



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 004908

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

Section 67 of the Coroners Act 2008

Findings of:	Coroner Leveasque Peterson
Deceased:	Kristy Ann Mitchener
Date of birth:	6 October 1978
Date of death:	19 August 2024
Cause of death:	1a : Complications of sepsis secondary to sacral pressure wound in a woman with genetic developmental and epileptic encephalopathy and severe intellectual disability despite intravenous antibiotics
Place of death:	Austin Hospital 145 Studley Road Heidelberg Victoria 3084
Keywords:	Supported disability accommodation, disability, in care, natural causes, pressure ulcer

INTRODUCTION

1. On 19 August 2024, Kristy Ann Mitchener was 45 years old when she died in hospital. At the time, Kristy lived in Supported Disability Accommodation (**SDA**) provided by Aruma at Winn Grove in Fawkner. She is fondly remembered as having a *'cheeky smile and an infectious laugh'* and as an individual *'who enjoyed a social lifestyle with a zest for people'*.
2. Kristy had an extensive medical history. Her father, Steve Mitchener recalled that during Kristy's childhood, she was *'labelled "Developmentally Delayed"'*. She received diagnoses of cerebral palsy, autism spectrum disorder, epilepsy and oesophageal dysmotility, amongst others.
3. Kristy lived at home until 2000 when she moved to a supported disability facility in Mill Park. She continued to see her family and visited home from time to time.
4. Around 2010, Kristy's condition deteriorated, and she could no longer walk independently and used a wheelchair to get around. She was incontinent and non-verbal. In 2010, her aunt, Ms Anita Fisher (**Ms Fisher**) was appointed to be Kristy's Medical Guardian by the Victorian Civil and Administrative Tribunal (**VCAT**).¹
5. Due to Kristy's oesophageal dysmotility, she experienced trouble maintaining adequate nutrition. Clinicians considered a percutaneous endoscopic gastrostomy (**PEG**) tube² however, they determined that she was not a suitable candidate.³
6. In 2012, all residents at the Mill Park facility, including Kristy, were moved to Winn Grove in Fawkner, in a facility operated by Aruma (**Aruma**).
7. Kristy had a history of recurrent pressure ulcers in her sacral/coccyx region. On these occasions, Aruma staff contacted Ms Fisher, who would apply a dressing or instruct staff to do so.

¹ More information regarding the role of VCAT-appointed guardians can be accessed via their website at <https://www.vcat.vic.gov.au/case-types/guardians-and-administrators/guardians>.

² A tube which is surgically inserted, and which travels from the abdominal wall directly to the stomach to allow for direct feeding.

³ Evidence indicates that clinicians concluded that it would not reduce the risk of aspiration and was a risk of Kristy forcibly dislodging/pulling out the tube causing peritonitis.

THE CORONIAL INVESTIGATION

8. Kristy's death fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**) as she was a 'person placed in custody or care' within the meaning of the Act, as a person receiving funding for Supported Independent Living (**SIL**) and residing in an SDA enrolled dwelling immediately prior to her death. This category of death is reportable to ensure independent scrutiny of the circumstances leading to death given the vulnerability of this cohort and the level of power and control exercised by those who care for them. The coroner is required to investigate the death, and publish their findings, even if the death has occurred as a result of natural causes.
9. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.
10. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.
11. Victoria Police assigned an officer to be the Coronal Investigator for the investigation of Kristy's death. The Coronal Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.
12. This finding draws on the totality of the coronial investigation into the death of Kristy Ann Mitchener including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.⁴

⁴ Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

Background circumstances

13. On 30 June 2024, according to Ms Fisher, Aruma staff '*noticed the beginnings of a pressure area, friction rub*' on Kristy's sacrum. The skin was irritated but '*there was no wound or broken skin*'. Ms Fisher attended Winn Grove and applied a pressure injury dressing to the area. She informed Aruma staff that she was going to '*return in two days to check the dressings*' and gave instructions to contact her if she had concerns. Ms Fisher also changed the cushion on Kristy's wheelchair to one designed for pressure care '*for added protection*'.
14. On 1 July 2024, Ms Fisher visited Kristy. She inspected the area of irritated skin and '*noted that there was significant improvement and no broken or rough skin*'. She re-applied the dressing and gave Aruma staff the same instructions as the day prior.
15. On 5 July 2024, Ms Fisher telephoned Winn Grove to inform them she was coming to see Kristy. The House Supervisor '*told [Ms Fisher] not to come as she had already changed the dressing*'. The House Supervisor reassured Ms Fisher that she used the same kind of dressing as Ms Fisher had used the day before and explained that she changed it because it was '*soiled*'. Given that Kristy would be spending the weekend at Ms Fisher's house (commencing the following day), she '*took the supervisors word that all was good*' and did not attend Winn Grove.
16. The following day, 6 July 2024, Kristy's Key Worker telephoned Ms Fisher and informed her that while helping Kristy in the bathroom, she noticed '*the dressing was not correct and had disintegrated overnight*'. The Key Worker observed a pressure ulcer estimated at 5 x 3 centimetres. Ms Fisher provided instruction over video call to clean and dress the area. Kristy spent the weekend with Ms Fisher as planned.
17. On 8 July 2024, Ms Fisher sourced an external nursing company to assist Aruma staff to manage Kristy's wound. This process was complicated by the upcoming expiration of Kristy's NDIS plan. This will be discussed further below.
18. The home care service, Nurse Next Door, began assisting Kristy on 16 July 2024. By this time, she '*had become unusually quiet and tired*'. Ms Fisher arranged an appointment with Kristy's general medical practitioner (GP). On examination, '*a deep ulcer was noted in the*

coccygeal region that did not appear infected at the time'. The GP referred Kristy to a wound care nurse.

19. By 18 July 2024, Ms Fisher observed that *'there were signs of infection with swelling and redness across a large area surrounding the wound'*. The following day, they re-visited Kristy's GP who agreed with Ms Fisher's observations and prescribed antibiotics with a plan *'to continue with daily wound care through the private wound nurse and review in one week'*. Nurse Next Door continued to clean and re-dress the wound daily.

Proximate circumstances

20. On 24 July 2024, Aruma staff telephoned Ms Fisher and reported that *'Kristy wouldn't eat or take medication and was very floppy'*. Ms Fisher contacted emergency services and Kristy was transported to Austin Hospital. Kristy's oesophageal dysmotility had acutely worsened which caused an inability to consume food and/or fluids. She was, therefore, unable to take her medication. As a consequence, she demonstrated an increase in seizure activity.⁵
21. Clinicians assessed Kristy's pressure ulcer and categorised it as *'Grade 2-3'*.⁶ Kristy's oesophageal dysmotility also prevented her from taking her antibiotics and analgesia,⁷ and her medication was changed to intravenous antibiotics. A blood test showed an elevated c-reactive protein level.⁸
22. Kristy was admitted and clinicians planned to stabilise her various conditions and sought input from other disciplines including the gastroenterology unit and the pharmacy. They also made a plan to tend to pressure area care and continence care every two hours, seek a wound care nurse review and implement pressure offloading techniques.
23. On 27 July 2024, clinicians assessed Kristy's pressure ulcer. The necrotic tissue⁹ was resected and it was categorised as *'Grade 4'*. There was a *'large area of erythema'* and soft tissue swelling. Clinicians consulted with an occupational therapist regarding pressure relieving

⁵ Kristy had previously experienced seizures around once per week, but by the time of her admission to Austin Hospital, was estimated at around five times per week.

⁶ The depth of a pressure ulcer is graded according to severity with:

Grade 1: Non-blanchable erythema of intact skin.

Grade 2: Partial thickness loss of skin with exposed dermis.

Grade 3: Full thickness loss of skin, where fat may be visible.

Grade 4: Full thickness tissue loss with exposed bone, tendon, or muscle.

Unstageable: Full thickness tissue loss where the base of the ulcer is covered by slough or eschar.

⁷ Pain relief.

⁸ An inflammatory marker known as *'CRP'*.

⁹ Dead or decaying tissue.

techniques. By 29 July 2024, the wound had not improved, and clinicians identified that Kristy likely had a poor prognosis due to the difficulties offloading pressure and her medical comorbidities. Following discussion with the Plastic Surgery team, Kristy was not a suitable candidate for surgical intervention (debridement).

24. Kristy's condition appeared to improve momentarily, and clinicians intended to discharge her the week of 8 August 2024. However, her condition deteriorated overnight and on 9 August 2024 carers noted a small collection around the sacral pressure ulcer.
25. On 14 August 2024, clinicians discussed Kristy's condition with and her family and carers, and indicated that her inflammatory markers were rising, and she was feverish despite intravenous antibiotics. She had a poor prognosis and clinicians acknowledged that '*she did appear to be improving briefly last week, but [. . .] has deteriorated*'.
26. Kristy was transitioned to a palliative pathway and on 19 August 2024, she was declared deceased.

Identity of the deceased

27. On 19 August 2024, Kristy Ann Mitchener, born 6 October 1978, was visually identified by her aunt and Guardian, Anita Fisher.
28. Identity is not in dispute and requires no further investigation.

Medical cause of death

29. Forensic Pathologist Dr Joanne Ho of the Victorian Institute of Forensic Medicine (VIFM) conducted an examination on 21 August 2024 and provided a written report of her findings dated 27 August 2024.
30. The post-mortem examination revealed an ulcer to the sacral region measuring 4 x 2.5 centimetres and which extended down to the bone. The ulcer was also apparent on a computed tomography (CT) scan.
31. Dr Ho provided an opinion that the medical cause of death was 1(a) *Complications of sepsis secondary to sacral pressure wound in a woman with genetic developmental and epileptic encephalopathy and severe intellectual disability despite intravenous antibiotics*. She stated that the death was due to natural causes.

32. I accept Dr Ho's opinion as to cause of death.

CONCERNS RAISED BY MS ANITA FISHER

33. In correspondence to the Court dated 30 August 2024, Ms Fisher expressed her concerns regarding the events preceding Kristy's death. These concerns canvassed three main areas which I will discuss in turn below.

The provision of funding to Kristy under the NDIS

34. Ms Fisher spoke to the difficulties she encountered when trying to secure onboard nursing support in mid-July 2024. She stated that under Kristy's NDIS plan, she did not have the funding for this service, and the plan was set to expire at the end of the month.

35. Despite her attempt to organise alternative funding and submitting a Change of Circumstance form, Ms Fisher did not receive a response. Around the time Kristy was admitted to hospital, in late July 2024, the Change of Circumstance request had been escalated to '*urgent*'. However, Ms Fisher stated that there was no communication from the NDIA and Kristy's plan was rolled over, unchanged, in mid-August 2024. She stated that '*the lack of funding for a nurse and the time to plan expiry prevented [her] from engaging a nursing service for over a week*'.

36. It is apparent that the difficulties associated with securing funding for onboard nursing support delayed an escalation in Kristy's care and caused significant stress for Ms Fisher. Such complexities regarding the level of NDIS funding when a client's needs acutely escalate are not unheard-of. I commend Ms Fisher for her diligence in securing onboard nursing care and for submitting the Change of Circumstance forms when indicated.

Care provided by Aruma

37. Ms Fisher referenced the '*Medical Communication Protocol for Winn Grove*' which was in effect at the time of Kristy's death, and which outlines Aruma staff's obligations to keep her informed of Kristy's care and health status.

38. Ms Fisher stated that '*when the protocol is followed, [herself and Aruma staff] were able to work together to understand Kristy's needs and manage her health and wellbeing effectively*'. However, Ms Fisher expressed concerns regarding the actions of the House Supervisor, whom Mr Fisher stated was not trained apply pressure area care. She referenced the events of 5 and

6 July 2024, which are outlined above, and hypothesised that the incorrectly applied wound dressing of 5 July 2024 contributed to the deterioration in Kristy's pressure ulcer. She wrote:

'The dressing had been changed and incorrectly redressed causing rubbing that had torn the skin and allowed contamination of the wound. I later discovered that the house supervisor had stepped outside [their] role and changed the dressing without any communication on two occasions.

[. . .]

It was the incorrect dressing that led to the skin tearing and I firmly believe that the introduction of contaminants initiated the infection in the wound'.

Care provided by Austin Hospital

39. Ms Fisher spoke to the difficulties she experienced in early-August 2024 when clinicians were initially intending to discharge Kristy. She stated that there was a gap in the care provided by Austin Hospital and Aruma staff and stated that: *'the house [Aruma] was refusing to have Kristy home without a Care team meeting and suitable documentation training from the hospital regarding the changes in Kristy's support needs'.*
40. She expressed a concern that few hospital staff demonstrated pressure relieving techniques: *'At one point I complained to a doctor that no one was assisting us with how to help Kristy to off-load the pressure and still be able to eat and drink'.*
41. This extract from Ms Fisher speaks to the inherent difficulties in managing Kristy's pressure ulcer and oesophageal dysmotility simultaneously as best care practices contradicted one another. This is addressed further below.

STATEMENT FROM THE NATIONAL DISABILITY INSURANCE AGENCY

42. I sought a statement from the National Disability Insurance Agency (NDIA), which administers the NDIS, regarding the Change of Circumstance review request submitted by Ms Fisher. Damien Poel (**Mr Poel**), General Manager of Victoria and Tasmania Regional Services of the NDIA, provided a statement dated 4 July 2025 regarding the same.
43. Mr Poel confirmed that on 14 June 2024, the NDIA received a Change of Circumstance form (**the Form**) via email from Kristy's Support Coordinator and that the Form was signed by Ms Fisher. The Form outlined requested changes and additional funded supports for Kristy based on her diagnosis of severe oesophageal dysmotility including increased 1:1 care, wedges for

incline during changes and toileting, appropriate bedding to facilitate incline and prevent aspiration, a new wheelchair to address pressure sores and discomfort resulting from weight loss while providing postural requirements including wheelchair modifications.

44. Mr Poel explained that when a Change of Circumstance Form is submitted and has been assigned, a delegate will conduct a risk assessment and may consider that pursuant to section 47A of the *National Disability Insurance Scheme Act (2013)*, that a review of the plan is needed due to immediate risk or specific factors. Otherwise, the applications are processed according to the risk assessment triage and within the NDIA's operational timeframe.
45. On 27 June 2024, an '*actionable item*' was made and marked as '*high priority*'. On 9 July 2024, Kristy's Support Coordinator and Ms Fisher contacted the NDIA seeking an update on the processing of the Form. According to Mr Poel, they '*requested that this be prioritised as [Kristy]'s new diagnosis impacts her breathing and eating*'. The priority rating of the Form was raised accordingly.
46. On 8 August 2024, the NDIA was updated that Kristy had been hospitalised. On 12 August 2024, the NDIA's Hospital Liaison team was also advised of her admission.¹⁰ The same day, a Health Liaison Officer of the Hospital Liaison team attempted to call Ms Fisher four times, with no success. The Health Liaison Officer followed up by emailing Ms Fisher, who responded and confirmed details of Kristy's hospitalisation.
47. Mr Poel noted that '*during this period, the standard processing time for plan change requests was 110 days*' and that '*this case was actioned within 55 to 70 days*'.
48. Mr Poel also pointed to the particulars of Kristy's NDIS plan including that he had funding allocated for '*composite funding for delivery of health supports by a clinical nurse*' for a period of six hours per year and that this funding covers wound management by a clinical nurse. He stated, '*this funding was not fully utilised by [Kristy]*'.

¹⁰ The role of the Hospital Liaison team within the Agency is to support a participant during their hospital stay, and to work with the participant to support them in leaving hospital. The Agency has Hospital Liaison Officers in the Hospital Liaison team who will work with the health system and the participant or their representative during their hospital stay to ensure the participant is appropriately supported when they are medically ready to leave.

49. He continued that in order for wound care to be funded under this allocation, the NDIA must have a copy of wound management plans, wound assessments or pressure care plans. The NDIA had not received this documentation with respect to Kristy's care.¹¹
50. More broadly, Mr Poel noted that between 18 July 2022 and 19 July 2024, Kristy's total funding allocated under the NDIS was not fully used. He stated that the role of a Support Coordinator is *'to support a participant to understand and implement supports included in their plan'* and to *'link a participant to provides and other capacity and government services'*.

STATEMENT FROM ARUMA

51. I sought a statement from Aruma regarding the care they provided to Kristy in the lead up to her hospitalisation. The Project and Occupational Manager of Aruma provided a statement dated 17 April 2025 regarding the same and addressed the pressure area care qualifications of staff.
52. Aruma explained the pressure area care training provided to staff who care for residents at a high risk of developing pressure injuries (measured according to the Braden Scale).¹² It stated that four of the five Aruma staff¹³ who cared for Kristy had completed training modules on Pressure Care, however, the House Supervisor had not completed this training. None of the five staff members had undertaken training in Complex Wound care: *'at the time of [Kristy]'s death, staff had not completed the training in accordance with Aruma's policies and procedures'*.
53. Regarding, the Medical Communication Protocol for Winn Grove (**the Protocol**) which was in force at the time of Kristy's death, Aruma explained the Protocol was unique to Kristy and Ms Fisher and was not a regular document implemented by the organisation and/or other guardians.
54. Aruma that staff were required to keep Ms Fisher informed of Kristy's status including if they believed she required any medical attention;¹⁴ *the records indicate that Aruma staff and [Ms Fisher] were in frequent contact about [Kristy]. Aruma staff consistently made efforts to*

¹¹Mr Poel stated that these documents can be provided by the participant's doctor, specialist, enrolled nurse, registered nurse or clinical nurse.

¹² A standardised tool to assess an individual's risk of developing a pressure injury. It measures factors including moisture, mobility, nutrition and friction.

¹³ These five staff members comprised the House Supervisor,

¹⁴ In the event that Kristy required emergency medical attention, the Protocol outlined that Aruma staff were to contact emergency services first, followed by notification to Ms Fisher. In all other circumstances (non-emergency medical care), Aruma staff were required to contact Ms Fisher first.

inform [Ms Fisher] of any changes to [Kristy]'s health and/or presentation, including the appearance of reddened areas or pressure injuries'.

Skin Integrity Procedures at Aruma

55. The Skin Integrity Assessment paperwork used by Aruma requires that staff '*record any changes or anomalies to the skin*' either reported by the resident or observed by staff. The document outlined that '*this may include skin rashes, birthmarks, scratches, reddened areas, insect bites, bite marks etc.*' and that comprehensive record keeping is important '*to provide an accurate reference record eg for doctor's visit, reporting observations or complaints to the line manager*'.
56. Between 30 June 2024 and 3 July 2024, the Skin Integrity Assessments and records maintained by Aruma demonstrate that staff identified a '*red mark*' on Kristy's coccyx region and that staff contacted Ms Fisher who visited Winn Grove and applied a dressing. Aruma stated that '*[Ms Fisher] said that she would change [Kristy]'s dressing until a nursing service could be onboarded*'. There was no documented deterioration in Kristy's pressure ulcer between these dates, this is consistent with Ms Fisher's recollection of this time.
57. On 4 July 2024, an Aruma staff member¹⁵ collected Kristy from her day placement and was advised that the coccyx dressing and the tape '*had crinkled and scrunched leading to exposed skin*'. The staff member and Kristy returned to Aruma at around 4pm, and staff gave a handover to the House Supervisor regarding the same.
58. According to Aruma, the House Supervisor '*changed the dressing in the same manner [Ms Fisher] had previously demonstrated and advised*' over the phone. Aruma also stated that the House Supervisor '*offered to show the dressing to [Ms Fisher] on FaceTime [video call], however she declined*'.
59. In a Skin Integrity Assessment completed by the House Supervisor, they documented '*red mark to lower back near coccyx*' and '*Coccyx – Meliplex changed with borders. Ms Anita Fisher advised via phone*'.¹⁶
60. During the evening of 5 July 2024, a Support Worker assisting Kristy '*saw that the tape and Meliplex patch were soiled with excrement*'. The House Supervisor and a different Support

¹⁵ One of the five who cared for Kristy but who does not appear to be a Support Worker.

¹⁶ Meliplex is a brand of dressing.

Worker changed the dressing. The House Supervisor informed Kristy's Key Worker *'with the view that [the Key Worker] would inform [Ms Fisher] the following day'*.

61. The Skin Assessment Integrity form stated there was a *'red mark to lower back'* and that the House Supervisor and Support Worker changed *'coccyx patch due to soiling on border and Meliplex itself'*, it also stated *'communication diary – message left'*.
62. The following morning, on 6 July 2024, the Key Worker informed Ms Fisher of the dressing change the night prior and changed Kristy's dressing while on video call. An entry in Kristy's records read: *'Ms Fisher stayed on FaceTime to help instruct staff'*. It also documented that Ms Fisher had collected a roho cushion for Kristy.¹⁷
63. On 8 July 2024, Ms Fisher attended Winn Grove and changed Kristy's dressing and the following day, on 9 July 2024, Meeting Minutes documented that *'Ms Anita Fisher will come to Winn Grove to change Kristy [sic] coccyx dressing. Staff will not change the dressing at any time'*. Aruma staff did not change Kristy's dressing from this time.

ACTIONS TAKEN BY ARUMA SINCE KRISTY'S DEATH

64. Having acknowledged that staff had not completed Complex Wound Care training despite providing care for Kristy who had a known high risk of pressure injuries, Aruma explained that this has since been rectified.
65. It explained that:

'Aruma is aware that continuous improvement is crucial for identifying and addressing potential risks and quality issues, so as to ensure the safety of the participants it supports. Over the past six months Aruma has reviewed its policies and procedures relating to deteriorating health and skin integrity and updated them to assist staff recognise deteriorating health issues, such a pressure injuries and skin integrity'.
66. Since Kristy's death, all staff at Winn Grove have completed Complex Wound customised group training provided by an external nurse practitioner of Wound Wise, a mobile wound management education provider.

¹⁷ A roho cushion is a pressure-relieving device.

CORONERS PREVENTION UNIT

67. To better understand Kristy's clinical course prior to and during her hospitalisation, I sought assistance from the Coroners Prevention Unit (CPU).¹⁸ The CPU assessed the court file including the statement of Aruma and Ms Fisher's concerns.
68. The CPU identified that Kristy had progressive functional decline associated with her deterioration in her underlying health conditions and her trajectory was consistent with approaching end of life. It noted that she had a combination of cachexia and malnutrition associated with her impaired oesophageal function and epilepsy which was difficult to control. These factors compounded and lead to an advanced state of debility that, according to the CPU, would have been the major contributor to the development and progression of pressure injuries.
69. The CPU did not identify any shortcomings in the care or the need for pressure injury prevention and care at Aruma. It also noted that Aruma is not an aged care facility or nursing home, and its staff are disability support workers and are not nurses or otherwise clinically trained.
70. The CPU also commented on the dressing deterioration between 4 and 5 July 2024 when Aruma staff observed it was soiled. In relation to Ms Fisher's belief that the introduction of contaminants '*initiated the infection in the wound*', the CPU considered this was unlikely to be the case.
71. It acknowledged that it is true that shearing forces that cause skin tears are most common when there is insufficient subcutaneous fat and the sacral area is invariably highly contaminated. However, the CPU qualified that it is most likely that the primary injury was a pressure ulcer that became infected, and not an infection which caused a pressure ulcer.
72. The CPU also commented on Ms Fisher's frustrations regarding securing adequate funding through the NDIS and acute changes in Kristy's needs and noted they were likely to be true but not causally related to the death.

¹⁸ The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

73. The CPU concluded that due to Kristy's general end of life trajectory, and given the major contributor to her pressure ulcer was her underlying medical conditions, there are no opportunities for prevention.

DISCUSSION

74. The development of and management of pressure injuries is inherently complex, particularly in individuals with extensive medical comorbidities which may exacerbate the rate of deterioration. Indeed, Kristy had multiple diagnoses which prevented the implementation of several prophylactic measures and/or hindered the healing of pressure injuries.
75. Due to her limited oesophageal function (oesophageal dysmotility) she had poor oral intake leading to malnutrition. A 2018 study¹⁹ stated that '*nutritional deprivation and insufficient dietary intake are the key risk factors for the development of pressure ulcers and impaired wound healing*' and further that '*adequate fluid intake is necessary to support the blood flow to wounded tissues and to prevent additional breakdown of the skin*'. While clinicians considered feeding Kristy via a PEG tube, they concluded that it would not decrease the risk of aspiration and would not extend her life. Kristy was at a very high risk of removing the PEG tube and developing peritonitis. That is to say, she was not a suitable candidate.
76. Kristy's oesophageal dysmotility also limited the implementation of prophylactic and pressure-relieving methods. Medical literature recommends that individuals with oesophageal dysmotility (and dysphagia) sit upright following meals to promote the passage of food through the oesophagus, such as for several hours following mealtimes. However, an important element of pressure injury prevention and care is frequent positional changes and the reduction of direct pressure on bony prominences. Patients are recommended to lay at a degree of 30 degrees or less with pillows for support. It is apparent that to simultaneously accommodate both of these management techniques would be inherently complicated.
77. Evidence also indicates that when in hospital, Kristy became distressed when these techniques were implemented. Ms Fisher described that when nursing staff at the Austin Hospital demonstrated (albeit briefly in her account) such methods, Kristy '*found the whole situation extremely distressing*' when manoeuvred into a side-lying position.

¹⁹ Seied Hadi Saghaleini et al. 'Pressure Ulcer and Nutrition' *Indian Journal of Critical Care Medicine* 2018 22(4) and accessible at: <https://pubmed.ncbi.nlm.nih.gov/29743767/>.

78. Once Kristy's pressure ulcer was identified, on 30 June 2024, Aruma staff responded appropriately by escalating to Ms Fisher in accordance with the Protocol. It is apparent however, that on 4 and 5 July 2024, the House Supervisor had changed Kristy's dressing without having completed any training on pressure care management.²⁰ I note Aruma's evidence that the House Supervisor did so in accordance with Ms Fisher's instructions: '*[the House Supervisor] changed the dressing in the same manner [Ms Fisher] had previously demonstrated and advised Ms Fisher [sic] over the phone*'. It is unclear when this previous demonstration occurred given that the House Supervisor did not speak with Ms Fisher at the time.
79. When Ms Fisher was shown the dressing the following day via video call, she observed that '*the dressing had been changed incorrectly and redressed causing rubbing that had torn the skin*'.
80. There is no evidence that the House Supervisor contacted Ms Fisher on the afternoon of 5 July 2024 once Kristy's dressing had become soiled. I consider that this was a deviation from the Protocol which required that Ms Fisher was to be '*fully informed of all matters that impact Kristy including but not limited to [. . .] changes in Kristy's health and wellbeing*'. All Aruma staff were under an obligation, according to the Protocol, to '*always share consistent and factual communication*'.
81. I note Ms Fisher's concern that incorrect re-dressing performed on 4 and 5 July 2024 and subsequent soiling of the dressing lead to the deterioration of Kristy's pressure ulcer. Given Kristy's general poor health, and other comorbidities that increased her risk of developing serious pressure injuries and that decreased her wound healing ability, I cannot conclude that inappropriate dressing technique was a main or substantial contributing factor to her deterioration.
82. The difficulty in managing pressure injuries in general is demonstrated by Kristy's continued deterioration even with the benefit of onboarding nursing care. Aruma staff stopped attending to Kristy's pressure ulcer on 9 July 2024, at which time Ms Fisher provided all dressing changes until 16 July 2024 when Nurse Next Door provided daily wound care. However, even with the benefit of dedicated nursing treatment, Kristy's pressure ulcer continued to deteriorate, and the first signs of infection were observed on 18 July 2024.

²⁰ I note that when the House Supervisor changed Kristy's dressing on 5 July 2024, they did so with an Aruma staff member who had completed the Pressure Care training module, however, this staff member was not a support worker.

83. Pressure injuries are known to deteriorate rapidly. In this instance, Skin Integrity Assessments described the injury as a 'red mark' on 30 June 2024, 2, 3, 4 and 5 July 2024. Ms Fisher described that by 6 July 2024 it had become an 'open wound of about 5 x 3cm'. The wound further deteriorated and by the time the GP assessed the wound on 16 July 2024 it had become a 'deep ulcer'. I note that the progression of the ulcer in early July 2024, particularly overnight from 5 to 6 July 2024 is difficult to quantify. The information contained in the Skin Integrity Assessments refers to the injury only as a 'red mark' and as such, it is difficult to track the development of the pressure injury save to comment that it progressed rapidly despite escalating treatment.

Natural Justice

84. In anticipation of finalising the investigation into Kristy's death, I provided Aruma with the opportunity to respond to the conclusions which I intended to make.

85. Aruma did not make any submissions.

FINDINGS AND CONCLUSION

86. Pursuant to section 67(1) of the Act, I make the following findings:

- a) the identity of the deceased was Kristy Ann Mitchener, born 6 October 1978;
- b) the death occurred on 19 August 2024 at Austin Hospital 145 Studley Road, Heidelberg Victoria 3084, from 1(a) *Complications of sepsis secondary to sacral pressure wound in a woman with genetic developmental and epileptic encephalopathy and severe intellectual disability despite intravenous antibiotics*; and
- c) the death occurred in the circumstances described above.

87. I have reviewed the evidence and consider that Kristy's death occurred due to natural causes. Pursuant to the exception outlined in section 52(3A) of the Act, I have determined not to hold an inquest.

88. In the absence of an inquest, I have nonetheless conducted a thorough investigation of the care provided to Kristy in the lead up to and during her final hospitalisation including the several medical comorbidities which contributed to her physical deterioration.

89. I have considered the opinion of the CPU and accept that Kristy was on an end-of-life trajectory and that her death could not have been prevented.
90. Notwithstanding, I find that Aruma staff who cared for Kristy had not completed relevant training in Pressure Area Care and/or Complex Wound Care. On the evidence before me, that the dressing to Kristy's coccyx may have been placed incorrectly on 5 July 2024, I consider that this was likely the result of staff performing tasks for which they had not received formal training.
91. However, I do not consider that this misstep was causal or contributory to Kristy's death. Nonetheless it represents a deviation from Aruma's policies and procedures. Aruma's restorative actions in this regard, to provide education to all staff (not just those managing residents with a high risk of a pressure injury) on pressure care management, obviate the need for further coronial recommendation or comment.
92. It is evident that despite Ms Fisher's best efforts, including close oversight of the care provided to Kristy and to secure individual, specialised treatment through onboard nursing care, Kristy's co-morbidities exacerbated her decline and her condition rapidly deteriorated.
93. I have not identified any want of care on the part of Aruma or of Austin Hospital which caused or contributed to Kristy's death.

ORDERS AND DIRECTIONS

Pursuant to section 73(1B) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

I extend my sincere condolences to Kristy's family for their loss.

I direct that a copy of this finding be provided to the following:

Mr Steve Mitchener, Senior Next of Kin

Ms Anita Fisher

Aruma Winn Grove

Austin Hospital

National Disability Insurance Agency

Senior Constable Adam Ramadan, Coronial Investigator

Signature:



Coroner Leveasque Peterson

Date: 12 February 2026

NOTE: Under section 83 of the *Coroners Act 2008* ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.
