



# MAGISTRATES COURT of TASMANIA

## CORONIAL DIVISION



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## Record of Investigation into Death (Without Inquest)

*Coroners Act 1995  
Coroners Rules 2006  
Rule 11*

I, Rod Chandler, Coroner, having investigated the death of Gweneth Elsie Lillian Jones

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

- a) The identity of the deceased is Gweneth Elsie Lillian Jones.
- b) Mrs Jones was born on 25 September 1932 and was aged 84 years.
- c) Mrs Jones died on 30 November 2016 at Devonport.
- d) The cause of Mrs Jones' death was left lower lung bronchopneumonia in conjunction with small distal pulmonary embolus following injuries sustained in an accidental, un-witnessed fall, leading to restricted mobility and palliative management.

### **Background**

Mrs Jones was a widow having been married to Basil Henry Jones. They had two daughters. In August 2013 Mrs Jones became a resident of an aged care facility operated by Meercroft Care Inc. (Meercroft) at Clements Street in Devonport.

Mrs Jones' past medical history included melanoma, coronary heart disease, chronic back pain and type II diabetes. She had limited mobility and used a 4-wheeled walker for support.

### **Circumstances Surrounding the Death**

At around 5.00pm on 23 November 2016 Mrs Jones had a fall in her room at Meercroft when placing a book on a bookshelf. She was attended by a staff member who was concerned that she had injured her right shoulder and hip. An ambulance was called. Mrs Jones' daughter, Mrs Gaylyne Marshall, was advised of the incident and she immediately attended. There was a significant delay before the ambulance arrived. In the meantime Mrs Jones lay on the floor, was uncomfortable and became increasingly agitated. Records from Ambulance Tasmania show that an ambulance attended the scene at 6.55pm. Mrs Jones was then conveyed to the Mersey Community Hospital (MCH) arriving at 7.24pm.

In the Emergency Department (ED) Mrs Jones was examined and assessed. Clinical observations showed an oxygen saturation of 77% on room air. She was given supplemental oxygen. A CT scan of the right shoulder showed a comminuted fracture of the proximal right humerus with impaction and displacement. An x-ray of the pelvis showed a subtle discontinuity in the medial aspect of the right superior pubic ramus and inferior pubic ramus

raising the possibility of minimally displaced fractures. Orthopaedic advice was sought from the North West Regional Hospital and a plan was settled for Mrs Jones to be given pain relief with a review in the orthopaedic clinic in one week. Meantime she was to be returned to Meercroft. Mrs Jones was given paracetamol. By this time her saturation level was 96% with supplemental oxygen but was noted to fall when the oxygen was removed.

Mrs Marshall had driven to the hospital and remained with her mother whilst she was in the ED. Staff advised her of the planned discharge to Meercroft and proposed that she travel in Mrs Marshall's car. When it became apparent that Mrs Jones was unable to weight bear a wheelchair was provided and an orderly wheeled her to the car. The orderly then lifted Mrs Jones into the vehicle. Mrs Jones was clearly in pain and was distressed. She repeatedly told her daughter that she should have stayed in hospital.

Mrs Marshall arrived at Meercroft at around 11.30pm. She required a wheelchair and assistance from staff members to convey her mother to her room. Staff were concerned that the hospital had not provided Mrs Jones with any documentation setting out the injuries and a plan for their management. Registered Nurse Ms Marsali Hay later made this entry in Mrs Jones' record: *"...MCH contacted as discharge summary not sent and spoke with Dr C Jarvis. He had not treated Gwen but informed from hospital notes that she had sustained a R) head of humerus # & inferior pubic rami #. She is full check x-ray & follow-up @ Fracture Clinic in one week. She may weight bear as tolerated & for sling to R) arm. Paracetamol only for pain on request of daughter. ED Dr agreed that ambulance transfer would have been more appropriate and would pass on to staff."* No specific information or advice was given with respect to clinical observations including oxygen saturation levels.

I am advised by Mrs Marshall that she was aware that her mother had previously had an adverse reaction to morphine and it was for this reason that she was initially treated with paracetamol. However, Mrs Marshall further advises that she did not insist that her mother's pain only be treated with non-morphine based drugs and she was quite content for her mother to be administered whatever medications were advised to make her comfortable and to relieve her pain. I accept this to be so.

In the morning of 24 November Mrs Marshall visited her mother. She found her disoriented, confused and distressed. That afternoon she was seen by general practitioner, Dr M Abbassian. He noted her to be confused and dysarthric (difficulty articulating words). He discussed Mrs Jones' situation with Mrs Marshall including the treatment options. It was agreed to take a palliative approach and advice was sought from palliative care services, most particularly concerning pain control. Mrs Jones was then nursed in Meercroft's Care facility up to her death on 30 November 2016.

### **Post-Mortem Report**

This was carried out by pathologist, Dr Rosanne Devadas. In her opinion the cause of Mrs Jones' death was left lower lung bronchopneumonia in conjunction with small distal pulmonary embolus following injuries sustained in an accidental, un-witnessed fall, leading to restricted mobility and palliative management.

## Investigation

This has been informed by:

- a) A Police Report of Death.
- b) A statement from Mrs Marshall.
- c) A review of Mrs Jones' records at Meercroft.
- d) Patient Care Report from Ambulance Tasmania.
- e) A report from Meercroft.
- f) A report from Associate Professor (Adjunct) Robert Pegram for Tasmanian Health Service.
- g) A report from Dr A J Bell as medical advisor to the coroner.

In his report Dr Bell includes these observations:

- That a number of the anatomic and physiologic changes that accompany ageing place the geriatric trauma patient at greater risk of injury and death, and impair the capacity to respond to the stress of injury. One review of geriatric trauma reported a mortality rate of up to 30% in elder patients from acute or delayed complications of pelvic fractures.
- Mrs Jones required immediate review by an orthopaedic surgeon. It was inappropriate for her to be discharged back to Meercroft with a review to follow in one week.
- It was inappropriate to have Mrs Jones returned to Meercroft by private car.
- The type of shoulder fracture suffered by Mrs Jones usually involves a semi-recumbent position for sleeping. However, this may be inappropriate for a patient with a pelvic fracture. For Mrs Jones the combination of these two fracture injuries made treatment more difficult.
- It is probable that an orthopaedic review would have led to the conclusion that Mrs Jones' injuries could not be repaired in light of her age. It would have been at that point that palliation could have been commenced and the location of her place of care determined.

## Findings, Comments and Recommendations

I accept the opinion of Dr Devadas upon the cause of Mrs Jones' death.

In my view Mrs Jones' age and her underlying co-morbidities exposed her to the very real risk of the fracture injuries to her shoulder and pelvis causing a cascading deterioration in her health leading to her death. This likelihood was very real irrespective of the level of care provided by the MCH. Nevertheless there is an aspect of that care which in my view warrants comment. That relates to the decision taken to discharge Mrs Jones back to Meercroft utilising private transport and without the provision of any documentation setting out her injuries and detailing her care needs including pain control and the recommended clinical observations, notably her oxygen saturation levels. In my view this decision was inappropriate and ill-considered having regard to Mrs Jones' age, the time of night and the nature and seriousness of her injuries. Instead it would have been more appropriate, and in accord with Mrs Jones' needs, for her to have stayed in hospital and the next morning

undergone an orthopaedic review along with a considered assessment of the best treatment option. If it was then resolved that palliation was the best course then a proper plan would need to have been settled including whether Mrs Jones was to return to Meercroft or remain in hospital.

Finally, it is a matter of regret that there was a near two hour delay before Ambulance Tasmania arrived at Meercroft to attend Mrs Jones. During this time she lay on the floor and understandably became anxious and distressed. However, I have not investigated this issue further as the delay in the ambulance staff attending to her was unlikely, in my view, to have been a factor which contributed to her death.

I have decided not to hold a public inquest into this death because my investigation has sufficiently disclosed the identity of the deceased, the date, place, cause of death, relevant circumstances concerning how her death occurred and the particulars needed to register her death under the *Births, Deaths and Marriages Registration Act 1999*. I do not consider that the holding of a public inquest would elicit any significant information further to that disclosed by the investigation conducted by me. The circumstances of the death do not require me to make any further comment or to make any recommendations.

I convey my sincere condolences to Mrs Jones' family and loved ones.

**Dated:** 20<sup>th</sup> day of September 2018 at Hobart in the State of Tasmania.

**Rod Chandler**  
**Coroner**