



MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Simon Cooper, Coroner, having investigated the death of Barry Alyn Lumley

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

- a) The identity of the deceased is Barry Alyn Lumley;
- b) Mr Lumley died as a result of injuries sustained in a witnessed fall at the Meadow Mews Plaza, Kings Meadows;
- c) The cause of Mr Lumley's death was an acute subdural haematoma; and
- d) Mr Lumley died on 12 August 2019 at the Launceston General Hospital, Launceston, Tasmania.

Introduction

The above findings, and those that follow, are informed by the following information, documents and evidence:

- Police Report of Death for the Coroner;
- Declaration of Life Extinct – Launceston General Hospital;
- Opinion of Dr Donald Ritchey, Forensic Pathologist;
- Records – Ambulance Tasmania;
- Medical Records – Tasmanian Health Service – Launceston General Hospital;
- Affidavits establishing identity and life extinct;
- Affidavit of Mr Mark Lumley, sworn 8 November 2019;
- Affidavit of Mr Christopher Leeson, Coles employee, sworn 14 October 2019;
- Affidavit of Ms Lee-Anne Patterson, Manager, Glenara Lakes residential aged care facility, sworn 14 October 2019;
- Affidavits of attending police;
- Police photographic evidence;
- Reports dated 15 January 2020 and 20 April 2020 of Dr Anthony J Bell, Medical Advisor to the Coronial Division;
- Statement dated 2 April 2020 – Dr Paul Pielage; and
- Letter from MDA National dated 2 April 2020.

Background

Mr Lumley was born on 30 June 1938 and raised in Launceston.

After a period of national service in the Royal Australian Navy, he married Beverley Constance McLatham in 1960. Together they had two children, divorcing after 26 years of marriage. Mr Lumley married again in 1987 to Robin Lumley. The couple lived in Youngtown.

Mr Lumley worked in many different jobs over the years, including at a fencing company working his way up to management and then serving as a director of the Tasmanian Timber Promotion Board until his retirement. He was aged 81 years and living in supported accommodation at Southern Cross Care (Tas) Inc., Glenara Lakes Apartments, Youngtown, at the time of his death.

It is evident that Mr Lumley was active within his community and was a life member of several volunteer organisations. His contributions were recognised formally when in 2017 he was awarded the medal of the Order of Australia for his work in senior education.

He was described by a staff member at Glenara Lakes as 'very astute, caring [and] highly involved in village life'.¹ Mr Mark Lumley described his father as having a 'get on with it attitude'.²

Mr Lumley appears to have enjoyed relatively good health over the years, however, he was diagnosed and successfully treated for prostate cancer when he was 70 years of age. He also suffered high blood pressure. Mr Lumley's wife's health deteriorated to such an extent that it was necessary for him to become her carer. She passed away in June 2019.

In the twelve months prior to his death, Mr Lumley began to lose weight and mobility. He was described as shuffling when he walked and needed the assistance of a cane. His local GP provided advice as to how to regain physical condition during this time.

On the day before his death, Mr Lumley attended a resident's meeting. He was described as in good spirits.

On Saturday, 10 August 2019, Mr Lumley went to the Meadow Mews Plaza at Kings Meadows, Launceston, to shop for food and the like in preparation of a visit from his daughter, Michelle.

¹ Affidavit of Lee-Anne Patterson, sworn 14 October 2019, page 1 of 2.

² Affidavit of Mark Allen Lumley, sworn 8 November 2019, page 1 of 4.

As he pushed a shopping trolley (shuffling his feet), his legs began to shake and he fell to the ground. These actions were captured on CCTV. It is clear from the CCTV that Mr Lumley simply fell – nothing or no one caused him to fall.

He had a small bleeding injury to his head and was transported to the Launceston General Hospital (LGH) by ambulance, arriving there at 4.39pm. Upon arrival, Mr Lumley was confused. A small haematoma on the back of his head and some bruising on his arms were noted. Mr Lumley reported chest pain and was referred to cardiology and given an ECG at 7.51pm. His vital readings were noted at this time to be similar to previous ones.

No CT scan of his head was carried out at the LGH.

On 12 August 2019, at 6.57am, Mr Lumley complained of a headache. He was given paracetamol. Forty minutes later he reported the pain had passed. At 8.45am, he was found slumped forward in his bed, unresponsive and was taken for a CT scan which revealed a right side subarachnoid haemorrhage. At 11.45am, the bleed was deemed so severe that Mr Lumley would not survive and palliative care was provided. Mr Lumley died at 10.10pm.

Investigation

The fact of Mr Lumley's death was reported in accordance with the requirements of the *Coroners Act 1995*. Mr Lumley was identified by his son and then transported to the mortuary at the Royal Hobart Hospital (RHH).

At the RHH, experienced Forensic Pathologist, Dr Donald Ritchey, examined Mr Lumley's body and reviewed his medical records. He provided a report, in which he expressed the opinion, that the cause of Mr Lumley's death was an acute subdural haematoma, in the setting of a closed head injury sustained in a fall from standing height. Dr Ritchey observed that significant contributing factors were frailty of age and hypertension.

I accept Dr Ritchey's opinion.

I am satisfied that there are no suspicious circumstances associated with Mr Lumley's death.

Medical treatment

In his affidavit, Mr Lumley's son, Mark, said that his family and he were "curious to know why the hospital didn't conduct a CT scan when dad first went into hospital as he told the ambulance he had hit his head when he fell in Coles". The question is, in the circumstances, quite reasonable.

One premise of the question probably requires clarification. The Ambulance Tasmania report contains no record of Mr Lumley telling attending paramedics that he had hit his head, although there is reference in the records to a 'developing haematoma R parietal with small blood loss (self-control) from graze, without headache or visual disturbance'. Self-evidently, perhaps, that injury could only have been evidence of a head strike. And given that upon his arrival at the LGH ED, Mr Lumley was assessed and specific reference to a head strike in the right parietal region was recorded in his medical records, in practical terms, little turns on this.

The doctor who reviewed Mr Lumley upon his arrival in the ED seems to have discussed his case with Dr Pielage, the ED consultant. It seems that it was concluded that Mr Lumley had suffered some type of myocardial infarction causing a syncopal episode. Accordingly, Mr Lumley was referred for cardiology. An ECG was carried out, but showed nothing to suggest any cardiac problem, in particular, no evidence of ischaemic heart disease. No CT scan of his head was ordered. He was prescribed with anticoagulant medication.

He remained stable throughout Sunday, 11 August 2019. No CT scan of his head was ordered that day either. In fact, it appears that any consideration of the possibility that Mr Lumley had suffered a head injury was overlooked, ignored, or positively excluded once it was concluded that he was suffering a cardiac issue (which he was not).

The Canadian CT scan rule is the accepted 'best practice' guide for clinicians in relation to when, and in what circumstances, to order a CT scan. This rule lists criteria that require a CT scan. Included in that list as a standalone criteria is an age greater than 65 years. The application of that rule required a CT scan of Mr Lumley's head to be performed.

Conclusion

Imaging, in the form of a head CT without contrast, is standard practice for older patients with a head strike and probable mild traumatic brain injury.

There is no reason I can discern why a CT scan of Mr Lumley's head was not performed. His chances of survival and recovery were, in my view, markedly reduced by the decision not to carry out that standard procedure.

I note that Dr Pielage, at paragraph 29 (H) of his statement, highlights that the ED doctor had recorded 'Canadian CT head rule 1 – for age alone', apparently reflecting his intention for a CT scan to be performed on Mr Lumley.

It is evident that performing a CT scan was considered and ultimately, for reasons not clear, not performed.

Comments and recommendations

The circumstances of Mr Lumley'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 Barry Alyn Lumley OAM.

Dated 24 May 2021 at Hobart in the State of Tasmania.

Simon Cooper
Coroner