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 Grant Godfrey Maynard

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

a) The identity of the deceased is Grant Godfrey Maynard;
b) Mr Maynard died as a result of injuries sustained in a motor vehicle accident;
c) The cause of Mr Maynard's death was multi-organ failure, due to co-morbidities brought on by a motor vehicle accident; and
d) Mr Maynard died on 17 September 2019 at the North West Regional Hospital, Burnie, Tasmania.

Introduction

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

- Police Report of Death for the Coroner;
- An opinion of the pathologist who conducted the autopsy;
- The results of toxicological analysis of samples taken at autopsy;
- Affidavit of Ms Maureen Stafford, Mr Maynard's partner;
- Final RCA Report – Tasmanian Health Service;
- A report from the Medical Advisor to the Coronial Division;
- Medical records – Aboriginal Health Service, Tasmania;
- Medical records – Tasmanian Health Service; and
- Relevant police and witness affidavits.

Background

Mr Maynard was born on Cape Barron Island on 21 August 1959. He and Ms Stafford, partners for over 36 years, had two children together. He worked as an Aboriginal Education Officer.

He had a number of significant medical conditions which included dilated congested cardiomyopathy, recurrent ascites, obesity, poor renal function, cirrhosis, nodular thyroid, obstructive sleep apnoea and type II diabetes. Mr Maynard's heart condition required a pacemaker.

Circumstances of Death

On Saturday, 14 September 2019, Mr Maynard was involved in a motor vehicle accident on Main Road, Wivenhoe. He was the driver of his own vehicle and it crashed into another vehicle at slow speed.

Mr Maynard was taken to the Emergency Department (ED) of the North West Regional Hospital (NWRH) by ambulance following the accident.

Tasmanian Health Service medical records indicate that, at the ED, Mr Maynard's vital signs were stable. He was reviewed by a medical registrar who discussed his case with the senior ED consultant. The medical officer recorded that it was considered that Mr Maynard had suffered a possible syncopal episode.

A chest x-ray was performed which showed a small pleural effusion. There was no indication of rib fractures.

Mr Maynard's notes indicate he was taking doxycycline for a Lower Respiratory Tract Infection (LRTI).

Because Mr Maynard was at high risk of bleeding due to anticoagulation, a CT scan was ordered and performed. The CT scan of his head did not show any acute pathology. The CT scan of his chest showed a moderate left-sided pleural effusion with adjacent atelectasis (lung collapse). Mr Maynard had to lie on his right side in the CT scanner because he was suffering left rib pain. A further CT scan of his abdomen showed some ascites (abnormal build-up of fluid).

Mr Maynard was admitted to the hospital. The following morning, Sunday, 15 September 2019, he was reviewed by a consultant physician. Postural hypotension was noted with blood pressure dropping as Mr Maynard moved from lying to standing. His haemoglobin had fallen to 78 g/L.

A decision was made not to transfuse blood.

By now, Mr Maynard was in so much pain in his left chest he needed schedule 8 drugs.

Blood tests indicated Mr Maynard had acute kidney injury with elevated creatinine levels (126 micromoles/L from 126 micromoles/L).

The following morning, 16 September 2019, Mr Maynard was short of breath and required supplementary oxygen. An examination of his left lung base showed pleural effusion. His blood chemistry showed acute kidney injury with creatinine now 248 micromole/L.

At 2.30pm, broad-spectrum antibiotics were commenced, red blood cells transfused, anticoagulation ceased and hyperkalaemia treated. Another chest x-ray was ordered and performed. The x-ray demonstrated left-sided gross pleural effusion with mediastinal shift thought to be a haemothorax.

During the course of the evening, Mr Maynard was stabilised in the hospital's intensive care unit. The significant issues he faced were hypoxaemia and acute kidney injury. After discussion, Mr Maynard elected to receive pain relief and no increased medical care.

His condition worsened. On 17 September 2019, end of life palliative care was commenced, and Mr Maynard died later the same day.

Investigation

The fact of Mr Maynard's death was reported in accordance with the requirements of the *Coroners Act* 1995. His body was formally identified and then transported by mortuary ambulance to the Launceston General Hospital. An autopsy was performed on Mr Maynard's body by Dr Terry Brain, a pathologist. Dr Brain provided a report in which he indicated that the cause of Mr Maynard's death was the injury sustained in the motor vehicle accident. Specifically, he found fractured ribs and a collapsed left lung. Dr Brain noted that Mr Maynard suffered a number of serious comorbidities including type II diabetes, dilated cardiomyopathy, cirrhosis, and chronic renal failure. Mr Maynard had a pacemaker present.

Samples taken at autopsy were subsequently analysed at the laboratory of Forensic Science Service Tasmania. The result of that analysis was unremarkable.

The circumstances surrounding Mr Maynard's death was carefully reviewed by the Medical Advisor to the Coronial Division**,** Dr AJ Bell (MB BS MDF FRACP FCICM). Dr Bell provided a detailed report in which he expressed the opinion that the medical care afforded to Mr Maynard was below standard. I accept Dr Bell's opinion. Specifically, there was a failure on the part of medical staff to diagnose fractured ribs and a failure to recognise significant bleeding causing circulatory impairment which in turn led to acute kidney failure.

Comments and Recommendations

The circumstances of Mr Maynard's death are not such as to require me to make any 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 Maynard.

Dated 12 August 2020 at Hobart in the State of Tasmania.

Simon Cooper
Coroner