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 Julie Anne Holmes

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

a) The identity of the deceased is Julie Anne Holmes;
b) Mrs Holmes died as a result of injuries sustained in a motor vehicle accident;
c) The cause of Mrs Holmes' death was pneumonia; and
d) Mrs Holmes died on 24 July 2017 at the Royal Hobart Hospital, Hobart, Tasmania.

Introduction

1. In Tasmania a coroner has jurisdiction to investigate any death which appears to have been unexpected or unnatural. In this case, because Mrs Holmes died as a consequence of injuries received in a motor vehicle crash, her death was one that had to be investigated by a coroner.
2. When investigating any death, a coroner performs a role very different to other judicial officers. The coroner's role is inquisitorial. She or he is required to thoroughly investigate a death and answer the questions (if possible) that section 28 of the *Coroners Act* 1995 asks. These questions include who the deceased was, the circumstances in which he or she died, the cause of the person's death and where and when the person died. In doing this it is necessary to make various findings, but without apportioning legal or moral blame for the death. A coroner is required to make findings of fact from which others may draw conclusions.
3. Particularly important is the power of a coroner, if she or he thinks fit, to make comments about the death or, in appropriate circumstances, recommendations to prevent similar deaths in the future.
4. A coroner does not punish anyone or award anyone compensation arising out of a death the subject of an investigation. Punishment or compensation is for other proceedings in other courts, if appropriate. Nor does a coroner charge people with

crimes or offences arising out of the death the subject of investigation. In fact, a coroner in Tasmania may not even say that he or she thinks someone is guilty of an offence.[1]

5. As was noted above, one matter that the Act requires is finding how the death occurred. It is well settled that this phrase involves the application of the ordinary concepts of legal causation. Any coronial investigation – and this is no different – necessarily involves a consideration of the particular circumstances surrounding the particular death so as to discharge the obligation imposed by section 28(1)(b) upon the coroner.
6. The standard of proof in any Coronial investigation is the civil standard. This means that where findings of fact are made a coroner needs to be satisfied on the balance of probabilities as to the existence of those facts. However, if an inquest reaches a stage where findings being made may reflect adversely upon an individual, it is well settled that the standard applicable is that articulated in *Briginshaw v Briginshaw*, that is, that the task of deciding whether a serious allegation is proved should be approached with great caution.[2]
7. The material that I have had regard to in completing this investigation includes:
    - an opinion of the forensic pathologist who conducted the autopsy;
    - Mrs Holmes' complete medical records;
    - a report from the medical advisor to the Coronial Division;
    - a comprehensive report from Tasmania Police Southern District Crash Investigation Services;
    - Tasmania Police Report of Death to the Coroner;
    - Royal Hobart Hospital Death Report to Coroner;
    - a lengthy report from the Executive Director of Medical Services, Tasmanian Health Service – Southern Region;
    - a précis of Mrs Holmes' treatment at the Royal Hobart Hospital (RHH) prepared by the Coronial Division Forensic Nurse;
    - the results of toxicological analysis of samples taken at autopsy;
    - Ambulance Tasmania Patient Care Report;
    - a report from a Transport Inspector;
    - affidavits of a number of witnesses;

[1] See Section 28 (4) of the *Coroners Act* 1995
[2] (1938) 60 CLR 336

- affidavits of attending police;
- the results of a crash scene survey;
- Bureau of Meteorology records for Hobart;
- Tasmania Police Traffic Crash Report;
- photographic evidence; and
- relevant records from the Department of State Growth.

Mrs Holmes' background

8. Mrs Holmes was born in Clare Street New Town on 29 November 1945. She had a twin sister and an older brother and sister. Mrs Holmes was educated in the Hobart area. She was a young girl when she met her future husband Richard. After leaving school at the end of year 9, Mrs Holmes entered the workforce as a secretary within the Premier's Department. She later took up a position as a dental nurse in New Town.
9. At the age of 17 Mr and Mrs Holmes commenced their relationship. They were engaged at 20 and married at 25. Before their marriage Mr and Mrs Holmes bought a home at Fern Tree where they remained living up until the time of the crash. The couple had two children; a son Graeme and a daughter Robyn. Graeme and Robyn grew up in the family home at Fern Tree.
10. In about 1980 Mrs Holmes was diagnosed as suffering from Charcot-Marie-Tooth disease (CMT). CMT, a hereditary condition, is a spectrum of disorders caused by mutations in various genes whose protein products are expressed in myelin and/or axonal structures within peripheral nerves. Symptoms include general weakness, distal muscular atrophy, abnormal gait, sensory and feet defect pes cavus. CMT is incurable but rarely fatal. Despite the disorder Mrs Holmes remained active as a volunteer in the aged care sector and a keen bushwalker and gardener.
11. In 2013 whilst on a caravanning holiday Mrs Holmes suffered a minor stroke from which she made a good recovery. In 2015 she suffered another stroke. This stroke led to her suffering paralysis of the right side of her body. Confined thereafter to a wheelchair, Mrs Holmes did not make a recovery from the stroke. As a consequence Mr Holmes retired from his position as a technician at the University of Tasmania and became his wife's full-time carer.
12. On Friday, 21 July 2017 Mrs Holmes was a passenger in a vehicle driven by her husband. Mr and Mrs Holmes had been in the city of Hobart and were returning to

their home at Fern Tree. As the couple travelled south on Huon Road they were involved in a single vehicle crash approximately 150 m south of Summerleas Road.

13. Mrs Holmes suffered injuries in the crash and died at the RHH on 24 July 2017. This finding examines the circumstances of Mrs Holmes' death and particularly the treatment she received as an inpatient at the RHH.

Circumstances of the crash

14. The evidence from expert crash investigators enables me to make the following findings. At about 1.41pm on Friday, 21 July 2017 Mrs Holmes was a passenger in a white Toyota utility. Her husband was driving the utility. As they travelled south on the Huon Road (in the general direction of Huonville) Mr Holmes failed to negotiate a right hand curve in the road. This led to the vehicle leaving the road and heading down over an embankment. Mr Holmes later told investigators he thought he had momentarily fallen asleep immediately prior to the vehicle leaving the road. He estimated that he was travelling at between 45 and 50 km an hour at the time of the crash (the posted speed limit is 60 km an hour). I note crash investigators did not attend the scene of the accident until after Mrs Holmes' death and therefore were not in a position to confirm or refute Mr Holmes' contention in this regard. However, I have no reason to think that he was not being truthful.
15. Crash investigators subsequently calculated that the Toyota travelled approximately 15.8 metres over the embankment before coming to rest against several gum trees. Those gum trees blocked exit from the passenger's side door. Police, Fire and Ambulance officers were on the scene of the crash shortly after it happened. Tasmania Fire Service personnel assisted in extricating Mrs Holmes from the vehicle. She was treated at the scene and then loaded into an ambulance.
16. Mrs Holmes was assessed by Ambulance Tasmania officers as having suffered apparently only minor injuries. However, given her disability, she was transported by ambulance to the Royal Hobart Hospital. The attending Ambulance Tasmania officers were concerned that Mrs Holmes had the potential for a neck injury. Accordingly, a neck brace was applied. However Mrs Holmes complained of discomfort and it was removed. Manual stabilisation of her neck was applied with head rolls en route. Mrs Holmes complained of severe shoulder pain.
17. The evidence obtained as part of the investigation satisfies me that there was nothing about the road surface, weather conditions or mechanical condition of the Toyota which caused or contributed to the happening of the crash. Put another way, the road

surface was in good order, the weather was fine and clear and the Toyota was in good mechanical condition at the time of the crash.

18. Mr Holmes was subject to the usual police post traffic crash testing. The results of that testing satisfies me that neither alcohol nor drugs played any role in the happening of the crash.

Mrs Holmes' treatment at the RHH and death

19. The Ambulance carrying Mrs Holmes arrived at the Royal Hobart Hospital at 3.15pm. She was triaged at 3.20pm, and placed in a resuscitation cubicle. At 3.36pm an emergency registrar assessed her. The registrar took a full history from Mrs Holmes including details of her previous medical history and medications. He noted that Mrs Holmes said she had not struck her head during the accident and that she was complaining of pain in her right shoulder. He also saw a small laceration to her left finger. The registrar noted that Mrs Holmes denied any neck pain.
20. After taking her history, the registrar performed a physical examination of Mrs Holmes. Various investigations followed that physical examination. Those investigations included an ECG, a chest x-ray, an x-ray of the right shoulder, a CT scan of the right shoulder area and an x-ray of Mrs Holmes' left hand.
21. Following these investigations, the emergency registrar referred Mrs Holmes from the ED to the general surgical team for admission. However, whilst still in the ED observations of Mrs Holmes' vital signs indicated that her blood pressure had fallen and her heart rate had elevated. Concerned that this may indicate haemorrhage in the abdomen the registrar organised a further CT scan, this time of the abdomen and pelvis.
22. In the early hours of 22 July 2017 Mrs Holmes was admitted to the ICU where she was still complaining of shoulder pain. Monitoring of her condition and vital signs continued. She was noted to be hypotensive with low urine output and bilateral basal creps.
23. On 23 July 2017 Mrs Holmes was still complaining of back and shoulder pain. She had a chest x-ray which indicated bibasilar infection and she remained hypotensive.
24. During the night of 23-24 July 2017 Mrs Holmes' condition deteriorated markedly. She complained of increased shoulder pain, her oxygen saturations and Glasgow coma score dropped, she became febrile, her urine output dropped and it was necessary for her to have increasing amounts of medication to support her blood pressure. Later during 24 July 2017 an ECG was performed which showed Mrs Holmes was suffering right ventricular failure. Her condition continued to worsen and she began to suffer

multi-organ failure. After discussion with family a palliative care approach was adopted; Mrs Holmes was made as comfortable as possible and she died a short time later.

Investigation

25. The fact of Mrs Holmes' death was reported pursuant to the provisions of the *Coroners Act* 1995. After her body was formally identified, it was transferred to the hospital's mortuary. At the mortuary an autopsy was carried out by the then State forensic pathologist Dr Christopher Hamilton Lawrence. Dr Lawrence expressed the opinion that the cause of Mrs Holmes' death was pneumonia. The pneumonia followed a cervical spine fracture sustained in the motor vehicle collision. The fact of Mrs Holmes having suffered a fracture of her cervical spine was not diagnosed by staff at the Royal Hobart Hospital prior to her death.
26. I accept Dr Lawrence's opinion. Several matters arise from this finding as to Mrs Holmes' cause of death. They include:
    - the decision by the attending paramedics to remove the cervical collar at the scene because Mrs Holmes was complaining of shoulder pain;
    - the decision taken at the Royal Hobart Hospital not to image her cervical spine in the Department of Emergency Medicine notwithstanding the fact that she had bruising on the left side of her neck due to a seatbelt injury; and
    - the failure of medical staff to detect the cervical spine injury when a CT scan on her right shoulder was carried out.
27. It would appear that paramedics were alive to the potential for Mrs Holmes having suffered a neck injury. This was the reason why the neck brace was applied in the first place. Removing that brace (even though manual stabilisation was applied with head rolls whilst the ambulance was en route to the hospital) was, in my respectful view, a poor decision. It is axiomatic that for any patient with possible cervical spine injury spinal immobilisation is essential at the scene. Typically this includes a backboard, rigid cervical spine and lateral head support.
28. Advice from the medical advisor to the Coronial Division, Dr Anthony J Bell MB BS MD FRACP FCICM indicates that clinical assessment looking for a fractured neck is especially inaccurate in the elderly. I note that advice received from the Acting Executive Director of Medical Services at the RHH indicates that at the time the Hospital cervical spine clearance guidelines included radiology for all motor vehicle accidents when a patient's age is greater than 65 years. It is therefore apparent that the guideline was not followed in Mrs Holmes' case and that her cervical spine was not

appropriately cleared. However I understand that the RHH has reviewed its guidelines and produced in November 2017 guidelines for Cervical Spine Management in Adult Blunt Trauma.

29. Dr Bell advises that the ICU team "failed in precise diagnosis [and] an interpretation of ongoing observations". I accept that this was so, although I note obviously the ICU management was made difficult in this case due to the failure to identify the presence of the cervical spine fracture in the first place. There was also a misleading radiological report of a liver laceration which may have served to make more difficult proper assessment and treatment of Mrs Holmes.

Conclusion

30. The evidence indicates that the treatment received by Mrs Holmes was not of an acceptable standard. I do note that after her death the RHH reviewed and implemented an improved guideline in relation to cervical spine management.

Comments and Recommendations

31. I extend my appreciation to investigating officer Constable Adam Hall for his investigation and report.
32. The circumstances of Mrs Holmes' death are not such as to require me to make any comments or recommendations pursuant to Section 28 of the *Coroners Act* 1995. My decision not to make any recommendations is essentially because of the steps that have been taken already by the RHH to address the shortcomings in Mrs Holmes' treatment.
33. I convey my sincere condolences to the family and loved ones of Mrs Holmes.

Dated 29 October 2019 at Hobart in the State of Tasmania.

Simon Cooper
Coroner