STATE CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	**Inquest into the death of Patricia Northcote**
Hearing dates:	8 December and 10 December 2015
Date of findings:	5 April 2016
Place of findings:	State Coroners Court, Glebe
Findings of:	Magistrate Teresa O'Sullivan, Deputy State Coroner
Catchwords:	CORONIAL LAW – Pressure Sores- Aged Care
File number:	2014/00034477
Representation:	Mr Jake Harris, Counsel Assisting the Coroner instructed by Ms Peita Ava-Jones of the Crown Solicitor's Office. Mr Patrick Rooney instructed by Mr Edward Osborne of Sparke Helmore Lawyers.
Submissions received:	5 January 2016 – Counsel Assisting 27 January 2016 – Tony and Peter Northcote (sons of Patricia Northcote) 26 February 2016 – Catholic Healthcare Ltd
Findings:	Patricia Northcote died on 7 December 2012 at the Royal Prince Alfred Hospital, Camperdown NSW from major organ failure. The antecedent causes were sepsis, due to gram-positive bacteraemia arising from a urinary tract infection. The sacral area pressure sore was a significant condition contributing to her death.
Recommendations:	Not required

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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 Ms Patricia Northcote

Introduction

1. Patricia Northcote died on 7 December 2012 at the Royal Prince Alfred Hospital ("RPAH"), Camperdown NSW.

2. The cause of death was major organ failure. The death certificate records the antecedent causes to be sepsis, due to gram-positive bacteraemia arising from a urinary tract infection. It also records that a sacral area pressure sore was a significant condition contributing to the death.

3. Up until 22 November 2012 Mrs Northcote had been a resident at the Holy Spirit Nursing Home ("HSNH"). The inquest therefore focussed on events during the final weeks of her residence at the nursing home and prior to her admission to RPAH.

Background

1. I have essentially adopted the factual background and summary of the evidence as set out in Counsel Assisting's very helpful submissions.

2. At the time of her death, Mrs Northcote had a number of health problems; most significantly, she had become paraplegic after developing an infection in her spine in November 2005.

3. In June 2006 she became a resident at HSNH. The nursing home accommodates 127 residents across 9 houses. Mrs Northcote was accommodated in Joseph House, which is described as a non-dementia ward with 14 high needs patients.

4. Because of her paraplegia Mrs Northcote needed assistance to transfer from bed to wheelchair. She preferred to do this with the use of a slide board. She had used this method throughout her time at HSNH, usually with the help of at least one staff member. However, there were concerns at the nursing home that this method was becoming increasingly unsafe, both for Mrs Northcote and for staff who assisted.

5. Ms Rose Boulous, who is a physiotherapist, made a recommendation as early as July 2011 that Mrs Northcote should be transferred with the use of a hoist or lifter. Despite that recommendation, staff continued to allow Mrs Northcote to use a slide board. In June 2012, Kim Doolan, who is a physiotherapy assistant, observed that Mrs Northcote's arms were becoming weaker and becoming painful and she asked Ms Boulous to review Mrs Northcote. Following this review, and some discussion with the Deputy Residential Manager Ms Pokharel, a decision was made on 8 August 2012 to perform all transfers with the lifter.

6. I do not intend to make a determination about the correctness of that decision. It is apparent, however, that Mrs Northcote resisted being moved by the hoist and that staff spent considerable time and effort trying to persuade her to use the lifter and to explain the reasons why it was preferred.

7. In order to try to resolve the issue, referrals were made to another physiotherapist, Robyn Smith, and to Dr Lee, a rehabilitative medicine specialist. Both assessed Mrs Northcote's capacity to use a slide board and their assessments are within the brief. They each felt that Mrs Northcote appeared capable of moving herself by slide board, with assistance from staff to move her legs, and recommended this could continue, provided it could be done safely. However, an assessment from a Work Health and Safety perspective concluded that the method was unsafe, both for staff and for Mrs Northcote.

8. There was frequent conflict between Mrs Northcote and staff about this issue. She often refused to be moved by hoist, and resisted or obstructed the process, although at other times she would agree after encouragement. She also continued to transfer herself by slide board; sometimes she was observed or assisted by staff and sometimes she would do it alone when staff were not present.

9. It was obviously a significant issue for Mrs Northcote. Perhaps the use of the lifter represented a further loss of her independence, where she already had difficulty coming to terms with her disability. However, it is also a very significant matter that her cognitive function was deteriorating. This appears to have been the case for a number of years. This may explain her behaviour over this period, which staff describe as demanding, uncooperative and sometimes rude.[1]

10. In light of Mrs Northcote's increasingly concerning behaviour, she was assessed by a psychogeriatrician, Dr Kitching, on 4 September 2012. Dr Kitching concluded that Mrs Northcote suffered only mild cognitive impairment and had some problems with concentration. He made a number of recommendations for her management. An expert opinion review has since been performed by Dr Rosenfeld, geriatrician, which suggests that that assessment may have underestimated the extent of Mrs Northcote's problems; in Dr Rosenfeld's opinion Mrs Northcote was suffering from dementia.

[1] Notwithstanding her challenging behaviours, I note HSNH maintains (through the evidence of Ms Julie Knox provided at inquest) that Mrs Northcote was a delightful person and well respected resident at HSNH.

The evidence

The development and progression of the pressure sore

Development

1. The pressure sore was first identified by Nurse Pant on 1 November 2012. At that stage she considered it to be a small area of broken skin. She observed it incidentally, when she was attending to Mrs Northcote's toileting. It is unlikely that the sore was present (or visible) prior to 1 November 2012, as staff helped her with toileting every day.

2. Mrs Northcote was predisposed to developing pressure sores, due to her paraplegia and lack of sensation in her sacral area. There is no evidence that she had ever developed a pressure sore prior to November 2012. This suggests that her general routine and pressure area care were normally adequate in meeting this risk.

3. It is not clear what other factors led to the development of the pressure sore. Mrs Northcote informed staff at the RPAH Emergency Department that it had started as a skin tear caused by the hoist.[2] However, there is no other contemporaneous support for this. Dr Rosenfeld considers it just as likely that the use of the slide board (and consequent friction on the skin) precipitated or worsened the injury.[3] Conversely, Dr Dalton states that a slide board can be used with techniques to minimise friction or pressure; in his view neither hoist nor slide had any impact on the development of the injury.[4]

4. The dispute regarding the hoist might have had an impact on the development of the injury. However, the evidence is insufficient to allow a finding to be made about this. There are references in the notes to "stand offs" between staff and Mrs Northcote regarding the hoist and she would often require encouragement to use it;[5] as a result, she might have remained in one position for a longer period of time. Nurse Pant in evidence denied that this was generally the case and, where Mrs Northcote resisted the hoist, she would simply be moved by slide board instead.

Progression

5. Reference should be made to the Agreed Statement of Facts, which summarises the entries made by staff regarding the progression and treatment of the pressure sore.

6. One of the factors that may have contributed to the progression of the pressure sore is that Mrs Northcote did not comply with staff direction. This appears to have been an issue generally throughout her time at HSNH. Her lack of compliance had

[2] Dr Latt vol 1 tab 5 at [9]
[3] Exhibit 5 at [152]
[4] Vol 5 tab 31 at p2
[5] See Agreed Statement of Facts Exhibit 2 at {28}

become problematic following the dispute over the hoist and this continued into November 2012. It is apparent from the evidence of Dr Rosenfeld that this was a feature of her dementia, and the appropriateness of action taken by HSNH regarding this is considered below.

7. According to Dr Latt, Mrs Northcote also suffered from frailty. She suffered from a number of medical conditions and her ability to cope with infection and disease was generally compromised. This may have had an impact on the progression of the pressure sore.

8. It is also significant to note that pressure sores can develop quickly, and that the underlying tissue damage can be concealed under the skin, with the extent of the injury only becoming evident after the skin breaks down.

9. Mrs Northcote initially complied with staff direction regarding the care of her pressure injury. However, from 7 November 2012 onwards she began to refuse to have dressings applied and wanted to use bee wax oil instead. Following this, on 8 November, Nurse Pant observed the sore to have increased in size and redness.

10. On 11 November Dr Smythe observed a small superficial pressure area of about 1cm on the sacral area. In evidence she conceded that she may have examined Mrs Northcote in a wheelchair and so may not have observed the whole of the sore, including the area on the coccyx. Her description of the sore can be contrasted with that of Nurse Gamboa from 5 November 2012, who described two areas on the right buttocks of 5 cent and 50 cent size.[6] However, Dr Smythe's advice to staff about usual pressure area care treatment was appropriate in any event.

11. Following Dr Smythe's attendance on 11 November, Mrs Northcote refused to comply with staff direction to change her dressing or the use the hoist.[7] The following day there was a long dispute about the use of the hoist and Mrs Northcote remained in bed for 5 hours.[8] The notes show that her lack of cooperation continued over the next few days.

12. By 16 November the wound had deteriorated significantly. Nurse Pant and Ms Pokharel examined the wound and observed an increased size ulcer on the sacrum and coccyx, with very red, purple and slightly black skin.[9] They agreed in evidence that this caused them concern and as a result the level of care was escalated. A photograph was taken, a message was left for Dr Smythe and a 2/24 hourly pressure area chart was commenced.[10]

13. The plan was for Mrs Northcote to remain in bed and be re-positioned at 2-hour intervals in order to relieve pressure from her sacral area. This did not happen. The pressure area chart was not completed consistently but from the available records it is clear that Mrs Northcote did not always comply with staff direction. From 18 November 2012 the pressure area chart was abandoned. As a result it is likely that

[6] Gamboa vol 1 tab 8 at [14g]
[7] Li vol 1 tab 12 at [51]
[8] Gamboa vol 1 tab 8 [14j]
[9] Wound Treatment Sheet, vol 4 tab 9 "Wound Chart"
[10] Pokharel, vol 2 tab 19 internal tab 14

pressure was not relieved from her sacral area, which may have contributed to its deterioration.

14. Nurse Gamboa called Dr Smythe's surgery again on 19 November 2012. Dr Smythe said in evidence she did not receive any messages, conceding that messages sometimes do go astray. However, as she pointed out, there were other resources available for advice, including the out of hours service.

15. By Monday 19 November 2012 the family had become aware of the worsening pressure injury. Messages had been left for Tony Northcote prior to this point, although apparently not received. Mr Northcote, in his written submissions, notes that staff may have been using his old contact details rather than the new contact number that he provided in an email to Julie Knox in September 2012. Tony Northcote emailed Ms Pokharel on 19 November 2012 and suggested she contact a clinical nurse consultant at Aged Care triage for advice about the wound.[11] By coincidence, Ms Pokharel stated in evidence that she had already done so earlier that day. It appears that an appointment could not be obtained prior to Mrs Northcote's admission to hospital.

16. Also on 19 November 2012, Ms Knox returned from a period of leave. She saw Mrs Northcote, and reviewed some of the notes, although she did not observe the wound. On that day she believed Mrs Northcote to be compliant with care and was not too concerned with her health. She considered the treatment regime to be adequate.

17. However, over the following days Mrs Northcote was not compliant with care, and the pressure sore did not improve. Mrs Northcote appears to have had a particularly bad day on 20 November 2012, and the progress notes records that she was uncooperative, demanding and crying and screaming at staff. [12] She continued to be non-compliant with staff direction, and on 21 November 2012 Ms Pokharel completed a Resident Incident form regarding this.

18. On 22 November 2012 Mrs Northcote was transferred to RPAH. The photographs taken by the family[13] show a significant pressure sore, which was described by Dr Latt as 5cm deep after debridement. However, Mrs Northcote was not taken to hospital for the pressure sore. The transfer form refers to her being delirious and febrile, refusing to drink and take her medication.[14] The progress notes record that she was taken to hospital at her own request.

19. Overall, it is apparent that the sore deteriorated significantly from 16 November 2012 onwards, and that a significant factor which contributed to this deterioration was Mrs Northcote's non-compliance with care.

[11] Exhibit 4 email of 19 November 2012
[12] See also Lamsal vol 1 tab 11 at [18c]
[13] Exhibit 3
[14] Transfer/Discharge form 22.11.12 vol 2 tab 25

The timing of the transfer to hospital

20. Given the deterioration of Mrs Northcote's condition from the 16 November 2012 it might be said that she should have been transferred to hospital sooner. However, both Dr Ehrlich and Dr Rosenfeld express doubt about whether an earlier transfer to hospital would have made any difference to the outcome.[15] In light of that evidence, no criticism can be made of the fact that HSNH did not transfer Mrs Northcote to hospital prior to 22 November 2012.

The care and treatment Mrs Northcote received at HSNH

21. It is beyond the scope of this inquest to consider the general care and treatment that Mrs Northcote received throughout her time at HSNH. For example, during the inquest the family raised a concern regarding a quantity of unused medication being found in Mrs Northcote's room after her death[16] (which Ms Knox conceded was inappropriate). However, it does not appear that issues with medication contributed to Mrs Northcote's condition.

Pressure care and wound management

22. Professor Ehrlich considered Mrs Northcote's treatment to have been "less than adequate".[17] He accepted in evidence that he judged the adequacy of action in retrospect, in terms of its effectiveness. It also appears that he did not take into account some of the action that was taken by staff, described below. In contrast, neither Dr Rosenfeld nor Dr Dalton criticised staff regarding their care of Mrs Northcote.

23. As noted, the regime relevant to skin care appears to have been generally adequate, because Mrs Northcote did not develop pressure sores prior to November 2012, despite it being an ongoing risk. Mrs Northcote was provided with an air bed, which Ms Knox described as a ripple mattress, which would have reduced pressure on the skin while Mrs Northcote was in bed. Other measures mandated by the care plan were a sheepskin underlay, pillows and moisturising cream, which appear to have been used appropriately. The family also make the comment in their submissions that their mother was very fastidious about her care routine and that was the reason that she had not previously developed a pressure injury.

24. The care plans and assessments refer to repositioning Mrs Northcote frequently, and the most recent assessment prior to her death stated this should happen at 2-hourly intervals during the day.[18] The progress notes do not confirm that this plan was carried out. Ms Pokharel's evidence was to the effect that she trusted her staff would do this.

[15] Dr Rosenfeld Exhibit 5 at [77], [157]; Prof Ehrlich vol 2 tab 23A at p6;Dr Dalton vol 5 tab 31 at p4
[16] See Exhibit 7
[17] Vol 2 tab 23 at p5
[18] Norton Scale for Predicting Risk of Pressure Ulcer, vol 5 tab 30

25. It emerged in evidence that in practice this was not done. Instead, Mrs Northcote's normal day-to-day routine would mean that she did not remain in one place for an extended period of time. She was moved from bed to chair, to the toilet, to the shower and for meals, at regular intervals. Nurse Pant also described how Mrs Northcote was able to rock herself on her buttocks in her chair in order to relieve pressure. Whether this was effective in relieving pressure from the coccyx and sacrum is not clear.

26. However, this method of pressure area care was not likely to have been adequate once a pressure sore developed. Professor Ehrlich stated in evidence that it is necessary to be very strict about repositioning in order to effectively treat a pressure sore. This requirement was obviously appreciated by Nurse Pant and Ms Pokharel, as they attempted to apply "strict" pressure area care from 16 November 2012. There does not appear to be any explanation as to why a repositioning chart was not commenced until more than 2 weeks after the injury was identified.

27. The pressure area chart that was commenced on 16 November 2012 was not completed consistently. It was suggested in evidence that this may have been because during some periods Mrs Northcote was compliant, during which time no record was needed. However, that interpretation is not consistent with the entries, which sometimes record that she did comply and sometimes she did not. It is more likely that entries were simply not made by the staff member who worked the morning shift on 17 and 18 November 2012. In any event, the chart was abandoned after 18 November when it became clear that Mrs Northcote was not compliant.

28. At that point, it was clear that Mrs Northcote was not cooperating and her condition was deteriorating. The action staff took in response was to contact Dr Smythe and the Wound Clinical Nurse Consultant for advice. While this was appropriate, it did not address the fundamental problem: that Mrs Northcote was not cooperating with her care. This is considered further, below.

29. Overall, staff appear to have taken adequate steps to try to provide pressure care and wound management for Mrs Northcote, but were frustrated in their efforts by her lack of cooperation.

Compliance with HSNH policy regarding pressure sores

30. Staff did not comply with the relevant HSNH policy regarding the recording of pressure injuries.[19] On 1 November 2012 Nurse Pant recorded the injury on a wound treatment sheet. She failed to complete a Resident Incident form, take a photo or complete a treatment plan at that stage. Nurse Pant explained in evidence that she considered she did not consider it to be a pressure injury, describing it as a small or superficial area of broken skin, and so did not think the policy applied.

[19] Wound management Flow Chart, vol 1 tab 10 internal tab 6

31. Nurse Paturi identified the injury to be a pressure sore on 3 November 2012. She completed the first page of a Wound Treatment Sheet including a treatment plan, but did not take a photo or complete a Resident Incident form.[20] On 5 November 2012 Nurse Gamboa recorded that she completed an incident form, although this document has not been produced. No photograph was taken until 16 November 2012.

32. These requirements would have ensured that management and other staff were made aware of the injury, so that its progression could be monitored and treatment could be maintained consistently. However, while it is regrettable that staff failed to comply with HSNH policy, and Ms Pokharel failed to correct those errors, the practical consequences were limited; staff became aware of the injury in any event, and treatment was commenced from 1 November 2012.

Mrs Northcote's dementia

33. In Dr Rosenfeld's opinion, Mrs Northcote suffered from dementia, probably vascular dementia, which he described in evidence as "moderate". This condition affected the frontal lobes of her brain, causing impairment to her executive functioning, including her judgment, insight and reasoning. The dispute regarding the hoist can be considered a manifestation of those problems, which impaired her ability to accept the advice of staff. That said, it was understandable that Mrs Northcote resisted the use of the hoist because of its impact on her independence. Ms Boulous noted that she grieved the loss of her former life and had difficulty coming to terms with her disability.

34. It was striking that none of the witnesses considered that Mrs Northcote suffered from dementia. Ms Pokharel felt her condition was normal for her age. Nurse Pant described her as resistant, although her mood was variable. Ms Knox was not sure Mrs Northcote was suffering from cognitive impairment, and noted she was quite delightful in her interactions, although she wanted things to be done a certain way. Dr Smythe believed Mrs Northcote was deteriorating but was not particularly impaired, though she was pre-occupied with the slide board. Overall, the impression is that staff viewed Mrs Northcote as a difficult resident, who could be uncooperative and unpleasant at times, and found interactions with her to be time consuming. It is probable that, if staff had understood Mrs Northcote's behaviour to be an aspect of her dementia, their approach would have been different.

35. The ongoing dispute with staff regarding the hoist resulted in frequent conflict and a deterioration in Mrs Northcote's behaviour and mood. As a result, an appropriate referral was sought from Dr Smythe to a psychogeriatrician, Dr Kitching, who attended to assess Mrs Northcote on 4 September 2012.

[20] Wound Treatment Sheet, vol 4 tab 9 "Wound Chart"

36. Dr Kitching provided a detailed handwritten opinion within the medical notes.[21] Dr Kitching provided advice on how to deal with Mrs Northcote's behaviour, noting that staff should be concrete and consistent. Unfortunately, staff did not find this particularly useful. Ms Knox reviewed the advice, but did not consider it to be any different from that provided in the previous psychogeriatric review by Dr Wallace in 2008. The advice on how to deal with Mrs Northcote's behaviour was largely reflected in the existing care plan. Dr Smythe had expected Dr Kitching to find Mrs Northcote to be depressed, and to prescribe medication, but in his view Mrs Northcote suffered only mild cognitive impairment and had some problems with concentration and memory.

37. In Dr Rosenfeld's view, Dr Kitching's advice to deal with Mrs Northcote consistently was also undermined by the fact that she was referred back to Dr Lee. Dr Lee's suggestion that Mrs Northcote's room be re-assessed for her to use the slide board, while no doubt appropriate in isolation, may have inadvertently entrenched Mrs Northcote's resistive behaviour. The assessment by a second physiotherapist probably had the same effect.[22]

38. In Dr Rosenfeld's opinion Dr Kitching may have underestimated the extent of Mrs Northcote's dementia. It appears that dementia can be very difficult to detect.[23] Dr Rosenfeld acknowledged that he had the advantage of reviewing a large volume of material, including the statements and notes made by staff. But in his view Mrs Northcote's impairment was significant; for example, she was unable to draw a clock face.

39. Unfortunately, Dr Kitching did not see any need for ongoing psychiatric input. In Dr Rosenfeld's view, this is precisely what was required. Dr Rosenfeld's opinion is that people with dementia should be case-managed by an appropriate professional, such as a geriatrician, who would consider the patient's needs holistically, instead of dealing with discrete issues in a compartmentalised way. Unfortunately, it seems that under the current model of care in Aged Care facilities the access to ongoing expert input is limited. Ms Knox noted that HSNH does have access to expert input where required, including a psychogeriatrician for the dementia patients, and other professionals through the Catholic HealthCare hierarchy. There are also external services, such as the Dementia Behaviour Management Advisory Service (DBMAS), which had been accessed for advice regarding Mrs Northcote in 2010.

40. One option that could have been usefully employed was a case conference. All those involved in Mrs Northcote's care could have been brought together to discuss the way forward. This could have included input from the GP, a psychogeriatrician, the physiotherapist, nurses and care staff and the family. Future options for care could have been discussed, including the use of medication and advance care directives. This is likely to have contributed towards a more consistent approach to Mrs Northcote's care.

[21] Vol 3 tab 1 "medical records" tab at 4.09.12
[22] See Boulous vol 1 tab 6, report of Robyn Smith 9.10.12
[23] See Dr Rosenfeld, Exhibit 5 at [85]

41. With the benefit of hindsight, one can observe that in November 2012, when Mrs Northcote's resistance was obviously frustrating staff attempts to treat her, the need for a case conference became more urgent. Some attempts were made to contact the family and Dr Smythe individually, but these were not followed up. Ms Knox acknowledged, in hindsight, that a case conference would have been useful. I note the family's concerns in their written submissions, that there may have been a failure to update contact details and that this may explain why they were not contacted sooner regarding Mrs Northcote's pressure injury.

42. I also note the submissions on behalf of HSNS regarding the limits and difficulties in arranging for all specialists involved in the care of a patient to be available at the same time. That indeed may be the case, particularly where a number of specialists are involved.

43. Ms Knox gave evidence that, since Mrs Northcote's death, she has held case conferences with treating staff for a patient with complex needs, and found this to be useful. She stated that she would continue to use this method in the future.

Treatment of urinary tract infections

44. It is also relevant to note, in light of the cause of death, that the care Mrs Northcote received for urinary tract infections appears to have been adequate. Mrs Northcote was at ongoing risk of developing UTIs due to her suprapubic catheter. The records show that her catheter site was cleaned and changed regularly. She was also treated frequently for UTIs with antibiotics. Staff were investigating a possible UTI at the time of Mrs Northcote's admission to hospital, and this was confirmed at RPAH.

The care and treatment Mrs Northcote received at RPAH

45. Dr Latt described Mrs Northcote's admission to RPAH in detail and was cross-examined. Mrs Northcote was appropriately treated with intravenous anti-biotics from her arrival at the Emergency Department; her wound was debrided and examined the following day; when Mrs Northcote's behaviour became a concern a special nurse was allocated to her for a period of 24 hours; she was provided appropriate analgesia and anxiolytics; the family were kept informed of her treatment and they were involved in decision making.

46. One issue that arose during the evidence concerned Professor Erlich's view that, by the time she was admitted to hospital, Mrs Northcote was "unsalvageable".[24] Dr Rosenfeld and Dr Dalton disagreed with this assessment because the notes record that Mrs Northcote improved after her admission.[25] A decision was ultimately made on 28 November to cease active treatment and palliate. None of the experts were critical of that decision.

[24] Prof Ehrlich vol 2 tab 23 at p2
[25] Dr Dalton vol 5 tab 31 at p5; and Dr Rosenfeld Exhibit 5 at [57]

47. Dr Latt was uncertain what was meant by the term “unsalvageable”; while his team may have been in a position to prolong her life for a short period of time, this was not necessarily an appropriate outcome. Predicting the outcome of different treatment is, in any event, speculative.

48. It would seem that the decision to cease active treatment was clearly appropriate, in light of Mrs Northcote’s condition, her express wishes (as recorded in the Resuscitation Plan) and the wishes of her family. Accordingly, there should be no criticism of the care and treatment Mrs Northcote received at RPAH.

The cause of death

Dr Latt did not disagree with the causes identified on the death certificate. He believed Mrs Northcote’s condition was caused by an infection, though it was hard to be certain about the origin of that infection. He also noted Mrs Northcote suffered from frailty, and described the illnesses that led to her death as “the straw that broke the camel’s back

Findings required by s81(1)

As a result of considering all of the documentary evidence and the oral evidence given at the inquest, I am able to confirm that the death occurred and make the following findings in relation to it.

The identity of the deceased

The person who died was Patricia Northcote

Date of death

Ms Northcote died on 7 December 2012

Place of death

Ms Northcote died in Royal Prince Alfred Hospital, Camperdown NSW

Cause and Manner of death

Ms Northcote died from major organ failure. The antecedent causes were sepsis, due to gram-positive bacteraemia arising from a urinary tract infection. The sacral area pressure sore was a significant condition contributing to her death.

Recommendations

Pursuant to s 82 of the *Coroners Act 2009*, Coroners may make recommendations connected with a death.

1. Since Mrs Northcote's death there have been a number of changes at HSNH, including an increase in staffing levels, policy improvements, further training on wound management and behaviour, and HSNH has participated in a pilot standards program. These changes were explained in detail by Ms Knox and explored briefly in evidence.[26]

2. In addition, Ms Knox stated that she now makes use of case conferences where appropriate, although she noted the difficulties in accessing professionals including geriatricians.

3. In these circumstances, it is not necessary or desirable to make any recommendations in this matter.

Closing remarks

4. I would like to thank my Counsel Assisting, Mr Jake Harris and his instructing solicitor, Ms Ava-Jones for their excellent work in assisting me.

5. Finally, I offer my sincere sympathies to Patricia's family for their sad loss and I thank them for their contribution to this inquest.

6. I close this inquest.

T. O'Sullivan

Deputy State Coroner

16 March 2016

[26] See in particular Exhibit 6