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 Jack Hedley Martin

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

a) The identity of the deceased is Jack Hedley Martin;
b) Mr Martin died as a result of pulmonary valve endocarditis and cardiac abscess due to Staphylococcus aureus in the circumstances detailed further in this finding;
c) The cause of Mr Martin's death was sepsis; and
d) Mr Martin died on 7 December 2018 whilst a patient in the Mersey Community Hospital at Latrobe, Tasmania.

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Mr Martin's death. The evidence includes:

- an opinion of the forensic pathologist who conducted the autopsy;
- a report from the medical advisor to the Coroner's Office;
- Police Report of Death for Coroner;
- Tasmanian Health Service Final Root Cause Analysis Report;
- Mr Martin's medical records; and
- relevant police and witness affidavits.

Mr Martin, a former miner, was, at the time of his death, 76 years of age, and married to Cherry. He was the father of four children.

Mr Martin was diagnosed with Type 2 diabetes in his late 40s or early 50s, but was diagnosed with Type 1 diabetes in 2010. Around 2014 he was diagnosed as suffering from dementia.

In 2014, Mr Martin suffered a stroke, which damaged his ability to swallow. At that time a feeding tube was inserted to allow him to feed on liquids rather than solids by mouth. In approximately 2015, the feeding tube was removed at Mr Martin's request. Later the same year, Mr Martin broke his left leg when he had a mishap whilst loading/unloading a ride-on lawnmower onto a trailer which tipped during the process.

In August 2018 Mr Martin was treated for pain and difficulty walking. It seems likely that the difficulty with mobility was due to arthritis, which he apparently had suffered from for a number of years.

On 29 November 2018 Mr Martin attended the Mersey Community Hospital as an outpatient for the removal of a skin lesion from his left forearm/wrist. Because he had pre-operative hypoglycaemia, a left sided antecubital fossa intravenous cannula was inserted. The lesion was removed without incident and he was discharged the same day. Unfortunately, the cannula was still in place - although the hospital records indicated that it had been removed.

By the late afternoon of 3 December 2018 Mr Martin was gravely ill. An ambulance was called. It arrived at the Martin home in Port Sorell at about 6.00pm. Paramedics found the cannula was still in Mr Martin's arm. The area around the cannula was obviously infected. Mr Martin was suffering from back pain, and was feverish and confused. He was taken by ambulance back to the Mersey Community Hospital.

Sadly, Mr Martin's condition did not improve. Hospital staff cared for him until he died at around 2.15pm on Friday 7 December 2018.

The fact of Mr Martin's death was reported pursuant to the *Coroners Act* 1995. His body was formally identified and then transferred by mortuary ambulance to the Royal Hobart Hospital. At the Royal Hobart Hospital, Forensic Pathologist, Dr Christopher Lawrence, carried out an autopsy. Dr Lawrence expressed the opinion, which I accept, that the cause of Mr Martin's death was sepsis due to pulmonary valve endocarditis and cardiac abscess due to Staphylococcus aureus.

The circumstances of Mr Martin's death, and the treatment received at the Mersey Community Hospital, were reviewed by the medical advisor to the Coronial Division, Dr Anthony J Bell. In short, Dr Bell expressed the opinion that Mr Martin died because of the failure to remove the intravenous cannula before his discharge from hospital.

A Root Cause Analysis carried out by the Tasmanian Health Service confirms Dr Bell's opinion.

It is apparent that Mr Martin died as a result of a very basic error. If his IV cannula had been removed, then he would not have developed sepsis and died. The Tasmanian Health Service has indicated that a number of changes in relation to systems and processes for patients discharged after day surgery at the Mersey Community Hospital have been implemented following Mr Martin's death. These changes to processes and procedures are designed to attempt to avoid an incident occurring like this again in the future.

**Comments and Recommendations**

Because the Tasmanian Health Service has implemented a number of changes following Mr Martin's wholly unnecessary death I am satisfied this that there is no requirement for me to make any formal comments or recommendations pursuant to Section 28 of the *Coroners Act* 1995.

I convey my sincere condolences to the family and loved ones of Mr Martin.

**Dated** 21 November 2019 at Hobart in the State of Tasmania.

**Simon Cooper**
**Coroner**