MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995

Coroners Rules 2006

Rule 11

I, Olivia McTaggart, Coroner, having investigated a death of Freda Lillian Florence Dent

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

a) The identity of the deceased is Freda Lillian Florence Dent;
b) Mrs Dent died in the circumstances set out below;
c) The cause of death is ischaemic heart disease; and
d) Mrs Dent died on 22 September 2016 at Lindisfarne, Tasmania.

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Mrs Dent's death. The evidence comprises the police report of death, an opinion of the State Forensic Pathologist who conducted the autopsy, identification and life extinct affidavits, medical and nursing home records and reports, family statements, and an opinion of the coronial medical consultant.

Freda Lillian Florence Dent was born on 29 August 1931 and was 85 years of age when she died. Mrs Dent was widowed and has four children.

The evidence indicates that Mrs Dent had a significant medical history, including coronary artery disease for which she underwent a coronary artery bypass in 1996. Prior to her death she also suffered chronic obstructive pulmonary disease, bronchiectasis, hypertension and chronic kidney disease. Mrs Dent was under the regular care of her general practitioner, Dr Alice Frampton, who prescribed medication for her conditions. Dr Frampton described Mrs Dent as being cognitively competent.

In June 2015, Mrs Dent became a resident of the Freemasons Home, now known as Masonic Care Tasmania. Dr Frampton continued to see Mrs Dent on a regular basis whilst she was a resident there. Mrs Dent also had the support of her children.

The evidence indicates that, whilst at Freemasons, Mrs Dent enjoyed various activities and that her care and medical needs were attended to appropriately.

Although Mrs Dent died of natural causes, family members instigated a report of death to the coroner due to questions concerning her care and treatment on the day of her death.

I set out below the circumstances surrounding Mrs Dent's death and consider the relevant issues.

On 22 September 2016, Mrs Dent telephoned Dr Frampton asking her to visit for the purpose of ceasing her rosuvastatin medication (for cholesterol control) as it was causing her gastrointestinal upset. Accordingly, Dr Frampton left her consulting rooms in Clarence and drove to see Mrs Dent at Freemasons. The time of the consultation was about 1.00pm. There were no nurses or care staff present during the consultation. Mrs Dent expressed to Dr Frampton that she was certain that the medication had caused her nausea, vomiting and diarrhoea and said that, as she had skipped a dose of it, she was feeling better. Dr Frampton agreed to cease it as requested. Dr Frampton noted that Mrs Dent had no abdominal pain and no fever at the time of consultation.

Dr Frampton then recorded on Mrs Dent's medication chart at Freemasons that the rosuvastatin medication was ceased and, on returning to her surgery, she wrote up her clinical notes of the consultation and forwarded them immediately to Freemasons by facsimile. She stated in her report for this investigation that she did not have the opportunity to discuss her plan with any nurse at Freemasons, as there were none available whilst she was there. She noted in her report that she was particularly pressed for time due to other scheduled consultations.

At 4.55pm, Freemasons care staff reported that Mrs Dent had vomited three times, had two loose bowel actions, felt clammy and was feeling unwell. Vital signs were taken and were satisfactory, and Hydrolyte was administered. At that time, Mrs Dent indicated that she had burning and indigestion. These symptoms were reported to an enrolled nurse who gave Mrs Dent a dose of Zoton (lansoprazole, a proton pump inhibitor to reduce stomach acid).

At 5:55pm Mrs Dent reported an improvement in her indigestion and was not nauseated. This improvement in her symptoms was conveyed to the registered nurse in charge.

However, at 6.30pm a registered nurse (RN) noted that Mrs Dent was unable to keep fluids down. She telephoned Dr Frampton and told her that the plan was for hospital transfer to intravenous fluids. Dr Frampton was then given the vital signs taken about 90 minutes previously. There is no evidence that another set of vital signs were taken.

At 6.33pm, the same RN called Ambulance Tasmania (AT) and spoke to the operator.

The recording of the call was available to me in the investigation. The information conveyed by her to the operator was vague and ineffective, particularly relating to Mrs Dent's clinical signs and the correct place for arrival of the ambulance. The RN ultimately told the operator that the situation was not urgent, that she would monitor Mrs Dent and "would appreciate" an ambulance within an hour.

At 8.26pm, the same RN was informed by the enrolled nurse in charge that Mrs Dent had three episodes of diarrhoea and vomiting. The previous observations were again recorded. Mrs Dent was described as rocking back and forward with pain (reported as indigestion) and possibly had chest pain. The RN recorded in the nursing home notes that AT was telephoned again at 7.15pm and on this occasion the ambulance was requested urgently and immediately dispatched by AT. AT records show the call was, in actual fact, made by her at 8.35pm. I find that the call was made at 8.35pm in accordance with the reliable AT records, and not 80 minutes earlier as recorded by the RN.

During this call, Mrs Dent was noted to have ceased breathing and had become unresponsive. Further into the call, the RN advised the operator that Mrs Dent had died and that no resuscitation commenced in accord with Mrs Dent's previously expressed wishes.

At 8.50pm, Dr Frampton was informed by telephone of Mrs Dent's death by one of the nurses at Freemasons.

On 28 September 2016 the State Forensic Pathologist, Dr Christopher Lawrence, performed an autopsy upon Mrs Dent. He concluded that Mrs Dent died as a result of ischaemic heart disease due to stenosis of her coronary bypass grafts. He observed an old myocardial infarction with coronary artery bypass grafts and he noted that the graft to the back of the heart had become blocked. He reported that the abdominal pain complained of by Mrs Dent may have actually been referred cardiac pain. Although he was not able to positively assess any state of dehydration, he noted that Mrs Dent appeared in reasonable condition. I accept the conclusions of Dr Lawrence.

Dr AJ Bell, coronial medical consultant, reviewed Mrs Dent's medical treatment and care in the hours before her death and provided a report in the investigation at my request. The issues identified by him are set out as follows.

Firstly, Dr Bell stated that older frail adults who suffer gastrointestinal upset are more susceptible to dehydration and subsequent complications (for example, syncope and hypotension). Persons with medical comorbidities also require closer follow-up and a

lower threshold for hospitalisation. He therefore indicated that the best practice on the part of Dr Frampton would have been to report directly to nursing staff at the time of the consultation and request that close observation of vital signs should be performed.

Nevertheless, I note that Dr Frampton did take immediate steps to fax her clinical notes to Freemasons, where it might be assumed that the nursing staff would be sufficiently aware of the need to regularly monitor Mrs Dent and record observations. There is no indication of any consideration of Dr Frampton's written notes by the staff.

Secondly, Dr Bell noted that there appeared to be no planned observations and recording of diarrhoea and vomiting volumes, when this should have taken place. The only indication of the vomiting volumes is found on the AT recording of the first call. The vomiting was described as "more than 4 vomits - at least 250mls". Thus, the volume may have been interpreted as a total level of 250mls or alternatively 1000mls. In any event, the nursing staff did not appear to have an action plan for Mrs Dent that included vital sign observations and accurate recording of fluids in and out, so as to be able to assess her state.

Thirdly, the evidence indicates that the nursing staff only became aware of Mrs Dent's symptoms at 4.55pm, nearly 5 hours after the visit by Dr Frampton. Presumably, Mrs Dent did not notify staff or use her alarm bell. Alternatively, staff members did become aware of her symptoms but did not record them in the notes.

Fourthly, the nursing records following this time are repetitive and difficult to follow. Notably, the time of the second AT call is incorrect. This may have been an inadvertent error.

Finally, the first AT call records poor communication and information transfer by the RN to the AT operator. There is no sense of urgency conveyed to the operator. The second AT tape again has poor information transfer by the nurse.

Dr Bell concluded in his report that, in this case, "the picture as a whole is unconvincing as appropriate nursing care". I agree with his assessment.

Comments

In Dr Frampton's helpful and comprehensive report to the coroner, she indicated that Mrs Dent's death has caused her to review her practices so that she now provides care in aged care facilities which are situated only a short drive from her workplace. Further, Dr Frampton now insists that patients discuss their health concerns with the nurses at the

facility, and ensures that nursing home staff are present at consultations to discuss with her the management of the patient.

The Masonic Care report regarding this incident from Ms Jenny Hill, the Executive Director of Clinical Services, accepts the opinion of Dr Bell and the issues set out in this finding. Ms Hill indicates that there is currently a focus on improving communication with general practitioners so that staff can follow clear orders.

Ms Hill also advises that the registered nurse's role in recognising early signs of deterioration in a resident is currently under review; and that the "ISBAR" communication tool is currently being implemented to improve communications with the Ambulance Service.

Finally, Ms Hill indicates that there has been implementation of processes to convey to family members the capabilities of a residential aged care facility, to discuss advanced care directives, protocols for hospital transfer and to ensure regular family conferences.

Despite the issues surrounding her treatment as discussed, Mrs Dent suffered a severe blockage of her coronary artery graft (a "heart attack") causing her death. The evidence does not permit me to determine whether more timely action to transfer Mrs Dent to hospital could have prevented her death. However, it would appear, given her poor general health and seriousness of her heart condition, that the same outcome may have eventuated.

The proposals for improvement in response to medical events indicated by both the nursing home and the general practitioner will, if implemented fully, increase the chances of delivering optimal care and treatment to the residents.

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

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

Dated: 30 October 2018 at Hobart in the State of Tasmania.

Olivia McTaggart
Coroner