MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

# Record of Investigation into Death (Without Inquest)

*Coroners Act 1995*
*Coroners Rules 2006*
*Rule 11*

I, Robert Webster, Coroner, having investigated the death of Roswitha Czerniejewski

**Find, pursuant to Section 28(1) of the *Coroners Act* 1995, that**

a) The identity of the deceased is Roswitha Czerniejewski (Mrs Czerniejewski);

b) Mrs Czerniejewski died in the circumstances set out below;

c) Mrs Czerniejewski's cause of death was aspiration pneumonitis and gangrenous necrosis of both feet; and

d) Mrs Czerniejewski died between 6 and 7 November 2021 at Gunns Plains, Tasmania.

In making the above findings, I have had regard to the evidence gained in the investigation into Mrs Czerniejewski's death. The evidence includes:

- Tasmania Police Report of Death for the Coroner;
- Affidavits as to identity and life extinct;
- Affidavit of the forensic pathologist Dr Donald Ritchey;
- Affidavit of the forensic scientist Mr Neil McLachlan – Troup of Forensic Science Service Tasmania;
- Affidavit of Mr Ralph Czerniejewski;
- Affidavit of Ms Jolene Hampson;
- Medical records obtained from the Patrick Street clinic;
- Records obtained from Hireup Pty Ltd;
- Records obtained from the Mersey Community Hospital (MCH);
- Report of the coronial nursing consultant Libby Newman; and
- Forensic and photographic evidence.

**Background**

Mrs Czerniejewski was 66 years of age (date of birth 4 August 1955) and she was separated although not divorced from her husband at the date of her death. Mr and Mrs Czerniejewski had one child together.

Mrs Czerniejewski was born in Germany and moved to Australia with her parents in 1959 at 4 years of age. She grew up in Sydney where she met her future husband. They shared a house with some other students when they were both studying at the University of New South Wales. They were married on 17 September 1977. Mrs Czerniejewski qualified as a primary school teacher.

In 1979 the couple moved to Albury and their daughter was born in 1980. After her birth Mrs Czerniejewski started having problems with rheumatoid arthritis and she suffered from problems with mobility and pain. They then moved to Alice Springs in the Northern Territory where Mrs Czerniejewski worked as a teacher in a number of schools until 1993 when they moved to Erriba in Tasmania. Mrs Czerniejewski moved over on her own initially and Mr Czerniejewski joined her after selling their property. They then moved to Gunns Plains in 1994. After moving to Tasmania Mrs Czerniejewski was awarded a disability support pension because she was having difficulty completing daily tasks and she had restricted mobility.

In 1996 the couple officially separated but they did not divorce. Mr Czerniejewski returned to Alice Springs but would visit his wife on a couple of occasions each year. In 2011 he moved back to Tasmania to look after her. They lived in adjoining cabins at the Gunns Plains property. On his return Mr Czerniejewski noted his wife was still independent in that she could move with a walker and she could still drive a car. She was able to perform her shopping although people at the shops would help pack it for her and bring it to the car. She was still able to independently perform the necessary activities of daily living. Mrs Czerniejewski did have some assistance though with respect to cooking and cleaning.

By 2018 her situation had changed dramatically and through the assistance of her general practitioner a level two home care package was provided which included assistance on one day per week. By the end of that year Mrs Czerniejewski required a lot of assistance with her activities of daily living and she had lost her independence. From February 2019 nurses assisted once per week in order to treat her legs as they needed to be bandaged due to recurrent infections. Later her home care package was increased to level four after which she applied successfully for funding from the National Disability Insurance Scheme. By early 2020 she

needed assistance with everything. From 2019 she essentially lived on her couch or in bed, she was immobile and she could not shower or wash properly.

Mr Czerniejewski says his wife had no issues with communication and she insisted on the assistance she received being provided in a certain way. Accordingly the carers needed to be very patient and empathetic with her. By way of an example he says his wife refused to go to hospital when an ambulance arrived to collect her and she did not want to go into a home. He noted the nurses ceased coming to change the bandages on her legs in about the middle of September 2021 because there were *"issues between them"*. Mr Czerniejewski says his wife acknowledged she had agreed in a document not to abuse the nurses that came to assist her. He says she had a different opinion on what had actually occurred as she believed she was acting in self-defence due to the rough treatment she received at the hands of the nurses and the fact that they wore perfume which she found too strong on occasions.

**Circumstances Leading to Death**

On 3 November 2021 the carer advised Mr Czerniejewski his wife would not eat anything. The next day the carer advised him she would neither eat or take her medication. She did not eat or take any of her medication on 5 or 6 November 2021 and she was still insisting she did not want an ambulance.

Mr Czerniejewski last saw his wife at about 10:30pm on 6 November 2021. She was seated on the couch. She did not eat but he had left some food and water nearby on her table. Due to concerns with Mrs Czerniejewski's health her carer in conjunction with her ex case manager decided to call an ambulance so that she could be assessed. This was to take place on the morning of 7 November 2021. The carer arrived at approximate 10:45am to discuss this with Mr Czerniejewski. When they both went inside at 10:50am they found Mrs Czerniejewski deceased on the couch. Police and Ambulance Tasmania were called.

**Investigation**

On the arrival of police both Mr Czerniejewski and the carer were present. All lights in the house were turned off except for the lounge room light where Mrs Czerniejewski was located. She was sitting on the couch in front of the television with her table and a nebuliser close by. She was dressed on the top half of her body only with her lower half covered by blankets. This was explained to be due to the fact that this assisted with toileting. Her legs were observed to be severely infected. There was an incontinence pad under her feet to catch liquid from her legs. No defensive wounds were observed on her hands and there was no obvious trauma to her neck or petechiae in her eyes. There was a significant amount of medication surrounding her on her

couch table, both in bottles and lying free in cups. No suspicious circumstances with respect to entry were identified. Further there was no evidence of suicide.

Dr Ritchey conducted a post-mortem examination on 9 November 2021. He identified there had been perimortem large volume aspiration of gastric contents which caused acute inflammation; that is pneumonitis. This and the gangrenous necrosis of both feet were the cause of Mrs Czerniejewski's death. It was also noted by the forensic pathologist Mrs Czerniejewski had centriacinar emphysema, advanced atherosclerotic coronary vascular disease and rheumatoid arthritis. I accept Dr Ritchey's opinion.

Both Mr Czerniejewski[1] and his daughter, Marina, have raised concerns about the quality of care provided to Mrs Czerniejewski especially with respect to cleaning and dressing the wounds on her legs. Accordingly I arranged for the coronial nursing consultant, Libby Newman, to examine all the hospital and nursing records that were obtained in this investigation.

Ms Newman reports Mrs Czerniejewski's past medical history includes rheumatoid arthritis (postpartum onset) – untreated, osteoarthritis, asthma, gastro-oesophageal reflux disease, hypertension, lower limb lymphoedema, multiple allergies, a left elbow joint replacement which was complicated by sepsis and associated issues, recurring lower limb cellulitis, a personality disorder, chronic pain disorder and obesity.

In her report Ms Newman sets out information from the records which describes Mrs Czerniejewski's condition and challenges along with comprehensive details of the care provided to her and the challenges the care-givers faced. The material in the report commences in late 2018 and is as follows.

**Admission to North West Regional Hospital (NWRH): 25 December 2018 until 14 January 2019**

The admission was due to bilateral lower limb cellulitis. During this admission a psychiatric assessment was carried out on 01 January 2019 – at this time no mood disorder or psychosis was noted, Mrs Czerniejewski was reportedly cognitively intact and had capacity. A *'demanding personality'* was noted. Other relevant information from this assessment explained that physical disability had markedly affected Mrs Czerniejewski's life along with a note that Mrs Czerniejewski's ex-husband, who lived on site but in a separate dwelling, was her carer however

[1] Documentation provided by the care agency suggests Mr Czerniejewski had no such concerns.

his personality had changed following him suffering a stroke. Mrs Czerniejewski was noted to be unable to transfer/mobilise/toilet herself/eat or prepare meals independently however she consistently refused to consider a nursing home placement. Pain was a major issue and she stated the nurses were rough. She consistently refused clinical observations being taken, she refused medications, pressure area care and other aspects of nursing care. Her leg wounds were surgically debrided during this admission. Mrs Czerniejewski was officially referred to the Ulverstone Community Health Nursing Service (CHNS) for wound dressings on 14 January 2019. On the day of discharge the NWRH physiotherapist and occupational therapist stated Mrs Czerniejewski was unlikely to be able to safely manage or function at home. Mrs Czerniejewski accepted those risks and chose to discharge herself from the hospital.

**Admission to NWRH: 17 January 2019 until 2 February 2019**

Mrs Czerniejewski returned to hospital on 17 January 2019 via AT with an oedematous[2], erythematous[3] right leg and foot. She was noted to be non-compliant and aggressive towards AT staff. In hospital she refused occupational therapy. She was treated with antibiotics and dressings. An indwelling catheter (IDC) was inserted and she refused to have it removed. She was discharged on 2 February 2019.

On 24 January 2019 an email was written by a Social Work Manager to Dr Roberts-Thompson regarding Mrs Czerniejewski's capacity assessment (querying if the assessment carried out on 1 February 2019 was accurate) and it outlined multiple issues with her safety and wellbeing – including the safety and wellbeing of staff caring for her.

**Mersey Community Hospital (MCH): 10 February 2019**

Mrs Czerniejewski presented to the MCH with a blocked IDC and community nurses were concerned about her leg wounds. Mrs Czerniejewski was apparently wetting her dressings herself which was interfering with the nurse's dressing regimen. Nursing notes state Mrs Czerniejewski was screaming in pain even without being touched but that she requested a lot of assistance with feeding, repositioning etc. The notes state:

"*Staff phoned husband who said could we put pt in respite as he can no longer look after her. He stated that pt is very demanding and difficult and he does not know how to care for her anymore. Husband states that he does not know* [how] *he would be able to get her inside and on the couch. She does not*

[2] Abnormally swollen with fluid.

[3] Exhibiting abnormal redness of the skin due to the accumulation of blood in dilated capillaries (as in inflammation).

*leave the couch, wears pull ups to have bowels open, and has IDC in. Pt unable to stand, unable to step transfer and they have a level 2 package with community nurses coming in once a week to dress her wounds. Pt states she has not done anything about getting more help… Note put in for after hours for social* [?work] *to visit as husband states he would like respite as he can't even change her nappy properly any more. She does not shower or wash as she is couch bound. Pt stated that she has had all this already but doesn't need it as her husband should do it because he doesn't have anything else to do*"
Mrs Czerniejewski was discharged the same day.

**Presentation to NWRH Emergency Department (ED): 20 February 2019**
Called AT for issues with IDC – Mrs Czerniejewski stated it had been inserted incorrectly and was leaking. AT notes state the ambulance officers were verbally abused by her. The IDC was changed by ED nursing staff after the third attempt. Many notes of verbal abuse, screaming and yelling, refusing to cooperate or for example to have vital signs assessed in the ED. Mrs Czerniejewski was discharged the same day.

In August 2019 Community Health Nursing requested a community occupational therapist review Mrs Czerniejewski (she had previously refused to undergo this assessment) regarding appropriate seating in her house. A new couch/chair was ordered and delivered following the assessment however Mrs Czerniejewski was unhappy with it.

An ACAT[4] assessment was performed on 12 September 2019. It noted "*Ralph has limitations to what he can do realistically and safely, as he cannot lift Roswitha without risk of injury*". Mrs Czerniejewski declined various aspects of the assessment as she did not believe they were indicated. A level four home care package was recommended with high priority as it was "*aligned to support needs due to rapidly declining mobility, health concerns, vulnerability and caregiver stress and is a key component of enablement in line with Roswitha's wish to remain at home…*"

**Appointment at the eye clinic at the MCH: 22.06.2020**
Mrs Czerniejewski attended an eye clinic at the MCH and saw Dr Robert McKay. She had been referred there by her general practitioner (GP), Dr Fisher, whose referral letter included the following:
"… *Ros is severely disabled from untreated RA and lives in South Riana with assistance from an NDIS support package. She is confined to a couch in less than ideal living conditions, in a cramped living room*

[4] An Aged Care Assessment Team carries out an assessment to determine the level of care a person will require when they move into an aged care facility.

*of a dilapidated house. She is determined to continue living in this remote rural setting and holds entrenched ideas about her own management, no doubt an expression of personality disorder…*".

In Dr McKay's correspondence to the anaesthetic team following the appointment he noted:
"*In the eye clinic she was extremely difficult to examine. Part of this was no doubt due to her chronic pain and immobility… I found it extremely difficult to get her to follow any instruction at all in the clinic without complaint or unwarranted movement and objection… Either way, operating on her very dense cataracts is going to be extremely difficult if she cannot be positioned properly or will not lie still…*"

**Admission to MCH for left cataract extraction and intraocular lens implant: 3 November 2020 until 5 November 2020.**

Mrs Czerniejewski was admitted pre-operatively so some personal hygiene issues could be attended to. She was swabbed pre-operatively with heavy mixed growth plus Vancomycin Resistant Enterococcus (VRE) found in faeces and Methicillin-Resistant Staphylococcus aureus (MRSA) found in a leg wound. Nursing notes include the comment that Mrs Czerniejewski was verbally combative. Extreme care was taken by nursing staff to carry out care needs however Mrs Czerniejewski would complain they were hurting her when no one was in fact touching her. There was much refusing of care and requests by Mrs Czerniejewski during this admission.

**Admission to MCH for right cataract extraction and intraocular lens implant: 17 November 2020 until 19 November 2020**

Pre-operative leg dressings were attended to which took two hours. Mrs Czerniejewski is described as very demanding and particular about her medication regimen and other aspects of her care. This is the final hospital admission.

**Community Health Nursing care**

Community Nursing visits for wound care commenced in 2020 and are documented to have taken place on the following dates: 04, 11, 18 and 25 August; 02, 08, 15, 22 and 29 September; 06, 13, 20 and 27 October; 10 and 24 November; 01, 08, 15, 22 and 29 December.

These wound care sessions are all documented electronically in the Tasmanian Health Service (THS) medical records and the notes outline the difficulties which were experienced by staff in performing the dressing changes at Mrs Czerniejewski's residence. Two nurses usually attended

and took turns during the procedure. Mrs Czerniejewski is noted to be patient at times and compliant as well as being verbally abusive and extremely controlling and demanding. She was observed to pick at her wounds despite being advised not to. Sometimes the dressing change had to be delayed for up to one hour due to Mrs Czerniejewski's behaviour or complaints. She refused to discuss other pain relief options with her GP. The wounds themselves are described in the entries and from their description appear to be advanced and compromised with black and green sections and a lot of slough[5] and moist areas.

A 'Community Health Service Consent' form, dated 28 October 2020, is in the THS records signed by an RN and Mrs Czerniejewski.

Community Nursing visits for wound care continued in 2021 on the following dates: 06, 12, 19, and 26 January; 02, 09, 16 and 23 February; 02, 09, 23 and 30 March; 06, 13, 20 and 27 April; 04, 11, 18 and 25 May; 01, 08, 15, 22 and 29 June; 06, 13, 20 and 26 July; 03, 10, 17, 24 and 31 August; 07, 21, 23 and 28 September.

The issues encountered by nursing staff are demonstrated from the following entries in the notes:

On 19 January 2021:

"*Client agitated on arrival due to her uncomfortable position and repetition of dreadful furniture and discomfort. Pain throughout procedure caused many pauses in procedure, delaying wound care considerably. Frequently client was rude, demanding and using offensive language.*
*Condition of legs indicated a medical review but client refused that GP be contacted re this… Legs wiped with gauze under client's directive but she refused adamantly not to have jelonet* [dressing material] *applied to legs only inadine* [dressing material] *despite being advised that this would assist the wounds*"

On 16 February 2021:

"*Dressings removed, which took 1.5hrs due to Roswitha continually asking me to stop due to feeling like she was going to slip off her chair.*
*She refused to let me assist her back in the chair stating I "wouldn't know what to do."*
*I expressed concern today about the ongoing issues with Roswitha's legs, including a patch at the back of her right leg on the calf area which bleeds when the dressings are removed. I have suggested that she*

[5] Slough is the by-product of the inflammatory phase of wound healing comprising of fibrin, leucocytes, dead and living cells, microorganisms and proteinaceous material.

*could benefit from being transferred to hospital for intensive wound care and possibly antibiotics to help heal her wounds, however Roswitha refused adamantly for me to arrange ambulance transport to hospital stating she would "rather die than go to hospital". I stressed that her health could decline at any stage if infection takes hold due to her wounds, but Roswitha continued to refuse…*"

On 16 March 2021:

"…*CHN* [Community Health Nurse] *was told to stop several times during the removal of the dressings and how to continue to take the dressings off the leg. At nil time was CHN able to progress without the approval of the client and to follow the direction given by saying "there, can't you see, I'm not yelling this is how yelling SOUNDS…" CHN was told how to sit and where her head was placed as client was concerned about CHN posture even when reassured by CHN that this was okay if we could just continue with the dressing…*"

On 23 March 2021:

"*Wound care attended with RN K. Tait for 2.5 hours*

*Positioning of work table, removal of client's blanket, placement of water bottle, bluey under the legs all handled multiple times to client's preference.*

*Client instructed all aspects of bandage removal, debriding white slough, cleaning between the toes, applying inadine, bandaging.*

*Constantly giving derogative comments to writer for galloping too fast, not rolling dressings off in contour with the leg, pulling too hard, while nurse practices* 'less haste more speed.'

*Many pauses, some conversation to relief the intensity of wound care, nurses compassionate of her situation, chair bound and pain in her legs and body.*

*Many times spent adjusting bluey under legs, client taking sips of fluid, inhaler*

*Conforming bandage for bows too long, for knots too short, nurses measuring appropriate lengths and placement to hold Zetuvit* [dressing material] *in place.*

*Client had bleeding around top edge of R) leg due to scratching.*

*At 2 hours writer in tears from the constant verbal instructions and complaints, K. Tait took over. At end of procedure garbage disposed of in outdoor bin, cat let out of bedroom, cat food positioned and blanket replaced onto client as she instructed.*"

On 27 April 2021:

"*…Client appeared agitated, was moaning, groaning & calling out but not specifically to anyone. When writer began to approach client she immediately began telling writer that she could smell the perfume on me (although I was not wearing any).*
*Client began coughing & told writer 'You're going to make my mucus in my throat build up & I won't be able to breathe & I'll die because of all that perfume your wearing'…*
*… Client then began to complain about heat in room. She requested that writer check thermometer near bedroom door for temperature which was 27.4 degrees & then check temperature of thermometer near lounge window which was 24.5 degrees. Client immediately became agitated again about the temperature & stated that 'Ralph knew it wasn't allowed to get that hot in here', 'no wonder she was feeling like this' & 'he has not lit the fire properly'*
*Client asked writer to open hallway door to allow airflow through & same attended.*
*By this time 25 minutes had passed & writer explained this & that the new process was that the dressings were to be commenced within 15 minutes. Client stated 'stop rushing me' but then allowed writer to remove blankets from her legs, whilst instructing writer on how to do so.*
*Writer attempted to explain to client that I had not worn any perfume that day but was cut off by client stating 'what you don't even wash your hair with shampoo or put moisturiser on your skin?' writer again tried to explain to client that on days that I know I am visiting her I try to ensure I do not put any products onto my skin & that all of my clothes washing products & skin care products are natural, vegan & perfume free. Writer was cut off multiple times as client interjected stating 'I don't care what you think you do or don't use, I can smell it & feel my airways building up with mucus & I won't be able to breathe before long'.*"

On 13 July 2021:
"*Home visit attended for wound care and dressings with RN C Graham, client was refusing to have a male give her care, she found it demeaning, she continued to state she didn't want any nurses in her home, she was continually rude and abrupt during the time we spent there, she reluctantly agreed to nursing care, she insisted on smelling my arm and ranted about perfume and deodorants, all the time agitated and accusing us of lying, I told her she will not be smelling my arm or any part of my body as it is demeaning as I am not an animal, the client refused to let us take photos of the lower legs for the wound chart.*
*After what was a 40 minute dressing change and wound care for one nurse, became a 120min stressful experience for both nursing staff.*"

A file note entered in the Community Nursing notes on 24 August 2021 says:

"*Conversation had with B. Miles NUM re the emotional difficulty and mental endurance required by writer and other staff to attend to client's wound care.*
*She maintains control over every aspect of procedure; set up, removing conforming bandages, cleaning, dabbing, wiping, folding gauze, tying bows or knots, positioning bluey, pushing back cushion on foot stool. When technique is not quite to her liking staff have to try every which way before progress can continue. Throughout the 90 minute treatment staff are berated and ridiculed ie ( nurses tearing skin off, going against what she asks, making wounds too wet, make her legs worse, thinking they know best, not listening, not doing as she says) When staff attempt to correct or defend themselves the situation worsens, then often after a while she may mellow a little.*
*Staff have been unable to improve condition of legs and feet due to immobility and hanging down and she resists all treatments other than those she allows us to do."*

The following long entry was made by one of the community health clinical nurse consultants on 10 September 2021:

"*Home visit attended at 1130hrs with EN Sarah Waite also in attendance.*
*Upon arrival Sarah said hello to Roswitha, to which she replied* "Oh, for F*** sake". *Writer introduced self to client, Roswitha groaned loudly, stated that writer stinks and that the smell of perfume was unbearable. She demanded that writer step back and stand beside the lounge room wall on the opposite side of the room.*
*House unkempt, with lots of clutter. Floors and surfaces visibly dirty. Soiled cushions beneath Roswitha and unwashed blankets sitting on her wounds also contacting the floor. Majority of wounds exposed, large areas of slough present, with substantial oedema present in bilateral feet with large amount of exudate visibly leaking onto the floor.*
*Sarah completed wound care. Please see her notes for further details regarding this.*
*Writer observed and offered to assist, but Roswitha declined, stating "you sit down, shut up and don't move, or you can get out".*
*Roswitha was verbally abusive for most of the home visit. She swore at both nurses multiple times, raised her voice and yelled at nurses several times. Writer told Roswitha that her behaviour was unacceptable and that she could not speak to the nurses in this manner. This angered Roswitha further and her behaviour escalated.*
*Roswitha controlled every aspect of her wound care and dictated to the nurses regarding their actions and behaviour. The wound care process was time consuming due to Roswitha's demands, including placement of blankets, blueys, tables and chairs. Roswitha would not allow Sarah to use the sterile forceps or gloves and insisted that wound care be completed with hands using non-sterile gloves. She also refused nurses to use hand sanitiser despite education. She would only allow Sarah to remove approx. 1cm of*

*dressing at a time and was requesting that Sarah take part in actions that are inappropriate. For example, she wanted Sarah to debride viable tissue from her leg, and she wanted Sarah to pull the dressings off that were stuck and would not allow a soak prior. Roswitha would dictate which direction each dressing had to be pulled, rolled, cut or tied. She also determined whether cleansing would consist of dabbing or swiping and would only allow certain sections of her wounds to be cleansed. Twice Roswitha kicked her foot at Sarah, which resulted in Sarah losing grip of the dressing. Roswitha would then yell and verbally abuse Sarah. Throughout the procedure, Sarah voiced her concerns with Roswitha's requests. In response Roswitha would yell at Sarah until she abided. Roswitha would then blame Sarah if an area inevitably bled or became painful. Writer intervened several times during visit as practice requested by Roswitha was unsafe and her behaviour was unacceptable.*

*Throughout wound care procedure, Roswitha held a back scratching device and she used this to touch the wound and dressings throughout. She would sit it on the soiled table beside her when not in use. She used the device to show Sarah which dressings needed to be removed when, in which order and which angle they were to be removed at. She cross-contaminated countless times during the procedure but accused Sarah of "double dipping" the gauze into the dressing tray. Roswitha blamed MLCHN for the wound infections she has experienced, despite writer providing insight that her requests of leaving the wounds uncovered and having various items touching the wound was a more likely cause.*

*Roswitha threatened the nurses present and MLCHN with legal action several times during the visit. Stating that MLCHN nurses had caused the wounds initially and are the reason they are not healing. On one occasion, Roswitha threatened that writer would be charged with murder in response to writer stating that writer and Sarah would leave the home if her abuse continued.*

*Writer attempted to educate Roswitha that the dressing regime she requests is inappropriate, ineffective and does not comply with evidence-based practice. Writer discussed that practice being performed at Roswitha's request is often unsafe, detrimental to her health and makes the nurses uncomfortable. Roswitha responded that MLCHN nurses are stupid, unskilled, and that her knowledge was superior. She said that the only reason her feet are leaking is because nurses cleanse the wound with water and it gets trapped beneath her dry skin and must escape somehow. Writer provided oedema education and Roswitha told writer to "shut up and stop being ridiculous".*

*Writer offered alternative dressing options and explained that an increased visit regime was needed. Roswitha declined this stating that she wouldn't want us in her house anymore than weekly as we are "unbearable and annoying". She also stated that she had tried every other dressing product the nurses recommended and that it never works because our knowledge is "useless", and we are "pathetic". Roswitha agreed that she recognised some of her requests are outside of the nurse's scope of practice and are not supported by evidence, however her response was that we could "shut up, stop arguing and do what we're told". Writer attempted to gain further information from Roswitha regarding her care*

*needs and the assistance she currently receives from carers etc. Roswitha stated it was "none of my business, hurry up and get out of my house".*
*Wound care took 2.5 hours in total. Ultimately, Roswitha requested applying two zetuvits to her posterior lower legs (areas that had no wounds and were not leaking). She requested that her bilateral feet were cleansed with undiluted betadine solution, and small strips of conforming bandage be applied loosely around various sections of the feet and tied with knots to keep them in place. Most of the wounds remained uncovered at Roswitha's request. Throughout the procedure, both nurses tried to educate Roswitha on the detriment this dressing regime may have, but she would not see reason and resorted to abuse. Her requests were unreasonable and unsafe the entire visit. The above has been reported to NUM Miles and SRLS will be completed*."

Following the above entry the following note was entered into the records on the same day:

"*Phone call to client as instructed by NUM Miles.*
*Sarah Waite also present for conversation as a witness, Roswitha informed of this.*
*Writer informed Roswitha of MLCHN* [Mersey Leven Community Health Nursing] *management decision to withdraw service.*
*Explained to Roswitha the reason for this decision being verbal abuse towards staff, behavioural concerns directed at staff, unsafe working conditions and non-compliance with nursing care.*
*Roswitha stated that she did not agree with this and that she had felt attacked by MLCHN nurses. She stated that MLCHN had no right to withdraw service.*
*Writer explained that Roswitha's behaviour has been a concern for a long period and that our service will not tolerate verbal and psychological abuse, or threatening behaviour, as per the THS zero tolerance policy.*
*Advised Roswitha that she would receive a formal letter of notification of service withdrawal next week.*
*Advised Roswitha to contact her GP for future care arrangements."*

On 15 September 2021 RN Miles, the nurse unit manager for the Mersey-Leven Community Health Nurses made the following entry in the records:

"*Phone call to Roswitha Tuesday 14th September at 1103. Introduced myself and explained to Roswitha that I was phoning in relation to my decision last week to withdraw service due to her ongoing abuse of staff. Roswitha responded saying that the nurses abuse her and are verbally aggressive towards her, I encouraged Roswitha to make a formal complaint if she is unhappy with the care she receives. Roswitha stated she has spoken with Dr Fisher about our withdrawal of service and he told her to find someone else. I asked if she had done so and she said no.*

*I explained to Roswitha that I would like to come and discuss with her further the reason the decision was made to withdraw service. I told her that I could come to see her and I would do the wound care while I was there. Roswitha asked if I would listen to her or would I do whatever I wanted. I explained to Roswitha that I would follow the wound care chart and assess the status of her wounds when I arrived. Roswitha stated that Dr Fisher had requested wound swabs, when I asked if she had the forms there she stated no. I asked if it was alright for me to contact the GP clinic to ascertain whether the request forms were there. Roswitha said no, I could just take the swabs and deliver them to the GP clinic. I explained to Roswitha that in order for the swabs to be processed there would need to be a request form, she again stated that she did not want me to contact the GP clinic regarding pathology forms.*
*The phone conversation lasted 49 minutes during which Roswitha made the following comments:*

- *The nurses don't listen to her;*
- *She knows how the wound care needs to be done;*
- *Just because it is in the "book" doesn't mean that is the way to do her wound care;*
- *She said the nurses are causing her infections because when they don't listen to her re how to attend the wound care they cause more wounds;*
- *The nurses wear perfume or the perfume from their washing powder/deodorant/shampoo causes her to have difficulty breathing due to her allergies;*
- *The nurses are liars;*
- *The nurses bump her legs causing injury;*
- *When removing the dressings the nurses cause more wounds because they don't listen to her about rolling off the dressing in one direction and then another;*
- *She hates having the nurses come and she is a wreck for 2 days afterwards due to the pain and breathing difficulties she has during their visits;*
- *The nurses are not telling me everything about their visits because they are afraid they will get in trouble;*
- *The nurses hurt her; and*
- *When she asks the nurses to stop what they are doing or change the way they do things they become verbally aggressive towards her.*

*Throughout the conversation I encouraged Roswitha to make a formal complaint if she is unhappy with the care the nurses are providing.*
*A number of times Roswitha stated that different nurses come to her all the time and the difficulty arises when new nurses do not listen to her regarding how to attend her wound care. On review of Roswitha's*

*notes she has had the same nurse each weekly visit since 22nd June except for 3 occasions. One of the two nurses who visited on the other three occasions had visited Roswitha previously.*
*Roswitha agreed to me visiting her tomorrow at 12 pm to attend her wound care and to document a plan of care that she is happy with and that the nurses can follow*."

RN Miles visited Mrs Czerniejewski on 15 September 2021. There are comprehensive notes in the THS records. The visit (including attending to the dressings) took three hours and twenty minutes. A plan of care was written up, given to Mrs Czerniejewski and also sent to the GP, Dr Fisher.

On 17 September 2021 a referral to Community Nursing is in the medical records requesting "Resumption of visits for wound care".

What transpired in a phone call to the Community Health Nurses from Dr Fisher on 21 September 2021 is recorded as follows:
"*Phone call from Dr John Fisher (Patrick Street Clinic) earlier this morning in response to letter sent to him following visit to Roswitha last Wednesday 15 September. Dr Fisher stated he commiserated with the nurses in their frustrations regarding the care they are allowed to provide to Roswitha. He stated that Roswitha has always been extremely controlling of the care she receives. He stated that Roswitha's medication list is very much controlled by Roswitha, he also stated that her analgesia is not ideal but it is all Roswitha will accept. Dr Fisher stated he has told Roswitha that there is really nothing more that can be done with her feet and that the antibiotics are tokenistic only. Dr Fisher would also be interested in participating in a case conference with community nursing and Roswitha's NDIS package providers if one can be arranged. He stated it is difficult caring for someone with a "Personality Disorder" and it is important that all involved are aware of the overall situation*."

File notes made on 28 September 2021 include the following:
"*NUM followed up with client re the signing on the service consent form prior to care today. Client had completed the form prior to arrival giving consent to one component only of consenting to 'take part in an assessment and be involved in decisions about my care needs'. All other components of consent form were completed 'no' consent given. Client expressed not understanding the form post another discussion today with her to further explain. Client was offered the opportunity to discuss with Advocacy Tasmania which client declined. NUM to follow up again on signing the form next visit. Client also provided her 'plan of care' to staff this visit with amendments she feels are required prior to agreeing with plan. NUM to follow up.*

*Wound care attended as per 'plan of care'. Client directed the care during visit. Care paused multiple short periods during the visit for client to have a drink, reposition and have a 'break' due to pain. As indicated in plan of care, care resumed after short rest intervals. Whilst removing dressings as directed by client, one area of bandaging on right leg had adhered to wound which caused skin to lift when removing the dressing. A betadine soak was provided with minimal effect on releasing the bandage. Client declined any photos to be taken this visit feeling that the photos did not explain the situation and instead conveyed the opinion of service. During cleanse client identified pain, particularly to her right foot. With pressure of gauze only, this was causing pain and a level of distress to client. Betadine only dripped over toes due to pain tolerance and client request. Small areas of unviable, macerated tissue removed with cleanse from foot. Wound care attended to within one hour and five minutes this visit. On departure there were open areas of wound still exposed and blueys replaced onto the floor underneath client's feet.*

*Client reported the wound swabs taken recently were 'inconclusive'.*

*Client reported she is developing a pressure area where her 'leg meets the bottom' because of the couch springs. This area was not viewed during our visit at client request.*"

On 04 October 2021 RN Miles noted,

"*Phone call to client. I asked Roswitha if she wants Community Nurses to continue visits. She stated only after amendment to "Plan of Care" as it is biased and one sided. I asked if Roswitha would sign the consent form. She stated she does not need to sign it if she does not choose to. I explained that it is the Charter of Aged Care Rights that she can choose not to sign, she does need to sign the Community Health Service Consent before the Community Nurses can continue to visit. I explained to Roswitha that she has signed this form twice before. Roswitha stated that there have been changes to the form and she would not sign it without seeking legal advice. I stated she was welcome to seek legal advice and explained that the form is a statewide form and all of our clients sign it as a consent to us providing them with nursing care. Roswitha again stated that it needed some amendments and she needed to look it over again. I reminded Roswitha that she has had the consent for 2 weeks now. I explained to Roswitha if she would not sign the form the Community Nurses are unable to provide her with our service and that I would notify Dr Fisher of the same. Roswitha again stated she would not sign the consent form without seeking further advice. I told her that I would wait to hear from her. She responded saying "Good luck".*

*Discharged from Mersey-Leven Community Health Nursing.*"

The THS notes include a Community Health Services Discharge form (dated 04.10.2021) which was sent to Dr Fisher and states the reason for discharge, "*Discharged as client declined signing consent form*". A letter was also sent to Dr Fisher informing him about the reasons for the discharge from the Community Health Service.

Ms Newman says from her perspective the Community Health Nurses attempted to provide appropriate care to Mrs Czerniejewski however due to her entrenched ideas, what care she would accept and her general combativeness the care able to be provided was compromised. This was not a fault or a reflection on their capability as nurses; rather Mrs Czerniejewski refused to have it any other way.

Mrs Czerniejewski appears to have been prone to blaming others for the predicament she was in. Ms Newman noted Mr Czerniejewski was not allowed to stay in the room or even the residence when the nurses were present to attend to her dressings. This was pursuant to Mrs Czerniejewski's wish. Ms Newman therefore did not believe any credence can be taken from Mr Czerniejewski's affidavit that the nurses were rough with Mrs Czerniejewski. I agree.

Ms Newman does not doubt Mrs Czerniejewski was in a terrible situation and her pain issues were very real. Unfortunately her attitude and behaviour made caring for her extremely challenging and next to impossible to carry out in an appropriate manner. Nursing staff have thoroughly documented every attendance at her residence and it appears they consistently intended and attempted to provide the correct treatment to Mrs Czerniejewski.

Ms Newman concludes as follows:
*"It is reasonable and appropriate that no one should be subject to abuse and aggression when performing the duties of their occupation. Furthermore, to be obstructed from providing the professional nursing care that was required would have been extremely frustrating and placed the nurses in a very challenging position. The Community Health Nursing service tried to appropriately discuss and rectify the situation with Mrs Czerniejewski however she would not consent to the (fair and reasonable) agreement drawn up to protect both her and the nursing staff. The decision to withdraw nursing care from Mrs Czerniejewski would have been a highly difficult one, not made in haste or entered into lightly. I believe it was reasonable that their services were withdrawn."*

I accept the opinion of Ms Newman. There was nothing untoward about the level and standard of care provided to Mrs Czerniejewski. She received the level and standard of care which she would permit nursing and caring staff to provide. In my view the staff who assisted Mrs Czerniejewski ought to be commended for their dedication in providing the assistance set out above.

**Comments and Recommendations**

The circumstances of Mrs Czerniejewski's death are not such as to require me to make any comments or recommendations pursuant to Section 28 of the *Coroners Act* 1995.

I convey my sincere condolences to the family and loved ones of Mrs Czerniejewski.

**Dated:** 1 October 2023 at Hobart in the State of Tasmania.

**Robert Webster**
**Coroner**