



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 Mary Weir

Find That:

- (a) The identity of the deceased is Mary Weir;
- (b) Mrs Weir died in the circumstances described in this finding;
- (c) Mrs Weir died as a result of a subdural haematoma due to a closed head injury following a fall from bed whilst hospitalised;
- (d) Mrs Weir died on 6 September 2014 at Calvary Hospital, Hobart in Tasmania; and
- (e) Mrs Weir was born in Hobart on 18 January 1934, was aged 80 years at the time of her death; she was a widow whose occupation was a retired small business owner.

Circumstances Surrounding the Death:

Mrs Mary Weir was admitted to Calvary Hospital as the result of a referral from her general practitioner on 25 August 2014. Aged 80 years her health was poor with, in particular, chronic heart failure and cellulitis of grossly swollen legs.

Upon admission, Mrs Weir was assessed by staff as being a patient at high risk of falls and, appropriately, a high risk falls prevention plan was initiated.

Subsequent to her admission an improvement in her general medical condition was noted.

Unfortunately, in the early hours of 30 August 2014, Mrs Weir suffered an unwitnessed fall in the bathroom of her room. She had, according to notes in her medical record, neither rung for assistance (as she had been instructed) nor used her four wheel walking frame (also as she had been instructed).

Nursing staff were concerned that Mrs Weir had hit her head in the fall. She was observed for four hours. Her observations were stable. At 4.50am on 30 August

2014, Mrs Weir was reviewed by a House Medical Officer who concluded, wrongly as subsequent investigations would reveal, that Mrs Weir had not suffered any injury.

Subsequent reviews later that day and the next led to notes being made in her medical records that Mrs Weir was progressing well.

At 1.20am on 1 September 2014, Mrs Weir was found by nursing staff to be unresponsive and a 'Code Blue' emergency response was initiated. She was resuscitated and administered Digoxin IV for a rapid heart rate and the anticoagulant drug Clexane (60 mg) for what was presumed to be a thrombotic stroke.

At 2.10am Mrs Weir suffered a seizure. On the advice of an intensive care specialist doctor, the anti-convulsive drug Dilantin and Amiodarone for heart arrhythmia were administered to Mrs Weir. Another seizure followed and a CT scan of Mrs Weir's brain was carried out which showed an acute left cerebral convexity subdural haematoma without mass effect. A follow up CT scan seven hours later showed no change. A neurosurgeon reviewed Mrs Weir and concluded that because there was no mass effect from the haematoma, surgery was not required.

Responsibility for Mrs Weir's care was then taken over by an intensive care specialist. Unfortunately, she continued to suffer further seizures despite her receiving anti-convulsive therapy. Her condition continued to deteriorate, developing chronic renal failure and poor cardiac function. It was concluded that further treatment was futile, life support was withdrawn, and shortly after about 3.00pm on 6 September 2014, Mrs Weir died.

A report was prepared for the Office of the Coroner and an investigation commenced pursuant to the *Coroners Act* 1995 into the circumstances surrounding Mrs Weir's death.

That investigation included, after formal identification of the body, an autopsy at the Royal Hobart Hospital. The autopsy was performed by Dr Donald Ritchey MD, MSc, FRCPA, a forensic pathologist. Dr Ritchey's opinion was that the cause of Mrs Weir's death was a subdural haematoma caused by a closed head injury sustained in a fall in a hospital. I accept this opinion.

The care afforded to Mrs Weir whilst a patient at Calvary Hospital was reviewed as part of the coronial investigation by Clinical Professor Anthony Bell MD FRACP FCICM. Prof. Bell concluded, and I accept, that no fault can be attached to the nursing staff in respect of Mrs Weir's fall.

However two issues arose from a consideration of her care. First, given her age and the fact that Mrs Weir was taking antiplatelet agents, aspirin and clopidogrel, as well as a small prophylactic dose of the anticoagulant drug Clexane, a CT scan of her brain should have been carried out on the morning of her fall. It was not, and as has already been indicated, no CT scan was carried out for two days.

Second, and of very serious concern, was the decision after the discovery of Mrs Weir being non-responsive at 1.20am on 1 September 2014, to treat her with a full dose of Clexane on the basis of a presumed stroke due to atrial fibrillation, without first carrying out a plain CT scan. It is a basic principle of treatment in the circumstances that then pertained to carry out a plain CT scan before any thrombolytic therapy or anticoagulation, so as to exclude a cerebral haemorrhage. Moreover, to have administered a full dose of anticoagulant medication where there was clear evidence of a fall and likely resultant head injury was not sound practice. By the time the CT scan was carried out, belatedly in my view, the damage caused by the full dose of Clexane resulted in significant and accelerated bleeding from the subdural haematoma on Mrs Weir's brain (which in turn caused seizures).

It seems clear in the circumstances a decision was made to treat Mrs Weir with Clexane on the basis of a presumed stroke due to atrial fibrillation. The decision was wrong. It was unsound medical practice. The making of the decision by a House Medical Officer without consulting with the appropriate treating specialist was also unsound practice.

I am satisfied that the administration of a full dose of Clexane in the circumstances outlined contributed to the cause of Mrs Weir's death.

I record that Calvary Hospital was afforded the opportunity to comment upon this case during its investigation and comment upon my proposed draft findings. The Hospital replied by indicating that it 'takes the matter very seriously', that Mrs Weir's death is the subject of a review by the hospital's Clinical Review Committee and that recommendations arising from that review would be implemented.

Comments and Recommendations:

The circumstances of Mrs Weir's death require me to remind all hospitals and medical practitioners of the need not to administer anticoagulant medication to any patient with a history of a fall without first having a plain CT scan of the patient's brain done.

In conclusion I wish to convey my sincere condolences to the family of Mrs Weir.

Dated: 7 September 2015 at Hobart in the state of Tasmania.

Simon Cooper
Coroner