsis. He stated that the deceased's pre-existing illnesses were significant contributing factors, with diabetes mellitus exacerbating sepsis, and heart disease potentially making a fatal outcome more likely.[203]

167. In relation to the source of the sepsis, Dr Cooke stated that the deceased's sacral/buttock/upper thigh wounds could easily have been a source of systemic sepsis, but that other possible sources, namely urinary tract infection and chest infection, could not be excluded.[204]

168. Dr Cooke noted that the medical record indicated increased breath sounds with crepitations and an X-ray apparently showed shadowing around the mid-zone of the left lung, raising the possibility of a chest infection.[205] He also noted that aspiration pneumonia, resulting from the dirty mouldy dentures or, as I understand it, as a terminal event in the progression towards death, could not be excluded as a possible cause of the sepsis.[206]

169. KinCare's representatives submitted that the deceased's multiple co-morbidities make it almost impossible to determine what caused the sepsis. They submit that one thing that could be ruled out was 'a chest infection caused by pneumonia', which they say Dr Cooke suggested was a potential cause of the sepsis.[207] They submit further that the evidence indicates that the relevant infection, or the onset of the sepsis, was present on 29 January 2014 when the wounds were not infected. That, they submit, in addition to the evidence that Ms Peel thought that the deceased had a urinary tract infection on 30 January 2014, indicated that the source of sepsis was not the sacral wounds, and was most likely the cellulitis of the lower legs, or the urinary tract infection or a kidney infection.

[203] Exhibit 1, Volume 1, Tab 3.1
[204] Exhibit 1, Volume 1, Tab 3.1
[205] ts 408 per Cooke, C T
[206] Exhibit 1, Volume 1, Tab 3.1; ts 405-406 per Cooke, C T
[207] Submissions by KinCare, paragraphs 137 -147

170. I accept that it is not possible to find conclusively that a chest infection was a cause of the sepsis, but I am not convinced that it is possible to rule it out as contributing to the deceased's death, either as potential source of the sepsis or as a complication in the form of aspiration pneumonia. I can find no evidence indicating that a kidney infection was a potential source of the sepsis.

171. As to the source of the infection, I am unable to ignore the expert testimony of Dr De Silva and Dr Cooke and deduce my own conclusion. Dr De Silva provided a reasoned opinion that the source of the sepsis was the sacral wounds. Dr Cooke supported the likelihood that the wounds were the likely source,[208] but he was not able to rule out other possibilities as contributing factors.[209]

172. As to the commencement of the sepsis, neither Dr De Silva nor Dr Cooke was asked for an opinion specifically on this issue. Dr De Silva said that when the deceased presented to AKMH on 4 February 2014 she was already quite late in her disease because she was too sick to be managed in the ICU. However, he also said that treatment for septic shock needs to be started within one hour to get the best results, so 'late in her disease' may reflect a matter of hours rather than days.

173. Dr Cooke said that septic shock in an elderly person can be quite a subtle change, and can just be manifested by a change in the mental state such as confusion, or by listlessness or weakness.[210] He was not asked about the symptoms of sepsis, but I infer that they would be even more subtle than those of septic shock.

174. The evidence of Ms Hehir and the photos she took on 29 January 2014 together with the apparent concurrence of Ms Morey and Dr De Silva indicates that the deceased's sacral wounds were not infected on that date but that they had the potential to become infected. On the next day, the deceased may have had a urinary tract infection, but that is not clear. Ms Mayor's note indicates that on Friday

[208] ts 407 per Cooke, C T
[209] ts 405-409 per Cooke, C T; Exhibit 1, Volume 1, Tab 3.1
[210] ts 407 and 410 per Cooke, C T

31 January 2014 the deceased was not well and was incapable of standing in the shower, but that night Dr Hussain examined her and noted normal vital signs.

175. Ms Niceforo said in evidence that on Saturday 1 February 2014 the deceased was joking around with Mr Niceforo and that she was not apparently very ill.[211] Mr Niceforo said that he had been home during that weekend and the deceased was lucid.[212]

176. Ms Peel stated that when she attended the deceased on Monday 3 February 2014, she could see that the deceased was not well, appearing lethargic and mentally less aware than usual. The deceased had had a loose bowel movement that morning, her blood sugars were high[213] and she was a little hard to rouse. Ms Peel said that she had never seen the deceased in a similar state.[214]

177. On the basis of the foregoing, I am satisfied that the cause of the deceased's death was organ failure due to sepsis, likely from infected pressure sores, in the context of uncontrolled diabetes mellitus and ischaemic heart disease.

178. It seems reasonably clear that the deceased was not overly unwell on 29 January 2014 but that by 3 January 2014 she was septic and may have been in septic shock. Precisely when she became septic is open to debate but, on the basis that it coincided with the symptoms described by Dr Cooke, it appears to have been on 2 or 3 January 2014.

QUALITY OF KINCARE'S TREATMENT AND CARE

179. Section 25(2) of the Coroners Act 1996 provides that a coroner may comment on any matter connected with the death, including public health. Under section 25(3) of that Act, where the death is of a person held in care, a coroner must comment on the quality of the supervision treatment and care of the person while in that care.

[211] ts 175 per Niceforo, C A
[212] ts 113-114 per Niceforo, N
[213] ts 474 and 481 per Peel, M L
[214] ts 482 per Peel, M L

180. The deceased was not a person held in care, but it seems to me that, as she was a person receiving home-care at the time, and as home-care and residential aged-care appears to be an increasing trend in Western Australia, the circumstances of her death involve issues of public health.

181. While I refer below to standards of care and quality of care, I do so without intending to determine any question of civil liability.

182. In a letter to the State Coroner dated 7 April 2014, Mr Niceforo alleged[215] that the care provided to the deceased by KinCare was inadequate and unprofessional. In particular, he said that KinCare:

a. failed to provide sufficient bandaging supplies to enable its nurses to dress the deceased's wounds;

b. refused to provide nurses on weekends or public holidays; and

c. sent relief nurses who were not aware of what treatment was required.

183. Mr Niceforo also alleged that KinCare staff

a. scalded the deceased in the shower;

b. failed to administer the deceased's eye drops;

c. often failed to arrive on time;

d. treated the deceased roughly;

e. made the deceased feel unsafe in the shower; and

f. had no compassion.

184. Of Mr Niceforo's allegations, his primary complaint was KinCare's failure to provide supplies for the nurses.[216]

[215] Exhibit 1, Volume 1, Tab 2
[216] ts 73 per Niceforo, N

185. I shall address each of Mr Niceforo's allegations in turn.

Failure to provide supplies

186. There is no doubt that for some months after commencing with the care of the deceased, KinCare as an organisation regularly failed to provide their nurses, especially Ms Thornton, with all the supplies they required in order to treat the deceased. That much was accepted by KinCare.

187. However, there is no evidence to establish that KinCare's failure in this regard had any substantial negative effect on the deceased's physical health. Mr Niceforo agreed that he and his sisters bought supplies if KinCare failed to supply them, so the deceased did not miss out on dressings. He made the point, however, that he should not have had to do so.[217]

Failure to provide staff on weekends and holidays

188. The care and treatment provided by KinCare under the EACH package was limited by the funding in the package. The deceased was receiving the highest care available for home-care.

189. While it is clear in my view that the deceased required a higher level of care than she was receiving from KinCare for the final six months or so of her life, it is not reasonable to have expected KinCare to provide higher care without compensation.

Relief nurses did not know what to do

190. The direct evidence related to this issue is somewhat scant. In my view it is clear that the communication systems employed by KinCare within the care team were, at best, inefficient. As Ms Hehir said, the difficulties with communication led her to feel that there was no continuity of care.[218]

[217] ts 109-110 per Niceforo, N
[218] ts 324 per Hehir, R A

191. That inefficiency of communication, together with a language barrier arising from the deceased's difficulty speaking English, led to a potential for nurses to misapprehend the details of the care they were supposed to provide. In my view, those circumstances were the likely underlying basis for Ms Myhill not cleaning and dressing the deceased's sacral wounds on 3 February 2014.

192. Given the lack of comprehensive records, especially in relation to wound care management, it is not possible on the evidence to determine whether other relief nurses had also not fully treated the deceased.

193. In any event, the fact as I have found that the deceased was septic by 3 February 2014 indicates that it is unlikely that Ms Myhill contributed to her death by not dressing her sacral wounds on that day.

KinCare staff

194. The collection of complaints by Mr Niceforo in his letter was not the subject of detailed investigation in the inquest.

195. There are written records of two complaints of the deceased being scalded.[219] Mr Niceforo said that the deceased had told him that, a couple of times, personal care workers had put her in the shower and the water was so hot that it burnt her back. He said that he had seen that the deceased's back was very red after she had been burnt in the shower.[220]

196. However, on 20 November 2013 Ms Warner-Groves recorded that the deceased stated that 'she got burnt by hot H_2O' and that Ms Warner-Groves assessed the skin and found no marks.[221] On 20 January 2014, a personal care worker who went on to become a team leader with KinCare, Geraldine Groves-Price, requested in a lengthy message in the KinCare app that she not be sent to care for the deceased again because, she said, the deceased unfairly claimed that she had burnt her.[222]

[219] Exhibit 1, Volume 2, Tab 39.N; Exhibit 1, Volume 1, Tab 22, 20/01/14
[220] ts 76-77 per Niceforo, N
[221] Exhibit 1, Volume 2, Tab 39.N
[222] Exhibit 1, Volume 1, Tab 22

197. Ms Nigrone remembers the deceased calling out to her once when she was in the shower and the water was too hot. She said that she saw a red mark on the deceased's back.[223]

198. In the circumstances where the evidence appears to be in direct conflict, I am unable to determine where the truth lies.

199. The same consideration applies with respect to the other complaints by Mr Niceforo about personal care workers. However, he did say in oral evidence that he was generally much happier with 'the showering ladies' than he was with the nurses.

200. I also note that Mr Niceforo said that the deceased 'liked Andrea (Ms Thornton) very much',[224] was 'extremely happy with how Monique (Ms Warner-Groves) treated her',[225] and 'liked Michelle (Ms Peel) very much'[226]. Mr Niceforo also said that Ms Hehir 'made a great effort to provide professional service and a high level of care to Mum.'[227]

201. Ms Nigrone said that relief nurses would sometimes rip the tape off the deceased and it would hurt her. The regular nurses were quite gentle, she said.[228]

202. On my count, KinCare nurses attended the deceased about 95 times over all. Of those attendances, about 12 involved nurses other than Ms Thornton, Ms Warner- Groves or Ms Hehir. A nurse who was identified by Mr Niceforo as 'Janette' and who, he says, carelessly tore the deceased's skin by removing an incontinence pad,[229] does not show up on the attendance record, the service variation reports or the wound assessment form. However, there are entries by a personal care worker named 'Janine' on two occasions. There is also a record of a nurse named 'Jackie', who attended once on her own on 18 November 2013[230] but her

[223] 112 per Nigrone, C
[224] ts 84 per Niceforo, N
[225] Exhibit 1, Volume 1, Tab 2; ts 85 per Niceforo, N
[226] ts 94 per Niceforo, N
[227] ts 594 per Niceforo, N
[228] ts 133 per Nigrone, C
[229] Exhibit 1, Volume 1, Tab 2
[230] Exhibit 1, Volume 2, 39.B

notation in the service variation report only refers to redressing the wounds.[231]

203. In my view, the evidence establishes that the treatment and care provided by both nursing staff and personal care workers was generally at a reasonable standard having regard to the circumstances in which they were treating the deceased. In particular, I commend the deceased's regular nurses and carers, Ms Thornton, Ms Warner-Groves, Ms Hehir, Ms Peel and Ms Mayor for their professional commitment.

204. While I accept that there may have been occasions where the care could have been better, I am not able on the evidence to find the details of those occasions with any degree of certainty.

Standard of wound care

205. Wound specialist Pamela Morey RN provided a wealth of information about wound care in general and the deceased's circumstances in particular.

206. Ms Morey said that the most critical treatment of a pressure injury is to get the pressure off and that, if the pressure is not alleviated/relieved/managed, it is unlikely that the injury will heal. Mobilisation, walking, getting up, changing position, and lying in different positions are all important in trying to reduce the pressure over injured tissue.[232]

207. Ms Morey said that a person who is faecally incontinent is 20 times more likely to sustain a pressure injury and an accumulation of faeces or urine will increase the risk of infection.[233]

208. Ms Morey pointed to the Pan Pacific Clinical Practice Guideline for the Prevention and Management of Pressure Injury[234] as representing the best practice guideline for preventing and managing pressure injuries. It has been

[231] Exhibit 1, Volume 2, 39.N
[232] ts 186-188 per Morey, P
[233] ts 189 per Morey, P
[234] Exhibit 1, Volume 4, Tab 3

adopted by the National Safety and Quality Health Service Standards.[235] She said that the principles in those standards would apply to the home-care setting.[236]

209. Ms Morey said that she expected the nurses who attended the deceased to have assessed her wounds regularly and to document the assessments.[237] She was taken to the wound assessment form for the deceased, which she said lacked descriptions of a number of issues related to the deceased's wound at the time, and lacked a clear plan for the deceased's sacral wound as distinct from her leg wounds.[238]

210. In terms of the specific dressings used, Ms Morey appeared to say that she did not consider that the choice of dressings made much difference to the end result for the deceased.[239] Of much greater importance in her case was the need for her to be mobile and not be sitting on her pressure sores.[240] She said that Dr Lim, and by extension the KinCare nurses, provided reasonable care and had no contributing part in the deceased's whole deterioration.[241]

211. An important area of evidence provided by Ms Morey related to how quickly the deceased's wounds could have deteriorated from their condition on 29 January 2014 to their condition on 4 February 2014 given the deceased's comorbidities.[242] In particular, she said that a sudden change in condition, such as infection, systemic infection or cardiac problems such as a drop in blood pressure can make an enormous difference in terms of how quickly damage can occur, particularly if the person is not mobile. She said that experiments on rats have shown that pressure injuries can occur within 60 minutes or less.[243]

212. Ms Morey agreed that, given the deceased's comorbidities and the fact that KinCare staff were only present with her

[235] ts 190 - 191 per Morey, P
[236] ts 193 per Morey, P
[237] ts 205 per Morey, P
[238] ts 206 - 208 per Morey, P
[239] ts 254 per Morey, P
[240] ts 235 - 236 and 247 per Morey, P
[241] ts 254 per Morey, P
[242] ts 183 and 236-237 per Morey, P
[243] ts 183 per Morey, P

for a small percentage of time during the week, unless the deceased was mobile and not sitting on her pressure sores, those pressure sores would have been likely to deteriorate.[244]

213. In Ms Morey's view, it appeared that the deceased had a marked deterioration in her sacral wounds from about 14 January 2014 and that deterioration was caused by a decline in her condition generally.[245]

214. In light of the foregoing, I am satisfied that the quality of the wound care provided by KinCare nurses was reasonable in all the circumstances.

The deceased's dentures

215. In a letter to Dr Sureshkumar, Director of Nursing and Midwifery at Armadale Health Services Barry Morely OAM described the deceased's dentition at presentation to the emergency department at AKMH on 4 February 2014 as follows:

> The patient's upper dentures were in an appalling state with evidence of heavy soiling and black plaques and gave the appearance of having been in place for a long time. The mouth itself had evidence of thrush.

216. Consultant forensic odontologist Dr Stephen Knott OAM reviewed photographs of the dentures and concluded that:

> The presence of the accumulated plaque and indication of a (chronic) candida infection would suggest that the denture had not been removed from the mouth and cleaned for weeks/months.[246]

217. The state of the deceased's dentures was cited by Dr Sureshkumar as evidence of neglect.[247]

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[244] ts 236 per Morey, P
[245] ts 252 per Morey, P
[246] Exhibit 1, Volume 1, Tab 4
[247] Exhibit 1, Volume 1, Tab 6

218. The oral evidence established that the reason for the deceased's poor dentition was her refusal to allow anyone to assist her with cleaning her dentures.

219. Mr Niceforo expressed his understanding that the deceased liked to clean her dentures herself and that she was always capable of doing so. He did not think that the personal care workers were supposed to help her with her dentures.[248] Ms Nigrone echoed his evidence.[249]

220. Ms Niceforo told a registrar at the emergency department at AKMH that the deceased cleaned her own dentures and that the dentures were black because they were old. The registrar recorded that the dentures were cleaned in the emergency department. The deceased had them back in her mouth and would not let the registrar remove them to examine them.[250]

221. The client service plan in place from 30 July 2013 listed 'Oral care', 'Clean Teeth' and 'Clean Dentures' as activities for personal care workers to observe and assist if needed.[251]

222. Ms Peel said in a statement that she did not attend to the deceased's dentures. She said that the deceased was very independent and would want to do a lot of things for herself.[252]

223. Ms Grove-Price said that, on her first attendance on 11 November 2013, she asked the deceased if she wanted her to clean her dentures, and the deceased replied 'No, I do.' Ms Grove-Price did not ask again when she returned one week later for her last attendance.[253]

224. While it is apparent that the deceased's dentition was neglected, it is also clear that KinCare personal care workers were not responsible for that neglect.

[248] ts 71-72 and 100 per Niceforo, N
[249] ts 124-125 per Nigrone, C
[250] Exhibit 1, Volume 3, Tab 40.P ; ts 174 per Niceforo, C A
[251] Exhibit 1, Volume 2, Tab 39.G
[252] Exhibit 10
[253] ts 459-460 per Grove-Price, G

Conclusion in relation to KinCare's quality of care

225. KinCare's care and treatment of the deceased was hampered by its regular on-going failure to supply dressing supplies for nursing staff, by inefficient and confusing means of communication between staff members, and by an occasional lack of support, including lack of supervision and training.

226. Despite KinCare's organisational inadequacies, however, the professional commitment of field staff resulted in generally reasonable personal care and wound care of the deceased. There is no evidence to establish that those inadequacies resulted in a level of care that was so substandard as to contribute to the deceased's death.

227. This is not to say that improvements could not have been made in those parts of the system employed by KinCare in its provision of home-care generally.

228. In my view, there were three areas of KinCare's system which required improvement: the provision of adequate dressing supplies, the provision of an effective communication medium between field staff, and the provision of a means ensuring a clear understanding by the deceased's family members of their responsibilities in the deceased's care.

229. The supplies issue appears to have been addressed by KinCare.

230. The communication issue appears yet to be resolved despite an acceptance by KinCare of the priority to do so.[254] It is difficult to see why a system equating to integrated progress notes has not already been implemented while a long-term electronic solution is being devised.

231. The issue of the family's responsibilities arises because it was clear that the deceased's family members were unaware of the need for them to assist with some aspects of the deceased's personal care on the days when KinCare personal care workers did not attend. I shall address this

[254] ts 497-498, 513-514 per Hamann, R

in more detail below. It was also apparent from Ms Peel's evidence that she incorrectly understood what assistance the deceased's family was providing.

232. There was general agreement, including on KinCare's behalf,[255] that everyone involved in the home-care of a patient, including members of the patient's family should receive documentation providing clear details of his or her responsibilities.

233. That procedure should be part of a process of on-going reviews of a patient's condition, on both a regular basis and whenever there is a change to a patient's condition.

RECOMMENDATION 1

> **That, if reasonably practicable, organisations providing home-care generate a document describing the roles and responsibilities of each person involved in a patient's care, including where applicable the patient's family or friends, and provide a copy of such a document to those persons at the outset of that care and from time to time as is reasonably necessary.**

234. Another matter that became clear in the course of the inquest was that the system under which the deceased received care from KinCare resulted in the deceased receiving the same level of nursing care despite the fact that her condition deteriorated and the level of care she needed increased. Ms Thornton identified this situation as early as July 2013.

235. KinCare submits that, from April 2013, the deceased should have been in permanent care if she was going to avoid serious health consequences from her wounds, and that her medical needs could not be met in the home-care setting.[256]

236. While I do not accept KinCare's submission in total, the evidence does indicate that the deceased required more care than she was receiving under the EACH package.

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[255] ts 502, 509, 514-515 per Hamann, R
[256] Submissions of KinCare, paragraphs 52 to 58

237. KinCare submits further that, in circumstances where the deceased refused to go into residential care and where the EACH package was the highest level of home-care available, the only other option technically available to them was to withdraw their service from the deceased, which would not have helped her.[257]

238. I do not accept that submission. A potential alternative open to KinCare was to meet with the deceased and her family to provide them with a realistic appraisal of the deceased's needs and to discuss the options available to her. There is no evidence that such a meeting took place in those terms. One option which may have been possible, for example, was for additional care to have been provided or funded by the family.

239. Ms Niceforo was asked, hypothetically, what more KinCare could have done if the EACH package was not enough for the deceased and there was no other package or health care provider available. She answered that if KinCare had said that, she would probably have given up work and looked after the deceased.[258]

240. Ms Hamann said that, in late 2014, KinCare implemented a process that applies where a client's needs change, but it is an overview of what can be done.[259] She said that every client is reassessed annually and at the request or a client or carer. If a client's needs significantly change, KinCare can ask for a formal assessment with the family.[260]

241. In my view, home-care providers should have a means of on-going assessment of a patient's needs. If a home-care provider considers at any stage that the care it provides to a patient is not commensurate with the level of care a patient requires, it should so inform the patient to enable the patient to make an informed decision about his or her future care.

[257] Submissions of KinCare, paragraph 60
[258] ts 162-163 per Niceforo, C A
[259] ts 496 and 503 per Hamann, R
[260] ts 503 per Hamann, R

RECOMMENDATION 2

That, home-care providers assess their patients' needs on an on-going basis and, where a home-care provider considers that the care it is able to provide to a patient under a home-care package cannot meet the patient's needs, the home-care provider meet with the patient and the patients' next of kin where appropriate to so inform the patient and to discuss the patient's further care.

DR LIM

242. An issue that arose with respect to Dr Lim's care of the deceased was whether he was responsible for the wound care provided by KinCare nurses.

243. Entries which Dr Lim made in the service variation reports indicate that he had, at times, provided directions to nurses on the types of dressings to use. For example, in an entry dated 28 May 2013 he asked nurses to dress regularly the deceased's pressure ulcers on the gluteal fold area, sacral area and natal cleft with padded dressings with inadine.[261] He made three other entries in late August 2013 and early September 2013 related to treatment of the deceased's lower legs.[262] On 14 January 2014 he made an entry in relation to right trochanteric bursitis.

244. KinCare's wound care management guideline for managers and nurses provided that all instructions from a patient's managing clinician were to be followed,[263] but there is no evidence to establish that Dr Lim had regular input into the day-to-day care of the deceased's wounds.

245. On the contrary, Silver Chain nurse Ms Taylor agreed that Dr Lim would only intervene if there was a particular issue, and that he was supervising in only a general sense.[264] Ms Thungmun said that her case manager would direct her about wound management, not Dr Lim.[265] Ms Hehir said

[261] Exhibit 1, Volume 2, Tab 39.I
[262] Exhibit 1, Volume 2, Tabs 39.J and 39.K
[263] Exhibit 1, Volume 1, Tab 25
[264] ts 279 per Taylor, C
[265] ts 304 per Thungmun, A P

that she contacted a patient's GP once in relation to a medication incident, but otherwise it was generally not recommended.[266] She said that her understanding was that the wound care plan and variations to it for the deceased was devised by senior staff at KinCare and not by the general practitioner.[267]

246. On the basis of that evidence, it is apparent that Dr Lim had little or no regular involvement of the deceased's wound care. To the extent that he had directed the type of dressings to be applied to the deceased's wounds, Ms Morey said that his care was reasonable.[268]

247. It is also worth noting that Dr Lim did not see the deceased after 14 January 2014, so he would have been unaware of the deterioration of her general condition at that time.

248. In passing, I must commend Dr Lim for his practice of seeing the deceased and his other patients in their homes.[269] As Mr Niceforo graciously said:

> In the time when it's very hard to get doctors to your home these days, very few do, we really appreciated the fact that Dr Lim is one of the very few doctors that will make the effort to walk out of the surgery and actually come to your home.[270]

CARE OF THE DECEASED AT AKMH

249. KinCare submitted that the deceased was well diagnosed and treated in the emergency department at AKMH and that it was too late to have any real chance of successfully treating her sepsis.[271]

250. KinCare went on to submit that Dr De Silva made clear that the deceased could have been given more acute treatment in the ICU, but she was denied this level of treatment

[266] ts 321 per Hehir, R A
[267] ts 346 per Hehir, R A
[268] ts 254 per Morey, P
[269] ts 120 per Niceforo, N
[270] ts 123 per Niceforo, N
[271] Submissions by KinCare, paragraph 128

because she was not a young patient with a good prognosis. Instead, it submits, she had a poor prognosis and, given her age and comorbidities, a decision was made by the hospital to keep the ICU bed available for a more appropriate candidate.[272]

251. KinCare asks whether there might have been a different outcome if the deceased could have been admitted to the ICU.[273]

252. Taking that question at face value, I am satisfied that placing the deceased in the ICU was unlikely to have resulted in a different outcome for the deceased.

253. I have reached that conclusion on the basis of the note by ICU consultant Dr Leonard Wotton in which he states 'Poor outcome likely. Not appropriate for ICU'[274] and Dr De Silva's evidence that ICU consultants give priority to acute patients who have a chance of survival. Dr De Silva said '… if the consultant thinks that the patient's chance of survival are minimal, then they would give a comment like that.'[275]

254. That evidence is consistent with the likelihood that the deceased was in septic shock before she presented at AKMH and Dr De Silva's evidence that, if the administration of antibiotics is delayed for more than an hour from the onset of septic shock, the prognosis is not good.

255. Despite the fact that the deceased was not admitted to the ICU, her treatment under Dr De Silva resulted in her condition improving with the correct antibiotic treatment until 6 February 2014 before it deteriorated. Dr De Silva said that patients often do that.[276]

256. In my view the treatment and care of the deceased at AKMH was reasonable.

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[272] Submissions by KinCare, paragraph 130 - 131
[273] Submissions by KinCare, paragraph 132
[274] Exhibit 1, Volume 2, Tab 40.H
[275] ts 391 per De Silva, C
[276] ts 392 and 394 per De Silva, C

THE ROLE OF THE DECEASED'S FAMILY IN HER CARE

257. Mr Niceforo considered that the deceased's family's responsibilities for the deceased's care were to make sure that she was safe and healthy, to do shopping and any necessary cleaning, to get her out of the house, get some exercise and was not couped up inside.[277]

258. Mr Niceforo said that he was the deceased's primary carer, living at home.[278] I take that to mean that he was identified as such in relation to external agencies like KinCare, not that he was the person who primarily provided care to the deceased. He generally worked on weekdays, leaving in the morning and returning in time for the evening meal.

259. Mr Niceforo said that in the evenings and on weekends he would walk around the house with the deceased, but it is not clear what time-frame he was referring to.[279] He also said, that in the last three or four months of her life, she moved around less, but whenever he had a chance, he would make sure that she got up and moved about.[280] However, when the deceased was admitted to AKMH on 4 February 2014, Mr Niceforo told the medical registrar that the deceased spent most of the time in a chair because she was afraid of falling.[281]

260. Mr Niceforo did not take part in the personal care of the deceased. He assumed that KinCare addressed that.[282] For cultural reasons, he had never seen the deceased's sacral wounds, or assisted her in the shower[283] or assisted her to change an incontinence pad.[284] He understood that the deceased looked after her own dental care,[285] incontinence pads[286] and insulin injections.[287]

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[277] ts 73 and 110 per Niceforo, N
[278] ts 89 per Niceforo, N
[279] ts 84 and 111 per Niceforo, N
[280] ts 111 per Niceforo, N
[281] Exhibit 1, Volume 3, Tab 40.P
[282] ts 73 per Niceforo, N
[283] ts 113 per Niceforo, N
[284] ts 75 and 76 per Niceforo, N
[285] ts 71 per Niceforo, N
[286] ts 76 per Niceforo, N
[287] ts 65 per Niceforo, N

261. Ms Nigrone said that she would do whatever the deceased needed her to do, but that did not include personal care or wound care.[288] Ms Nigrone lived nearby with her own family. She said that every weekday she would go to the deceased's home after she had dropped her daughter off at school. She would stay for a few hours to make the deceased lunch, prepare meals, do the washing and ironing and anything else that needed to be done.[289]

262. Ms Nigrone did not shower the deceased or tend to her wounds. She had never seen the wounds on her bottom or sacral area. She did not change the deceased's incontinence pads as she understood that the deceased did it herself when the carers and nurses were not there, including on weekends. She said that the deceased had told her that she was capable of doing it herself.[290] She would not have expected that Mr Niceforo or Ms Niceforo would have given the deceased a shower on weekends.

263. Ms Nigrone said that, over the weekend of 1 and 2 February 2014 the family did not clean or move the deceased because she understood that the deceased moved herself. She said that, if the deceased had soiled herself, the deceased would have told her or Ms Niceforo.[291]

264. Ms Nigrone did not remember the nurses encouraging the deceased to mobilise and for Ms Nigrone to assist her. She said that she would take the deceased outside every second or third day and that the deceased would get up and walk around when the nurses were not there.[292] She agreed that the deceased spent long periods of time sitting, but she said that she did get up and walk around.[293]

265. Ms Niceforo worked during the day on all days except Friday and Saturday. She said that she would attend the deceased's home before the deceased woke up and stay

[288] ts 128 per Nigrone, C
[289] ts 124 per Nigrone, C
[290] ts 130 per Nigrone, C
[291] ts 147-148
[292] ts 137 per Nigrone, C
[293] ts 152 per Niceforo, N

until about 15 minutes before she started work. She would make the deceased breakfast and ensure that she was okay. She would then return at lunchtime and again after work at about 4.45. She would stay and cook and clean for the deceased and Mr Niceforo and would do the deceased's eye drops and make sure that she did her insulin levels.[294]

266. Ms Niceforo said that she would leave incontinence pads on the table for the deceased to change herself, and would call her during the day to make sure that the deceased had done so. She said that the deceased never told her that she had soiled herself.[295]

267. Ms Niceforo said that on Saturdays she would sometimes give the deceased a sponge bath of her legs and under her arms.[296] She said that she saw the dressing on the deceased's back and would sometimes reapply the tape to reinforce it. She never saw the wounds on the deceased's sacrum.[297]

268. In my view, it is clear that the deceased's family did what was within their capabilities to look after the deceased while she was also receiving care from KinCare, but it is also clear that their capabilities with respect to personal care of the deceased were limited by their understanding of what the deceased actually required. The limitation appeared to be caused by their assumptions about the care provided by KinCare and by what the deceased told them about her own abilities to look after herself.

269. That the deceased's family did not attempt to tend the deceased's wounds was entirely reasonable.[298]

270. As to the important issue of the deceased mobilising herself, there is little doubt that, however much the deceased did move around to relieve the pressure on her sacrum and bottom, it was far from enough. This appeared to be a result of the deceased's refusal to move due to a combination of the resultant pain and her fear of falling.

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[294] ts 155 per Niceforo C A
[295] ts 157-158 per Niceforo, C A
[296] ts 158 per Niceforo C A
[297] ts 165 per Niceforo C A
[298] ts 566 per Warner-Groves, M

THE DECEASED'S CARE OF HERSELF

271. The evidence indicates that the deceased had a strong personality and particular views about the nature of the treatment and care she would be willing to receive. At times, those views were not reasonable, as with her demands for insulin at Shenton Park Hospital, her refusal for a sight-saving operation from Dr McAllister and her refusal to use ROHO cushions.

272. The deceased became increasingly less able to look after herself over time. This is not unusual. However, the deceased also became less willing to move around in order to relieve the pressure on her sacrum.

273. The deceased's refusal to take steps to reduce her sacral wounds made the deterioration of the wounds inevitable, and her incontinence meant that the likelihood of infection increased.[299]

274. It is tempting to speculate about the deceased's psychology during the last few months of her life, when she confined herself to a chair in the face of warnings from nurses that she would end up in hospital. KinCare suggests, perhaps correctly, that the deceased would have been aware of her rapidly declining health, but chose to stay in her home surrounded by her family despite knowing that it would severely affect her health.[300] Ms Morey's evidence supports that suggestion.[301]

275. Whatever the underlying reason, it seems apparent that the deceased was mentally competent throughout the time KinCare looked after her and that she made her own choices. Ms Warner-Groves said that she discussed the need for pressure relief with the deceased and her family almost every visit. Her answer to the question of why the deceased did not do things intended to help her was eloquently simple: 'Because she didn't want to'.[302]

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[299] ts 189 per Morey, P
[300] Submissions by KinCare, paragraphs 31 - 37
[301] ts 203-204 per Morey, P
[302] ts 567 per Warner-Groves, M

HOW DEATH OCCURRED

276. In all the circumstances, I am satisfied that death occurred by way of natural causes.

CONCLUSION

277. The deceased died from infection resulting from a deterioration in her condition in circumstances where, due to choices she consciously made, the likelihood of life-threatening infection was significant.

278. While I have found that there were systemic failures in KinCare's care and treatment of the deceased, those failures did not contribute to her death.

279. Due to the deceased's conscious refusals to look after herself properly, the level of care provided by KinCare staff would inevitably be insufficient to preclude such infection occurring.

280. There are many lessons to be learned from the deceased's sad death. To my mind, the two most important lessons are:

a. care plans for patients in a home-care situation need to be reviewed regularly and whenever a change in the patient's condition occurs; and

b. in circumstances where a patient is partly reliant on the care of family members or other persons who are not health care providers, those persons need to be involved so far as is practicable in the care planning, including on-going reviews of that planning. In that way, they will have reasonable expectations of the type and level of care provided by the health care provider, they will be aware of their roles and responsibilities, and the health care provider will be aware of the level of care provided by those persons.

281. In the absence of reviews and family involvement, the persons involved in providing treatment, care and

assistance to the patient may act on incorrect assumptions and expectations of the nature and level of care and assistance provided by others.

282. That said, given the deceased's conscious refusals to adopt the advice of health professionals in relation to her own well-being, ensuring on-going reviews with her and her family's involvement may not have changed the result.

B P King
Coroner
22 November 2016