MAGISTRATES COURT of TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Rod Chandler, Coroner, having investigated the death of Margaret Evalina Bugg

Find that:

a) The identity of the deceased is Margaret Evalina Bugg;
b) Mrs Bugg was born on 14 February 1926 and was aged 89 years;
c) Mrs Bugg died on 30 December 2015 at the North West Regional Hospital (NWRH) in Burnie;
d) The cause of Mrs Bugg's death was pneumonia and acute renal failure following a fractured right femur due to a fall while being transported by a stand-up lifter.

Background

Mrs Bugg was a widow, her husband having died in 2000. In around August 2009 she had right knee replacement surgery. It was not completely successful and thereafter Mrs Bugg had difficulty mobilising. As a result she was unable to safely live at home. In November 2009 she became a resident of Yaraandoo Nursing Home at Somerset ("Yaraandoo"). Her medical history also included high blood pressure, dementia with a high falls risk, Type 2 diabetes, and a stroke in 2012. She was wheelchair bound.

Circumstances Surrounding Death

In the morning of 17 December 2015 Mrs Bugg was being attended by two carers at Yaraandoo, namely Jamie Hooper and Alison Bluett. They were in the course of transferring Mrs Bugg from her room to her ensuite using a hoist or lifter when a strap became detached causing her to fall towards the floor. She suffered a laceration to her right lower leg. A registered nurse at Yaraandoo inspected the injury and it was decided that Mrs Bugg should be taken to the NWRH for assessment and treatment. At the hospital's Emergency Department Mrs Bugg's lower leg laceration was dressed. She had an x-ray of her left hip which was reported as showing no fracture. She was then returned to Yaraandoo. Over the following few days Mrs Bugg was reluctant to have food and complained of pain. On 23 December 2015 she was taken back to the NWRH. An x-ray of her right leg revealed a spiral fracture of the distal right femur. It was decided with family involvement that the best course of treatment was comfort care with palliation. Mrs Bugg died on 30 December 2015.

Post-Mortem Examination

This was carried out by State Forensic Pathologist, Dr Christopher Lawrence. In his opinion the cause of Mrs Bugg's death was pneumonia and acute renal failure following a fractured right femur due to a fall while being transported by a stand-up lifter.

I accept Dr Lawrence's opinion upon the cause of death.

Investigation

This has been informed by:

- An affidavit provided by Mrs Rosemary Milne, a daughter of Mrs Bugg.
- Affidavits provided by Mr Hooper and Ms Bluett.
- An affidavit provided by Senior Constable Dale Wylie of Tasmania Police.
- A review of Mrs Bugg's records at NWRH and at Yaraandoo carried out by research nurse, Ms L K Newman.
- A report upon Mrs Bugg's medical care made by Dr A J Bell as medical adviser to the coroner.

The investigation has focussed upon two issues. The first concerns the circumstances of Mrs Bugg's fall from the stand-up hoist on 17 December 2015 and how this came to pass. The second concerns the failure to diagnose Mrs Bugg's right leg fracture when she presented at the NWRH on that same day. I will deal with each in turn.

Upon the first issue the investigation reveals the following:

1. That Yaraandoo employs two types of hoists to transfer residents with reduced mobility. One is known as a 'stand-up lifter' which can be utilised for residents who have some capacity to weight bear. The other is known as a 'full hoist' which is needed in the transfer of residents who are unable to weight bear.

2. That on 30 October 2015 Mrs Bugg underwent a mobility assessment at Yaraandoo. The report upon the assessment comments that she: *"now requires full hoist for all transfers, unable to WB (weight bear) safely enough to use stand up lifter."* It then expressly stipulates that Mrs Bugg required a full hoist for transfers. In accord with the assessment Yaraandoo management had affixed a notice in Mrs Bugg's room reminding staff that her transfer required the use of a full hoist.

3. That both Ms Bluett and Mr Hooper were experienced extended care assistants who were familiar with Mrs Bugg and had previously assisted in her transfer within Yaraandoo.

4. That on 17 December Ms Bluett and Mr Hooper were utilising a stand-up lifter and not a full hoist to transfer Mrs Bugg to her ensuite.

5. Ms Bluett says that initially a stand-up lifter was used to assist with Mrs Bugg's mobility but over time a full hoist was introduced. It was her understanding that at the time of the incident on 17 December the practice was for a stand-up hoist to be used

during the day and a full hoist at night. She explains: *"Basically, I thought the standing hoist was still being used for Peg during the day and only the full hoist at night. I had seen other staff using the standing hoist on Peg during the day right up until the day of the incident."*

6. Mr Hooper also confirms that the stand-up lifter was used. He provided this explanation: *"On this day, Alison brought the stand-up lifter in and I didn't check what was supposed to be used. There is normally a card up on the back of the toilet door of what you're supposed to use. I just went with it, so we used that lifter. We wasn't supposed (sic) to, no. I checked the card on the back of the toilet door afterwards and it was there. The card said we were supposed to use a full hoist for Peg. At this time I wasn't sure what lift was supposed to be used. I normally check, but for some reason on this occasion I just went with it. I guess I just trusted Alison. I mean, there's people there that were using the stand-up lifter with Peg, and some just used it by themselves."*

7. The stand-up hoist is fitted with straps that are used to hold the patient in an upright position during the transfer. In this instance the evidence shows that one end of a strap became detached from the hoist on the right side. Mrs Bugg was unable to hold herself upright and lost her grip with her right hand. She fell to one side but remained suspended by the strap which remained attached on the left hand side. Mr Hooper then used the controls of the hoist to then lower Mrs Bugg to the floor. It was then that a laceration on Mrs Bugg's right lower leg was noticed and the registered nurse called.

8. There is no evidence to suggest that the strap became detached from the lifter because of a mechanical fault. This makes it probable that the detachment occurred because of operator error.

I now turn to consider the circumstances surrounding the non-diagnosis of Mrs Bugg's right leg fracture. The evidence shows:

- That in the early morning of 26 November 2015 Mrs Bugg was found on a fall-out mat besides her bed. It was evident that she had fallen from her bed. The only injury noted was bruising to both hands.

- That it was recorded on 16 December that Mrs Bugg was suffering a stage 2 pressure injury to her left hip.

- That the paramedics from Ambulance Tasmania who transported Mrs Bugg to the NWRH on 17 December noted in their Patient Care Report that they did not observe any obvious deformity or new bruising of the right leg. They further noted that Mrs Bugg had had a fall three weeks previously and had significant bruising to her left thigh and arms. (This presumably is a reference to Mrs Bugg's fall from her bed on 26 November although the Incident Report concerning that event makes no reference to injuries affecting the left thigh and arms).

- That the paramedics also recorded that Mrs Bugg complained of pain to her head, abdomen, left arm and lower right leg.

- That a discharge letter written by the NWRH states:

    - *"Thank you for referring Margaret.*
    - *She has had a fall to day.*
    - *She has a skin tear to the right shin. This has been cleaned, steri-stripped and dressed.*
    - *She has been given ADT.*
    - *She has extensive bruising about the left hip from a fall a few weeks ago.*
    - *X-ray of the hip is normal.*
    - *She will need ongoing care of this leg skin tear……"*

- That Mrs Bugg's right leg was not x-rayed.

Findings, Comments and Recommendations

It is apparent, and I find, that because of her general state of health, but particularly because of her mobility difficulties, Mrs Bugg was unsuited for transfer by a stand-up lifter and instead required a full hoist. This state of affairs was recognised by Yaraandoo by late October 2015 and as a result it had caused a card to be placed in Mrs Bugg's room reminding staff of the lifting device to be used. Notwithstanding this notice Ms Bluett and Mr Hooper employed a stand-up lifter when attempting to transfer Mrs Bugg in her room on 17 December 2015. The evidence clearly shows that when the transfer went awry, seemingly because a strap had not been properly attached, Mrs Bugg was unable to support her own weight and fell.

I am satisfied that as a result of the lifting incident on 17 December Mrs Bugg sustained the spiral fracture of her right femur which led to her re-presentation to the NWRH six days later. I am further satisfied that the leg fracture precipitated a decline in her health which led to her demise.

Both Ms Bluett and Mr Hooper assert in their respective affidavits that they were unaware that a full hoist was required at all times to transfer Mrs Bugg. Further, they contend that other staff members were utilising a stand-up lifter for Mrs Bugg and that this practice was ongoing subsequent to the mobility assessment almost two months prior to 17 December 2015. These assertions raise serious concerns relating to the adequacy of those systems which Yaraandoo presumably has in place to ensure that its staff is aware of and complies with all the requirements of all patients care plans. In these circumstances it is my **recommendation** that Yaraandoo carry out a comprehensive review of its practices with a view to reducing the risk of its staff members failing to comply with patient care plans. Mrs Bugg's unfortunate death illustrates the urgent need for this to be done and for any recommended system changes to be implemented.

It is of course regrettable that Mrs Bugg's right leg was not x-rayed and its fracture diagnosed when she presented at the NWRH on 17 December. However, I make no criticism of the

hospital for this missed diagnosis, bearing in mind that Mrs Bugg did not make any complaint of upper leg pain and also given the history of another fall three weeks previously with evident bruising of the left thigh. In these circumstances it was understandable that the clinicians focussed their attention upon the left and not the right lower limb.

In his report Dr Bell has advised me that the surgical repair of Mrs Bugg's fracture was *"high risk"* in the light of her general state of health *"with minimal chance of success."* In these circumstances he advises that the decision to implement comfort care was reasonable. I accept this advice. It follows that in my view it is unlikely that Mrs Bugg's death would have been avoided if her right leg fracture had been diagnosed at the first opportunity.

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.

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

Dated: 12th June 2017 at Hobart in the State of Tasmania.

Rod Chandler
Coroner