STATE CORONER'S COURT

OF NEW SOUTH WALES

Inquest:	Inquest into the death of Sylvia Confos
Hearing dates:	16 July 2019 – 19 July 2019
Date of findings:	27 September 2019
Place of findings:	State Coroners Court, Lidcombe
Findings of:	State Coroner, Magistrate Teresa O'Sullivan
Catchwords:	CORONIAL LAW – Cause and manner of death – sacral ulcer-aged care-communication with family
File number:	2016/259208
Representation:	Mr P Aitken, Counsel Assisting, instructed by Crown Solicitor's Office Mr M Windsor SC, instructed by Ms Hilary Lee, Norton Rose Fulbright, for Castellorizian Aged Care Services, Ashraful Ahmed, Anamika Chand, Bindu Dewan, Linda Walton, Lorie Pedrosa, Catherine Brown and Keith Crossland Ms Katherine Doust, NSW Nurses and Midwives Association, for Aarti Singh, Manisha Awale and Shailendra Thapa Mr Colin Magee, instructed by Mr Ren Li, Avant Law, for Dr James Giallussi

Non publication order:	Pursuant to s. 65(4) of the *Coroners Act 2009***,** I direct that the following parts of the coroner's file are not to be supplied to any person: 1. The sensitive photographs listed in the schedule tendered as Exhibit 9; and 2. Any other photographs depicting Mrs Confos' sacral wound contained in Exhibit 1. Pursuant to s. 74(1)(b) of the *Coroners Act 2009***,** I direct that the following material is not to be published: 1. The sensitive photographs listed in the schedule tendered as Exhibit 9; and 2. Any other photographs depicting Mrs Confos' sacral wound contained in Exhibit 1.
Findings:	**Identity** The person who died is Sylvia Confos **Date of death** Sylvia Confos died on 26 August 2016 **Place of death** Sylvia Confos died at the Castellorizian Aged Care facility, Kensington NSW **Cause of death** Sylvia Confos died of natural causes, in the context of multiple co-morbidities including a sacral ulcer **Manner of death** Sylvia Confos died of natural causes, while suffering from a number of co-morbidities, including a sacral ulcer
Recommendations:	No recommendations are made

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The Coroners Act in s81 (1) requires that when an inquest is held, the coroner must record in writing his or her findings as to various aspects of the death.

These are the findings of an inquest into the death of Sylvia Confos.

Background

1. This inquest was directed to inquire into the circumstances of the death of Mrs Sylvia Confos, an 87 year old resident of the Castellorizian Aged Care facility ("the Home") in Kensington, Sydney, in 2016. Mrs Confos passed away on 26 August 2016 in the Home, and the post mortem suggested that it was as a direct result of the complications of a sacral ulcer, with suspected bacterial septicaemia. Mrs Confos suffered from multiple co-morbidities at the time of her death, including cortical atrophy and atherosclerosis of the circle of wills in the brain, dementia (which had first become apparent in about 2012), depression, high blood pressure and high cholesterol, as well as other issues.

2. Of particular focus in the hearing, both as to Mrs Confos' care and treatment and as to arriving at an understanding of the circumstances of her death, was an ongoing sacral wound or pressure injury that had apparently been observed in late 2015, had thereafter begun to heal, but had re-emerged in March 2016 and had significantly deteriorated to a stage 4 ulcer, which involved a cavity in the sacral area, by the time of her death. It was reported to police at first instance by a locum visiting GP, Dr Ugarte, who became concerned both at its appearance and when he was told by family members that they had not been made aware of the nature and the extent of the ulcer in the weeks leading up to her death.

3. Whether the family were made aware was of some importance in the hearing not only in considering whether the systems that the Home had in place were operating properly and whether the relevant staff members understood their obligation to keep the family informed, but also because a failure to communicate with family relating to the medical treatment of another resident from the Home in 2014 had been the subject of inquiry and education in the Home in the intervening period. The findings of this court in relation to that other matter are contained in '*Findings in the inquest into the death of Epenesa Pahiva*' dated 27 September 2019**.**

4. The hearing was mainly concerned with the manner of Mrs Confos' death; the time and place was not in issue. The court also heard evidence from several clinicians going to the nature of the wound and this in turn was relevant to the court's determination as to whether any contribution from potential sepsis could be established.

5. Communication with family was regarded as essential by the geriatrician appointed by the court to review the factual material in this case, Professor Joseph Ibrahim. This was because not only was Mrs Confos considered a vulnerable resident due to her age and co-morbidities, but because of her dementia, she was not able to make decisions about her treatment, or communicate effectively, and so the Home owed an obligation to her to ensure that a family member responsible for her would be aware of relevant medical conditions and treatment and be in a position to make decisions.

Sylvia Confos

6. Sylvia Confos was born on 8 May 1929 in Fremantle, Western Australia, to Greek migrant parents. This Court heard that she was a talented pianist, graduating with Honours from the Australian campus of the London School of Music. She married her husband Tony in 1948 and had two sons and six grandchildren. She was described as a devoted wife and mother and even more devoted grandmother or Yiayia, as well as a wonderful cook and keen kitty poker player. It is clear that she was much loved.

7. From 2012, family members noticed that Mrs Confos had deteriorated, becoming forgetful about things and starting to have falls. After two falls in 2013 arrangements were made for an ACAT assessment while she was in hospital and she was diagnosed with dementia. Admission to the Home was organised, to ensure her care, in about August 2013. Her long-term doctor at the Home, at least in the last two years of her stay, was Dr James Giallussi.

8. Her son, Nicholas, who already had enduring power of attorney for her also became her guardian and as such became the point of contact between the Home and Mrs Confos' family. During her time at the Home, Mrs Confos deteriorated

quite quickly, in that she became unresponsive and began to forget people's names.

The stages of Mrs Confos' care

9. These were considered from the perspective of the care and management of the sacral wound and included the following issues:

    (a) When a sacral sore was first identified and what plans were put in place to manage and treat it;

    (b) Whether appropriate procedures were followed to manage the sore/wound by way of attention to repositioning, bedding and air mattress settings;

    (c) Whether the directions and advice of the wound care specialist, Ms White in early August 2016 were immediately implemented or whether there was a delay (and, if so, why);

    (d) Whether there was appropriate treatment of the wound generally in August 2016, including written and verbal communication and consultation between the staff in the Nursing Home and with external clinicians (including visiting GPs) as to its developing seriousness;

    (e) When it was first determined that the wound was ulcerated and what measures were then put in place to treat it and consult about its treatment;

    (f) The adequacy of the medical notes recording progress and treatment of the wound, including in the period 12 August 2016 to 24 August 2016.

    (g) Whether there was a health care directive in place (separate from a palliative care directive) directing clinical management of Ms Confos' medical issues and information-sharing with relatives;

    (h) Whether there was a failure by the Nursing Home to inform appropriate next of kin/responsible relatives as to the presence and progress of the wound and/or seek informed consent for treatment and care; and

    (i) Whether relevant recommendations in relation to wound care and management and staff communication resulting from an audit of the Nursing Home conducted by a Ms Hannen in 2014 were adequately implemented and followed, so far as Mrs Confos' care was concerned.

Advanced health care directive:

10. Dr Giallussi gave evidence that an advanced health care directive was signed by Mr Nicholas Confos in December 2015. That health care directive agrees to palliative care; Mr Confos did not dispute that palliative care was discussed and

agreed. Dr Giallussi says that he told Mr Confos that his mother required mainly nursing and palliative care and provided Mr Confos with his mobile number if he needed to contact him. It appears that this Directive dictated care generally, but decisions still had to be made about active or passive care as it concerned new issues.

Procedures for managing the wound

11. On 24 November 2015, physiotherapist Anitha Vasudevan recorded in the Home's notes that Mrs Confos was to be repositioned every 2-4 hours to prevent the occurrence of pressure sores[1]. On 8 December 2015 the same physiotherapist recorded that Mrs Confos had been trialed in a water chair for more seating comfort and pressure care.[2] On 15 December 2015 Jyotsna Shrestha RN recorded that Mrs Confos had a pressure sore in her sacrum area. Palliative care directions were added by Ms Shrestha the same day.[3]

12. A wound assessment on 15 January 2016 recorded the pressure sore or wound as broken/shallow, with no exudate and epithelializing (pink), with no pain and "in healing progress".[4] Review was to occur on 15 February 2016 or as required.

13. Notes for February 2016 show a repositioning chart where staff were apparently meant to tick if Mrs Confos had been repositioned (every 2 hours in the day and every 3 hours at night).[5] A number of entries are left blank and where entries are completed the initial of the staff member is not always recorded. A repositioning chart for March and early 2016 also has gaps where no entries have been completed for a shift or part thereof, including the first four days of April 2016. The same applies for the remainder of April. In May the wound consultant recommended repositioning every 3 hours.

14. A repositioning chart exists for early June 2016.[6] There were again occasional shifts where no entries were recorded. A slightly more detailed chart was

[1] Exhibit 1, volume 5, p. 281.
[2] Exhibit 1, volume 5, p. 261.
[3] Exhibit 1, volume 5, p. 247.
[4] Exhibit 1, volume 4, p. 890.
[5] Exhibit 1, volume 4, p. 922-925.
[6] Exhibit 1, volume 4, p. 998.

commenced on 20 June 2016, which recorded actual times of repositioning. This appears to correspond with an email exchange between Registered Nurse Thapa and the external consultant Katrina Bailey about amending the chart.[7]

15. At times in July 2016 (e.g. 23 and 24 July 2016)[8] the Home's records suggest that repositioning sometimes occurred at 3 hourly intervals instead of the recommended 2.

16. On 2 August 2016, Ms Wendy White, a wound consultant, found that the mattress setting for Mrs Confos was on *'5.5'*, which on the scale shown on a printed sticker attached to the bed frame was for a person of 145kg in weight. Mrs Confos weighed about 40kg at the time. On 18 August 2016 a staff member, Krit Kumar Sharma, emailed one of the Clinical Care Co-ordinators, Manisha Awale, with bed settings for various residents. Mrs Confos' setting is recorded as '*5'*.[9]

17. The issue was explored with one of the nurses in oral evidence, Ashraful Ahmed. Mr Ahmed said that he did not know who was responsible for checking the dynamic mattress setting and he couldn't recall checking it. It later emerged on the evidence from other staff that the team leaders (AINs) had that responsibility. Evidence was taken during the hearing from the current facility manager of the Home, Mr Keith Crossland, to the effect that the mattresses had now been standardized and that the team leader must sign off on a form recording the setting and then hand that form to the Clinical Care Co-ordinator. Each mattress is also now fitted with an audible alarm. I am satisfied that the appropriate changes have been made by the Home to safeguard against the wrong mattress settings being applied in the future.

[7] Exhibit 1, volume 6, p. 278.
[8] Exhibit 1, volume 4, p.1033.
[9] Exhibit 1, volume 6, tab 30, p. 370-371.

Care and treatment of the wound generally and adequacy of the documentation

18. On 4 March 2016 a photo was taken of the wound, which appears to show an area of damaged surface skin.[10] No monthly photos appear to exist from December 2015, recording the progression and/or healing of the wound when it had previously emerged, despite that being a requirement of the Home's policy at the time. A skin integrity and pressure risk management assessment carried out on 4 March 2016 by Thi Tran RN recorded Mrs Confos as *"20+ very high risk of pressure ulcer"*.[11] A wound assessment the same day recorded the wound as approximately 2.5cm wide by 3cm long[12] and described it in these words: "the wound is a cavity", with no exudate. A photo taken the same day appears to show an area of broken skin with pale broken skin around the edges of the cavity.[13]

19. A subsequent accident/incident report entered in the electronic medical record by Nurse Manisha Awale noted that the visiting general practitioner for Mrs Confos, Dr Giallussi, had been notified, as had family member Nicholas Confos[14].

20. A further photo of the sacral wound was taken on 13 May 2016. Wound consultant Nurse Practitioner Ms Wendy White attended the Home on 23 May 2016 and was asked to review the wound. Ms White commented in her report as follows: "*Sacral PI [pressure injury] stage 2 noted maceration periwound skin* +++". There were two wounds, the larger being 1cm squared, and she noted that a build up of hyperkeratosis was unusual. She made recommendations about ongoing wound care and frequency of dressings and added: "*if failure progress in next 4 weeks with improved exudate management I may need to review to remove the unhealthy periwound* skin."[15]

21. A pain assessment conducted by a physiotherapist on 16 May 2016 recorded a score of nil,[16] noting that Mrs Confos was able to verbalise pain but was inconsistent and would get aggravated if someone moved her limbs beyond their

[10] Exhibit 1, volume 4, p. 926.
[11] Exhibit 1, volume 4, p. 927.
[12] Exhibit 1, volume 4, p. 929.
[13] Exhibit 1, volume 4, p. 926.
[14] Exhibit 1, volume 5, p 119.
[15] Exhibit 1, volume 1, tab 16.
[16] Exhibit 1, volume 4, p. 975.

normal range. There do not appear to be any repositioning records retained for May 2016.

22. There does not appear to be any photograph of the wound or wound assessment chart completed for June 2016 contained in the Home's medical record for Mrs Confos. However in the iCareHealth printout (the electronic medical record), Nurse Shailendra Thapa recorded on 21 June 2016 that "*resident sacrum wound frequency changed to every 3 days and apply Allevyn AG, nil improvement noticed on wound so wound care had been updated. Follow wound chart for wound care*".[17] This was also the subject of a clinical report email on the same day.[18] On 24 June 2016 nurse Linda Walton recorded in the same record that Mrs Confos was "*reviewed by Dr Giallussi. To commence on eye ointment and oral antibiotic*".[19] It does not appear that Dr Giallussi was asked to review the wound that day.

23. A photo of the wound taken on 24 July 2016 shows what appears to be a worsening ulceration.[20] Dr Giallussi was apparently not asked to review the wound during his visit on 27 July 2016,[21] where his notes simply say "*loose motions. Cease coloxyl"*. Nurse Walton emailed the then Director of Nursing, Aarti Singh, and the two external Nurse Consultants, Catherine Brown and Katrina Bailey, on 28 July 2016 noting that the sacrum wound "*is becoming quite deep. Waiting on new sacral dressings to come*".[22]

24. From 30 July 2016 to 26 August 2016, entries were made on iCareHealth on a daily basis about cleaning and dressing the wound.[23]

25. On 2 August 2016 wound consultant Ms White attended the Home to deliver an educational session. She was asked to review Mrs Confos by a Clinical Care Co-ordinator, 'Manisha' (Ms Awale) about ongoing issues with the wound, including dressing leakage, odour, dressing dislodging and deterioration of the wound.

[17] Exhibit 1, volume 5, p. 7.
[18] Exhibit 1, volume 6, tab 30, p. 280.
[19] Exhibit 1, volume 5, p. 5.
[20] Exhibit 1, volume 4, p. 1028.
[21] Exhibit 1, volume 4, p 1001.
[22] Exhibit 1, volume 6, tab 30, p. 307.
[23] Exhibit 1, volume 7, tab 31(31) and tab 31(36).

Ms White subsequently provided a detailed report,[24] which noted that the wound was now stage 3 and had worsened, in her view, due to Mrs Confos being left to sit in a tub chair on the wound, incorrect pressure setting of the dynamic mattress and moisture imbalance.

26. Ms White considered that there was a risk of overwhelming infection due to the level of anaerobic activity and non-viable tissue. She said: "*I suggest discuss with GP Rosex (flagyl gel) as primary-DAILY care from now*" and also "*discuss dietician-this is if her care remains active and is not palliative (if later wound may not heal*)" and to pay close attention and report any "*bogginess, redness or odour formation-may require antibiotics or debridement if active treatment initiated*". She also requested: "*please ensure GP notified of result* [of wound swab] *and discussion is had with family if they wish for ACTIVE intervention of antibiotics.*"

27. Ms White advised that there should be no seating in the tub chair and to ensure that the mattress settings were correct (as noted above, she had found that the dynamic mattress had been incorrectly set at 5.5 for a person who weighed 145kg).

Were all of the recommendations in the 2 August 2016 report of Ms White immediately implemented?

28. On 3 August 2016 a wound swab was taken at Dr Giallussi's request. It is not clear when the results were received by the Home (the document says *"printed 8/8/2016"*), but presumably by 8 August 2016.[25] It noted a mixed growth of enteric organisms which were said to frequently colonise ulcers without causing infection, and no staphylococcus aureus was isolated. The wound swab result was faxed to Dr Giallussi on 8 August 2016 and Dr Giallussi attended on 10 and 11 August 2016.[26] Rosex (flagyl) was charted at Dr Giallussi's direction on 10 August 2016.[27] A clinical report email from 11 August 2016 suggests that "*r/v by LMO checked*

[24] Exhibit 1, volume 4, p. 967-970.
[25] Exhibit 1, volume 4, p 103.7
[26] Exhibit 1, volume 4, tab 27, p. 103 and Volume 6, tab 30, p. 337.
[27] Exhibit 1, volume 6, tab 30, p. 339.

sacrum, NFO".[28] Dr Giallussi's notes from 11 August 2016 say "*deep bed sore sacrum* [indecipherable] *by wound specialist*".[29]

29. A nutrition assessment was conducted by Nurse Linda Walton on 13 August 2016.[30] On 16 August 2016, Christine Borthwick, dietician, was contacted by the Home and asked to provide dietary advice, and she was told that Mrs Confos had a pressure area. Ms Borthwick provided the same advice as her earlier advice from over a year ago, in March 2015, namely that Mrs Confos receive supplements, high protein and high kilojoule extras and Arginaid to assist her pressure area.

30. The medication chart,[31] appears to show Arginaid Extra first being applied on 17 August 2016. Rozex (flagyl) gel was first applied on 10 or 11 August 2016 (see further medication chart).[32] Ms Borthwick planned to review Mrs Confos the following week but it seems on the evidence that this did not occur before Mrs Confos passed away. Ms Borthwick noted in her statement to this inquest that the reason for Mrs Confos' weight loss in March 2015 was probably because she was not eating full meals.

31. On 15 August 2016 Nurse Anamika Chand emailed the Director of Nursing, Aarti Singh, with a clinical report that noted that they were waiting for the LMO to review the report from the wound consultant. Dr Giallussi however had already received the report and had attended the Home on 10 and 11 August 2016.[33]

32. The iCare Health EMR records provided to this inquest did not include dates beyond 4 August 2016.[34]

33. On 19 August 2016, Nurse Thapa, the Clinical Care Co-ordinator who had returned from leave on 15 August 2016, emailed Ms White to let her know that they had been providing the wound care recommended (applying Flagyl gel and packing

[28] Exhibit 1, volume 6, tab 30 p 341.
[29] Exhibit 1, volume 4, tab 27, p. 103.
[30] Exhibit 1, volume 4, p. 1054.
[31] Exhibit 1, volume 4, p. 1072.
[32] Exhibit 1, volume 6, tab 30, p. 992.
[33] Exhibit 1, volume 6, tab 30, p. 365.
[34] Exhibit 1, Volume 5, tab 29.

Inadine in the cavity and covering with Zetuvet plus). He provided an updated wound photo "*since wound has changed*".[35] Ms White replied by email on 24 August 2016 asking for the email of last Friday to be re-sent as she didn't have it. Then she further replied the same day at 4.05pm asking if the mattress pressure had been checked regularly and said (about the photo(s) sent) that: "*what has happened is the area of undermining which extended towards the head has now declared on skin-it was not getting blood supply but what is worrying is pic 2 which shows extension of further damage…"*.

34. Ms White asked in the email: "*Did the GP/family decide to treat with antibiotics…*" and "*do they wish for it to be debrided or left in situ (active or passive treatment)*" and said: "*Now is time to decide to clearly communicate if active treatment the desire of family as this is worsening ++ and the true extent of the wound now based on the erythema marked out is large*".[36] Ms White confirmed in her oral evidence that instructions about taking a decision for either active care (such as hospital admission) or passive care was a mutual family/GP discussion.

35. On 22 August 2016 a Meditrax review of Mrs Confos was carried out by Ms Hauptfleisch, at the previous request of Dr Giallussi, who was now away on leave. This is a resident medication management review. Ms Hauptfleisch noted that Mrs Confos was frail, weighed 39.5kg (3kg less than January 2016) and reviewed various medications. The review did not deal with the sacral wound or antibiotic treatment. A copy of the report was to be sent to Dr Giallussi.[37]

36. Dr Giallussi had gone overseas after 11 August 2016. Apparently a Dr Geourgouras was due to see his patients. However Dr Ugarte was approached on 23 August 2016 by Aarti Singh from the Home and he agreed to see Mrs Confos.[38]

37. On 25 August at 15:48pm Clinical Care Co-ordinator, Nurse Thapa, replied to Ms White by email, advising that Mrs Confos was on the air mattress and it was correctly set as recommended. She had two hourly repositioning (on her side). The

[35] Exhibit 1, volume 4, p. 1068.
[36] Exhibit 1, volume 6, tab 30, p. 382; Exhibit 1, volume 1, tab 16, p. 8.
[37] Exhibit 1, volume 6, tab 30, p. 387 – 388.
[38] Exhibit 1, volume 6, tab 30, p 402 – 403.

dressing was done daily. He noted that she had been seen by the medical officer and charted on *"Abs*" (antibiotics) for 5 days. The email stated: "*son was informed about her health condition*". The evidence from the family on this aspect was that Mr Nicholas Confos had been phoned about an Advanced Care Directive on 24 August 2016 but no mention of a sacral ulcer was made. This is dealt with further below. The wound was described as now 10cm long, 7cm wide and the cavity was 5.4cm.[39]

38. Dr Ugarte first saw Mrs Confos on 25 August 2016.[40] He had been at the Home on 22 August 2016, and could only see urgent patients. Nurse Anamika (Chand) told him that the others (which would have included Mrs Confos) could wait until tomorrow. Dr Ugarte returned the next night to see the patients he hadn't seen. He was told by a male nurse "*they are all done. There is no one to see*". Dr Ugarte said he had been told about a wound review but the nurse said the wound report wasn't back yet. This may or may not be referable to the email exchange between Ms Thapa and Ms White.

39. On 25 August 2016 Dr Ugarte returned to the Home and saw Mrs Confos and noted that the pressure sore was deep. He tried to find information from the staff about how long it had been like that but has said in his statement that he was unable to get assistance to his satisfaction. He spoke to Ashraful Ahmed who allegedly said that the family knew about the wound and that it was "*non-healing*", and were coming in "*today*" to do an Advanced Health Care Directive. Dr Ugarte prescribed oral antibiotics. On 25 August 2016 at about 9pm he received a message from a nurse called Sharon (presumably Sharon Wilson) who said in effect that Mrs Confos was possibly going to pass away. She was going to call the family. Dr Ugarte called the Home back the following morning and was told that Mrs Confos wasn't well the previous night but looked fine now.

40. Dr Ugarte went in around lunchtime on 26 August 2016 and was told that Mrs Confos was fine and could wait until the evening. Nurse Walton witnessed this conversation. She alleges that Nurse Thapa said that Mrs Confos was fine. Dr Ugarte received a call from Nurse Linda (presumably Walton) at about 5pm

[39] Exhibit 1, volume 6, tab 30, p. 375.
[40] Exhibit 1, volume 1, tabs 13 and 14.

saying Mrs Confos' condition had deteriorated. Nurse Walton confirms that she went and saw Mrs Confos and formed that impression. At 6.40pm, Dr Ugarte was told that Mrs Confos had passed away. When he was able to meet with family later he was told that they didn't know about the ulcer.

41. So far as the implementation of Ms White's recommendations are concerned, I find that, whilst the recommendations about wound management were followed, a representative of the Home did not follow up with the family as to whether they wished for active or passive treatment of the ulcer.

Was the family told about the wound having ulcerated, after the initial advice in early March 2016?

42. Mr Nicholas Confos told the inquest hearing that he was made aware that his mother had a sacral wound at some point, and later was told that it had healed. He said he did not recall being told that that it had re-emerged, or being told that it had become ulcerated. Whilst the records of the Home suggested that Mr Confos may have been informed by a staff member on about 9 March 2016 that the sore had re-emerged, it was generally common ground at the hearing that no-one had told Mr Confos or any other family member that the sore had subsequently become ulcerated, nor the extent of the wound in August 2016, with the exception of the evidence of the Clinical Care Co-ordinator with responsibility for Mrs Confos, Mr Shailendra Thapa.

43. Mr Nicholas Confos did recall a phone call on the day before his mother passed away, from a male called '*Shail*', suggesting that forms for his mother's hospitalisation be updated. He found this odd, as the geriatrician who had previously reviewed his mother, Dr Harper, had suggested that taking his mother to hospital should be avoided as being in unfamiliar surroundings could result in her going into cardiac arrest. When he visited his mother the next day he formed the impression that she was passing away. I found Mr Confos to be a credible witness and I accept his evidence.

44. Mr Michael Confos similarly gave evidence that he was surprised to learn after her death that his mother had a sacral ulcer and that he had been visiting her in the latter stages once or twice a week and staff had not informed him during his visits.

45. Nurse Ahmed, who was alleged by Dr Ugarte to have said on about 25 August 2016 that the family knew and that it was non-healing, disavowed any such statement in his oral evidence.

46. Nurse Thapa (the relevant Clinical Care Co-ordinator) was asked if a registered nurse had a concern about Mrs Confos' wound, what would happen. He said that the nurses usually contacted the doctor or the family and that he was more focused on contact with the external consultants. He said he was concerned about the wound on his return from leave but didn't recall thinking that Mrs Confos was in the end stage of her life, as her sacral wounds had healed before. He said the medical team was looking after her wound.

47. He agreed in his oral evidence that he became aware on his return from leave on 15 August 2016 that Ms White was recommending discussion with the family as to whether active intervention was required. He said he didn't recall why he didn't try to contact the family before 24 August 2016 and agreed that it was his job to ensure the recommendations were put in place. He suggested that he was focusing on the care point of view and that maybe he "*missed out*" on contacting the family. He agreed with counsel assisting's suggestion that missing out was a "*fairly big error*".

48. Later in his oral evidence when asked if he should have done something more he said "*yes, but I am not the only one responsible*". He explained that the registered nurses and After Hours Co-ordinator were highly involved and that he supported them and did other tasks.

49. In a statement he provided shortly before the hearing commenced, Mr Thapa said he had contacted Michael Confos "*to inform him of his mother's wound condition*", that Michael said he was at work and that he would come in and see his mother and get a report the next day. In oral evidence he said couldn't recall why he had contacted Michael Confos, when Nicholas Confos was the next of kin or person

responsible. He thought the conversation was quite short and they hadn't discussed the Advanced Care Directive and that maybe they didn't discuss the wound and that Mr Confos had said he would call him tomorrow.

50. When he was asked if he agreed that there didn't appear to be any urgency about contacting the family between 15 August 2016 and 24 August 2016 he said it was not the responsibility of the Clinical Care Co-ordinator, "*I thought the RN was doing it*" and that the family were available on weekends so it would be the After Hours Co-ordinator's responsibility. Later he suggested that the reason for the delay might be that they were putting everything in place and that "*first we do care decisions*". He said he was focused on wound care and was not involved in day-to-day care.

51. I accept the evidence of both Nicholas and Michael Confos that they were not told after March 2016 that their mother had developed an ulcer at her sacral area from a pressure wound. I note that senior counsel for the Home, Mr Windsor SC, made an oral submission in terms that I could find that there had been no notification to the family.

Evidence from the nurses more generally as to the various issues

52. Nurse Ashraful Ahmed started at the Home in July 2016. He had recently become a registered nurse. His understanding when he first worked there was that a photo would be taken of a resident's wound once a month, that dressings would be applied in accordance with instructions on a wound chart, and that the Clinical Care Co-ordinator would organise the taking of photos. The taking of photos was important because they could be sent to the external wound consultant for advice or comment, and potentially to the visiting GP, and they would form a record of a wound's progress.

53. The evidence showed that a photo of the wound was taken in March 2016 by staff, by the wound consultant during a visit in April 2016, and by staff in May 2016, but no photo was taken in June. By the time the next photo was taken, apparently on

24 July 2016, the wound had clearly changed from a skin wound to an ulcer. Because there was no photo taken in the intervening period, it was difficult to say when the wound had become ulcerated, although the wound consultant, Ms White, suggested that such a deterioration could be relatively rapid. The photo taken on 24 July 2016 prompted a visit again by Ms White as soon as she became aware of it.

54. Nurse Ahmed said that now the practice at the Home was to take a photo not only once a month, but more frequently when a wound gets worse. He said that now they call the doctor straight away if there is any deterioration. He said that he had discussed the worsening of the wound with Nurse Thapa in early August 2016. He denied that he had ever said to Dr Ugarte on the day before Mrs Confos' death that the family knew about the wound and that it was non-healing. Dr Ugarte, who was not required to give evidence at the hearing (and whose evidence was therefore not tested), had previously said in a statement that he had spoken to Mr Ahmed on 25 August 2016 after reading Ms White's August 2016 report on the wound and her suggestion that the family be spoken to. Dr Ugarte said that Mr Ahmed had said "*the family know and they know it's non-healing. They are coming in today to do an Advanced Care Directive*". Given Mr Ahmed's oral evidence that he didn't recall having such a conversation in those terms, this evidence does not affect my conclusion that the family were not notified of the ulcer.

55. Nurse Ahmed conceded that if infection of the wound was a possibility, that it would be a good idea to take the resident's temperature, but that he did not normally take Mrs Confos' temperature when attending to the wound and cleaning it. He took it on the day of her death as he was asked to.

56. Nurse Bindu Dewan accepted that she may have taken the photo on 24 July 2016, as she dressed the wound that day, although she didn't recall taking it. She said that she thought photos should be taken every month, or if the wound was deteriorating, or if it had healed. If it was deteriorating, the Clinical Care Co-ordinator and the doctor should be informed by the nurse on duty. She wasn't sure if, assuming she'd taken the photo, she took it because it was scheduled or because the wound was deteriorating.

57. Nurse Dewan accepted that elevated pulse or temperature may be a sign of infection but conceded that she didn't monitor such signs. She accepted that if the patient was deteriorating, the family should be contacted. She said it was her first job and she was new with everything. She understood that the Clinical Care Co-ordinator would contact families.

58. Nurse Anamika Chand accepted that no-one appears to have contacted the family about the ulcer and could not provide an explanation as to why, even though she said it was everyone's job to contact the family if required. Ms Chand could not recall whether the staff were aware in August 2016 that the family didn't know. She could not recall if she put her mind to the need to inform the family after the wound consultant had recommended this. She was not aware whether Mrs Confos was listed for active or passive care and did not know the difference. She had never seen an ulcer like the one Mrs Confos had and did have concerns about it but couldn't remember if she'd discussed those concerns with anyone. If there were changes they would usually bring it up with the Clinical Care Co-ordinator.

59. Nurse Linda Walton was involved with the dressing of Mrs Confos' wound on only two occasions, 28 July and 26 June 2016. She said that it wasn't the practice at the time to take observations such as pulse and temperature but rather to rely on visual observations. She accepted in evidence that it was the responsibility of the nurse doing the dressing to notify the family if required, and that progression of the wound to stage 3 would require notification. She said that about three quarters of the residents suffered from dementia. She suggested that the email system used now had improved communication with families, and that other improvements to communication included having to log on regularly, and having regular meetings, including registered nurse meetings, monthly resident and family meetings and team meetings.

60. Nurse Walton did not recall Dr Giallussi saying on 11 August 2016 that the family needed to be aware of the wound. She gave evidence that now she is more assertive and more pro-active in her practice and better able to communicate with families. She agreed that there had been a complete change in the environment at the Home since Mr Crossland had become the facility manager.

61. Nurse Aarti Singh was the Director of Nursing at the Home in 2016. She provided a statement to the inquest shortly before the hearing. She said that she had authorised the Clinical Care Co-ordinators to liaise directly with the wound consultant, nurse practitioner Wendy White. She did not do spot checks to ensure that communication with families was occurring, although she was aware after March 2015 of the issue of failure to communicate with family in a matter involving another resident, in 2014, and of a report from the investigator of that matter, Ms Hannen.

62. Ms Singh said that when she found out on 27 August 2016 that Mr Nicholas Confos hadn't been aware of the wound she was shocked. She said the Clinical Care Co-ordinators were there to be involved with families. She said that Ms White's last report on Mrs Confos wasn't copied to her. She said she'd asked the Clinical Care Co-ordinators if they had spoken to the family and that nurse Thapa had said he made a call but the family were busy and occupied with work. She said she had prepared a critical incident report. She claimed that discussing issues with families over the phone was not very fruitful; and that it was better to sit down with families.

63. A call was made for a copy of the critical incident report. None was produced. When the evidence recommenced being taken, Ms Singh said that an email outline of the report would get sent to the Home's board, but that it wouldn't have mentioned any issue about failure to communicate with the family as it was only about the wound. She suggested that the family was only available on weekends and that the Home had an After-Hours Co-ordinator but that she didn't speak to him or her as part of her investigation. She said that the reason she was asking Nurse Thapa about communication was a general part of the investigation and that the focus was on whether the recommendations of Ms White had been followed.

64. A number of the witnesses said they were not aware of the failure to communicate issue with a family in 2014; they had not been working at the Home at that time. The impression I formed from the evidence is that there was no one person who accepted responsibility for notifying the family, and that there was an assumption that someone else would do it. I accept Mr Crossland's evidence about the changes that have been made, and found his evidence, including of his own

'hands-on' approach to management and willingness to recognise issues and solve them, impressive.

65. Ms Singh said that she did not perform audits and trusted that the nurses and Clinical Care Co-coordinators were following systems. After having received Ms Hannen's report on the 2014 investigation, she did not carry out any audits. In cross-examination she accepted that responsibility for any deficiency in care not only falls on the shoulders of the individual but also on the Director of Nursing. She said that after Ms White brought up the incorrect mattress settings issue a checklist was set up and team leaders had to check the settings.

66. Nurse Lorie Pedrosa had been involved in dressing Mrs Confos' wound on 8 August 2016. She had recorded the wound (which a photo on 24 July 2016 appears to show had become an ulcer) as only stage 2. She accepted that that could have been an error. She didn't know whether the family knew that Mrs Confos was suffering from an ulcer; she accepted that they should have been informed, and she said it was the responsibility either of herself or the Clinical Care Co-ordinator. She said that because there had been a review by a wound specialist she thought someone involved would have contacted the family.

67. Nurse Manisha Awale was a Clinical Care Co-ordinator at the relevant time in 2016, but her responsibility did not normally include Mrs Confos. The other Clinical Care Co-ordinator, Nurse Shailendra Thapa, who did have responsibility for Mrs Confos, went on paternity leave from 8 July 2016 to 15 August 2016. Ms Awale told the hearing that she would cover for Mr Thapa on rostered days and sick leave, but thought that she hadn't covered for him during his leave and that there may have been a locum. She said there was a delay with getting stock of the antibiotic gel Rosex after Ms White had recommended it be introduced after her 2 August 2016 review.

68. Ms Awale accompanied Ms White on 2 August 2016 when she carried out her second review of Mrs Confos. Following that review, Ms White sent through a report that was received on 4 August 2016 by Ms Awale. Ms White's report noted that the wound was now stage 3 and had worsened, in her view, due to Mrs Confos being left to sit in a tub chair on the wound, incorrect pressure setting of the

dynamic mattress and moisture imbalance. She considered there was a risk of overwhelming infection due to the level of anaerobic activity and non-viable tissue. She said "*I suggest discuss with GP Rosex (flagyl gel) as primary-DAILY care from now*" and also "*discuss dietician-this is if her care remains active and is not palliative (if later wound may not heal)"* and to *"pay close attention and report any bogginess, redness or odour formation-may require antibiotics or debridement if active treatment initiated*".

69. Ms Awale agreed in oral evidence that she received Ms White's report on 4 August 2016. When asked if she contacted the family, she said no, she thought the other Clinical Care Co-ordinator would do it. When it was suggested that he was on leave until 15 August 2016 she said, in effect, "*but someone must have replaced him*". She accepted that the sacral wound was a bad example of one, in her experience. She said that she would now contact families about a deterioration in a wound or a change in treatment.

70. As noted previously, Nurse Thapa was the other Clinical Care Co-ordinator, whose responsibilities included Mrs Confos and the other residents on her side of the Home. He said there was an outside cost to get Ms White involved, and to do so he would need approval from his superiors. He accepted that he had received Ms White's May 2016 report, suggesting review in four weeks if there was no improvement, and that he had personally reviewed Mrs Confos about four weeks later, noted nil improvement, but had apparently not asked for Ms White to come back. He could not recall why that was.

71. He said that he also went on paternity leave quite suddenly. He said discussions at handover were verbal but accepted that notes could be made on the medical record. He said he couldn't recall who he handed over to as Clinical Care Co-ordinator as he was in a rush and that there was no-one replacing him when he came back from leave. He agreed that when he saw Dr Ugarte on 26 August 2016 that he had said Mrs Confos was fine, in that no-one had reported any problems with Mrs Confos to him.

72. In oral evidence Ms White said that she expected to be notified of any deterioration. She was clinically surprised when she saw the wound again on

2 August 2016. Mrs Confos had lost 2kg in the previous month. She said however that wounds could progress very quickly from stage 2 to stage 3, depending on the individual and interventions, nutrition and health. She would expect a photo to be taken every week if the wound was deteriorating. She agreed with a suggestion by counsel for the Home that the introduction of a Pressure Ulcer Healing Chart, with its scoring system, was a very useful tool introduced by the Home subsequently. She said that the appearance of Mrs Confos' skin in the August 2016 photos was in her clinical experience consistent with shutting down of organs at end of life.

Evidence of Dr Giallussi

73. Dr Giallussi's computer system recorded visits he had made to see Mrs Confos. Relevantly, he saw her 4 times in December 2015, once in February 2016, twice in March 2016, once in May 2016, three times in June 2016 and 3 times in August 2016.

74. Dr Giallussi provided two statements detailing his involvement with Mrs Confos' treatment. He would see her about once a month, perhaps more as she aged. He noted that Mrs Confos had a history of bedsores to her sacrum, some of which would heal straight away and others would last weeks. He said he first became aware of a sacral wound in December 2015. He did not communicate issues concerning the sores with Nicholas Confos, believing that the Home dealt with families. He said that he would only speak with family members if the patient was seriously ill or in imminent deterioration or required hospital transfer.

75. Dr Giallussi's view is that for the last six months of her life, Mrs Confos was mainly bed bound, in the foetal position and not very responsive. She had also started to refuse medications and food. He has said that in his view the sacral wound would start to improve and then deteriorate again. Poor blood circulation and skin health did not improve the situation. He has said that he considered that she was too frail for hospitalisation for surgical intervention. He said there was regular swabbing of the wound to exclude bacterial infection. She was prescribed Panadol and did not appear to be in pain when he examined her.

76. He has said that he believed that the nursing staff were keeping the family informed of any deterioration in her health and any new developments including wounds. He said he would dictate notes for the nurses to enter in the nurses' notes/patient history, and would supplement them with brief notes of his own. He was not faxed the wound specialist Ms White's report of 2 August 2016 until 8 August 2016.

77. In oral evidence Dr Giallussi said that he did not recall being asked to inspect Mrs Confos' wound during each of his visits where the wound was not mentioned in the notes. He said it was covered with a dressing which might be meant to be in place for a number of days and that he was aware that a wound consultant had been engaged to provide advice and care. He said in effect that he would defer to her expertise in pressure wound care. He wasn't made aware that it had ulcerated until 8 August 2016 and was not sent the photo taken on 24 July 2016. He assumed that, in terms of possible infective processes, that the nurses would be taking vital signs daily. The evidence was that this was in fact done by the AINs and it appears from the limited evidence, irregularly rather than daily.

78. He said that because the wound swab from 2 August 2016 tested negative for bacteria, he agreed with using flagyl gel. He felt that it was the nurses' job to liaise with family, until such time as a decision was made about surgical treatment, for example. He said that when the wound progressed from stage 2 to stage 3 another review by the wound consultant should have occurred, to be organised by the Clinical Care Co-ordinator. He said in hindsight he should have communicated with the family, but his view at the time was that he had a directive requiring palliative care. I accept that concession and I note that the expert geriatrician, Dr Ibrahim, also appeared to accept that a general practitioner could reasonably defer to a wound consultant's expertise in that regard.

Expert appraisals:

79. Expert appraisals of the evidence were sought from a clinical nurse consultant, Hazel Bucher, and a geriatrician, Dr Joseph Ibrahim.

80. Ms Bucher noted a number of deficits, including in keeping wound charts. She considered a weekly wound chart should be completed for a major wound. She was critical of non-communication with the family. She did however feel that appropriate plans were put in place to treat the wound. The wound care policy was not sufficiently adhered to.

81. In oral evidence Ms Bucher suggested that while the GP could defer to the wound specialist, he/she should be kept in the loop. She noted that in an older population with vascular disease and immobility there was a higher risk of pressure injuries progressing from stage 2 to 3 and having difficulty healing. She was mildly critical of the nurses in not following up with Ms White 4 weeks after her first visit, as recommended. She suggested that with the benefit of hindsight Mrs Confos' system may have been shutting down generally and that the wound could deteriorate quite rapidly. She said that clinicians should always be talking to families about decisions, whether palliative or curative, and at every change in condition.

82. Ms Bucher adopted a neutral stance concerning whether Mr Thapa should have contacted the family as soon as he returned from leave and saw Ms White's 2 August 2016 report, but considered he should have taken the time to consider the report. She was critical of the failure by management to check on wound reporting and the scoring of the wound, which varied considerably. However she maintained that management of the wound itself was appropriate.

83. Dr Ibrahim is a Professor and Head of the Health Law and Ageing Research Unit at Monash University as well as Clinical Director of Subacute Medical Services at Ballarat Health Service. He has been a consultant specialist in geriatric medicine since 1996. Dr Ibrahim in his report considered that at the time of death the wound had progressed to stage 4. He said that occurrence of pressure injuries in residential aged care services is well known. He noted multiple consultations provided with clinicians for Mrs Confos. He couldn't find evidence of a ROHO cushion being used for Mrs Confos when she was still seated in a chair. He felt that the gravity of the situation when the wound developed was not fully appreciated. Greater gains may have been achieved with early debridement and ensuring the area was protected from pressure.

84. He expected bed settings to be documented in the nurses' notes. He couldn't find any evidence that active treatment was discussed with the family. The apparent failure to communicate a significant change in her health status was "*hard to fathom*", at least after the wound became stage 2. He would have expected a monthly update with the family, at least in the last 3 months of her life. He did not see any significant additional clinical management options that could have been provided. There was little evidence that Mrs Confos had distressing physical symptoms and he did not find any evidence of inadequate pain management. Occupational therapy referral would have been beneficial.

85. In oral evidence Dr Ibrahim said that he was impressed that the facility manager oversees clinical communications now at the Home. He said it was "*distressing but plausible*" that wound care would have been assessed as the domain of nursing staff and that Dr Giallussi would not have been kept up to date with deterioration of the wound. Either more photos needed to be taken or the doctor might need to be present at times when dressings were applied. Having said that, he also deferred to the expertise of wound specialists such as Ms White. He accepted her evidence that the skin appearance in August 2016 may have indicated end of life and that pressure injuries usually occur at end of life, but that good skin care prevents them. He was strongly supportive of case conferences with families.

86. The Home's contracted external Nurse Consultant Catherine Brown provided a statement annexing various policy documents. They included for example recommended charting of ulcers (which the Home now performs) and a wound care schedule now used by the Home. In oral evidence she said that other improvements introduced after Mrs Confos' death included wound deterioration guidelines requiring more than monthly photos, guidelines about GP review of wounds and guidelines about notifying families. She noted that the Home now uses the services of geriatric flying squads from the local health district as well as a wound consultant. The Home now uses more alert systems in the electronic medical record to prompt clinicians to attend to various obligations.

87. Ms Brown said that audits are now run every Friday by the Clinical Care Co-ordinator prior to writing up handover sheets. The handover is checked by two

people. If a Clinical Care Co-ordinator goes on leave, another nurse is rostered into that role. In terms of vital signs observations, Ms Brown however considered that you wouldn't look for elevated temperature to indicate an infective process in an older person as they often don't get elevated temperatures in that context and that you rely on clinical observations including if they are off their food or signs of overall deterioration.

88. Ms Brown said that she expected that the Clinical Care Co-ordinator should have organised a further wound consultant review when the wound progressed to stage 3.

89. As noted earlier in these findings, the Home's current facility manager, Mr Keith Crossland, gave evidence at the end of the hearing, including as to his view of a hands on approach and top down management. He described how embarrassed and ashamed he was at the evidence he had heard about how clinicians each expected that someone else would be contacting the family. He described his active role in the clinical oversight of residents, including daily and monthly reports. In terms of wound assessments, he was looking to have the system changed so that it would not be possible for someone to assess a wound from stage 2 to 4, or from 4 to 2, for example, without an alert. Multi disciplinary case conferences occurred annually or more frequently as required. Family conferences could occur once a month if required.

90. The inquest heard that changes had been made to certain staff and recruitment processes and job descriptions. A geriatric 'flying squad' from the Local Health District is used to provide external assistance with wound management. New policies concerning wound deterioration, the deteriorating resident and appropriate case conferencing had been introduced. Other changes included monitoring of communication with families on the electronic system, with alerts to be followed up if communication has not been made. Since 1 July 2019 external audits had also been mandated at a federal level.

91. I had previously heard evidence from Mr Crossland about changes to the Home in the *Inquest into the death of Epenesa Pahiva*. Having regard to all of the evidence, the concessions made about deficits in systems and communication and the

evidence about improvements, I am satisfied that no further recommendations are required in the circumstances arising from Mrs Confos' death.

Cause and manner of death

92. I note the following about the evidence. First, the limited autopsy report had been prepared without the assistance and benefit of the later evidence which emerged from Ms White and the experts, and without the full records as to Mrs Confos' co-morbidities and the swabs results from the wound (showing no infection). Second, the pathologist reported a suspicion of sepsis and did not positively conclude that there was sepsis, although there was histopathological evidence of osteomyelitis. Third, Ms White's evidence, which I accept and with which Dr Ibrahim agreed, was that the appearance of the skin around the wound had changed in August to that of the appearance at end of life. Fourth, Dr Ibrahim gave oral evidence that pressure injuries usually occur at end of life and a severe pressure injury will worsen if a person is dying. Fifth, Ms Bucher suggested that the swallowing issues noted and the vascular disease were consistent with end of life.

93. I note that Mrs Confos was steadily declining in weight. Mrs Confos had significant co-morbidities, including dementia, and had been bed-bound for some time. Having regard to all of the evidence, I am not satisfied that Mrs Confos' death could be attributed to sepsis or as a direct and sole consequence of the ulcer. I find that Mrs Confos died of natural causes, while suffering from multiple co-morbidities, including a sacral ulcer.

Closing remarks

94. I would like to thank my counsel assisting, Mr Peter Aitken and his instructing solicitor, Ms Jessica Natoli from the Crown Solicitor's Office for the enormous amount of assistance they provided me.

95. I offer my sincere condolences to the family of Mrs Confos, a wonderful woman who lived a full life, surrounded by her loving family.

Findings

96. The findings I make under section 81 of the Act are:

Identity

The person who died is Sylvia Confos

Date of death

Sylvia Confos died on 26 August 2016

Place of death

Sylvia Confos died at Castellorizian Aged Care facility, Kensington, NSW

Cause of death

Sylvia Confos died of natural causes, in the context of multiple co-morbidities, including a sacral ulcer

Manner of death

Sylvia Confos died of natural causes, while suffering from multiple co-morbidities, including a sacral ulcer

I close this inquest

Magistrate Teresa O'Sullivan
State Coroner
27 September 2019