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 Shirley Gwendoline Button

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

a) The identity of the deceased is Shirley Gwendoline Button;
b) Mrs Button died as a result of injuries sustained in a witnessed fall from standing;
c) The cause of Mrs Button's death was a subdural haematoma; and
d) Mrs Button died on 19 November 2017 in the Launceston General Hospital, Launceston, Tasmania.

**Introduction**

1. In making the above findings I have had regard to the evidence gained in the investigation into Mrs Button's death. The evidence includes:

- An opinion of the forensic pathologist who conducted the autopsy;
- The results of toxicological analysis of samples taken at autopsy;
- Ambulance Tasmania Electronic Patient Care Report;
- Mrs Button's medical records from the Kings Meadows Medical Centre;
- Mrs Button's pathology records;
- Results of radiological investigations;
- A report from an emergency physician;
- A report from a radiologist;
- A précis of Mrs Button's medical records prepared by a forensic nurse;
- A report from the medical advisor to the Coronial Division;
- Photographs of the scene of Mrs Button's fall; and
- Relevant police and witness affidavits.

2. Before an analysis of the circumstances surrounding the treatment and death of Mrs Button is undertaken something should be said about the role of a coroner. A coroner in Tasmania has jurisdiction to investigate any death "that occurs during a medical procedure, or after a medical procedure where the death may be causally related to that procedure, and a medical practitioner would not, immediately before the procedure was

undertaken, have reasonably expected the death".[1] "Medical procedure" is defined in the same Act of Parliament as meaning a procedure performed by or under the general supervision of a medical practitioner. It includes imaging, any examination or surgical procedure. Because I am satisfied that the circumstances of Mrs Button's death falls within this definition, her death is being investigated.

3. 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 (the Act) 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. This process requires the making of 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. A coroner may, if she or he thinks fit, make comments about the death and, in appropriate circumstances, must make recommendations to prevent similar deaths in the future.[2]

4. A coroner does not punish, or award compensation to, anyone. Punishment and compensation are 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. I should make it absolutely clear that I do not consider anyone has committed a crime or offence in relation to Mrs Button's death.

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 necessarily involves a consideration of the particular circumstances surrounding the particular death (or deaths) so as to discharge the obligation imposed by section 28(1)(b) of the Act upon the coroner.

6. The standard of proof applicable to a 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 investigation reaches a stage where findings may reflect adversely upon an individual, the law is that the standard applicable is that set out in the well-known High Court case of Briginshaw v Briginshaw, that is, that the task of deciding whether a serious allegation is proved must be approached with great caution.[3]

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[1] See section 3 of the *Coroners Act* 1995.
[2] Section 28 (2).
[3] (1938) 60 CLR 336.

**Circumstances of Mrs Button's Death**

7. At the time of her death Mrs Button was 69 years of age. She lived independently at a retirement village in Prospect, Launceston. On 17 November 2017 at around 5.15pm Mrs Button was walking with some friends when she tripped, hit her head on a brick wall and then fell to the ground. She reportedly lost consciousness for approximately one minute. Upon regaining consciousness, Mrs Button told her friends she had a headache and was having trouble seeing. She also vomited.

8. Her friends called an ambulance. It arrived within minutes. Mrs Button was administered pain killing medication and medication for her nausea. Ambulance paramedics took spinal precautions but were unable to fit a rigid collar due to Mrs Button's body shape. She was transported to the Launceston General Hospital (LGH) for further investigation arriving there at 6.15pm.[4] The Ambulance Tasmania notes clearly indicate that Mrs Button had significant head and neck trauma.

9. Upon assessment after admission, Mrs Button's heart rhythm was found to be rapid atrial fibrillation and a laceration / abrasion was found on her occipital region (i.e. lower back area of the skull). The atrial fibrillation was noted to be "new". Mrs Button continued to be nauseated and dizzy at times. Medical records indicate that Mrs Button was sent for CT scans of her head, cervical spine, chest, abdomen and pelvis. The scans revealed a fractured spinous process at the level of C3 with mild separation, left hydronephrosis, enlarged lymph nodes in the para-aortic, mesenteric and retrocrural regions. However, it was interpreted by the treating emergency physician as "negative for any major injury".[5] Similarly the existence of a right tentorial subdural haematoma was not detected by the emergency physician or more significantly the radiologist concerned with interpreting the results of the CT scan.6

10. Anticoagulant therapy was commenced (although the reason for the administration of a full dose of anticoagulation was not recorded in Mrs Button's medical record). In addition to anticoagulation therapy, antibiotics were administered for a suspected urinary tract infection. It was intended that Mrs Button have her neck immobilised in a cervical collar however because of her refusal to wear a hard collar and an apparent lack of alternatives available at the LGH she was not in fact immobilised.

11. The following day (18 November 2017), Mrs Button's medical records indicate she complained of headaches and nausea. Around midday, Mrs Button's cardiac monitor

[4] Ambulance Tasmania Patient Care Records.
[5] See report Dr Alfredo Mori dated 10 January 2019, page 4 of 11.
[6] See report of Dr Kwok-Pan Kenneth Lau dated 10 January 2019, paragraphs 2 and 3.

alarmed and showed a six-second 'pause'. A medical clinician reviewed Mrs Button and consulted with a cardiologist. It was suggested that there was no need for cardiological review of Mrs Button but that she should continue to be monitored. The chronology of the next few hours in her medical records is somewhat unclear due to documentation issues however it appears Mrs Button's condition deteriorated in the evening when she suffered left sided weakness and exhibited confusion.[7] She was sent for CT scans of her brain and spine which demonstrated a large subdural haematoma on the right with midline shift and herniation. Initially a plan was made to send Mrs Button to Hobart for neurosurgical management however before that could occur she deteriorated rapidly.

12. After consultation with family, Mrs Button was transferred to a single room in the ED and provided with end of life care. Mrs Button was treated with medications via a syringe driver for comfort care and was visited by her family during 19 November 2017. Sadly, her condition did not improve and she died just before midnight that evening.

**Investigation**

13. The fact of Mrs Button's death was reported in accordance with the requirements of the Act. After formal identification[8], Mrs Button's body was transported to the mortuary at the Royal Hobart Hospital. At the mortuary an autopsy was carried out upon Mrs Button's body by Dr Christopher Hamilton Lawrence, the then State Forensic Pathologist. Dr Lawrence found at autopsy what he described as "substantial injury" namely a subdural haematoma and a stable fracture of C3. He expressed the opinion that Mrs Button's death was caused by the subdural haematoma.[9] I accept his opinion.

14. Mrs Button's medical records were obtained from the LGH and analysed. Reports were sought (and obtained) from the consultant emergency physician and the diagnostic and interventional radiologist involved in her care. The emergency physician acknowledged that he did not see the C3 fracture on review. Similarly, the diagnostic and interventional radiologist offered his apologies for failing to detect what he described as a "very small and subtle right tentorial haematoma".

15. A review of those reports and the treatment received by Mrs Button was undertaken by the medical advisor to the Coronial Division Dr AJ Bell MB BS MD FRACP FCICM. In summary Dr Bell agreed that the initial CT scan showed a *subtle* subdural haematoma and that although the existence of the haematoma was missed by the reporting radiologist the diagnosis was a difficult one. I am satisfied that there is no basis to criticise the

[7] See précis prepared by Forensic Nurse Libby Newman, page 1.
[8] Affidavit of Constable Madeleine Hayward, sworn 20 November 2017.
[9] Rule 19 affidavit of Dr Christopher Hamilton Lawrence, sworn 15 January 2018.

radiologist in the circumstances. Similarly, it is not reasonable to have expected the consultant emergency physician to have detected the presence of the subdural haematoma, given the fact the radiologist did not.

16. However, the C3 fracture is a different issue. Although it did not cause or contribute to Mrs Button's death, the care she received must be recognised as being of concern and had the very real potential to have significantly endangered her life. Further, the fact that the fracture was 'missed' is difficult to understand in light of the fact that it is expressly mentioned in the radiological report that accompanied the CT scan results.

17. It seems that the issue of Mrs Button's atrial fibrillation served to obscure, at least to an extent, the actual situation in relation to her medical condition. There was ample evidence that her fall was a heavy mechanical one (see in particular the Ambulance Tasmania Patient Care Report). However, it would appear that the treating response was directed toward atrial fibrillation instead of trauma sufficient to cause a fracture of the C3 vertebrae, and thus a subdural haematoma.

18. Finally, I observe that this finding, in draft, was sent to the LGH for comment. The LGH indicated it did not dispute any aspect of this finding.

**Comments and Recommendations**

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

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

**Dated** 1 April 2020 at Hobart in the State of Tasmania.

**Simon Cooper**
**Coroner**