MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (With Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Olivia McTaggart, Coroner, having investigated the death of Margaret Ann Whitney

With an Inquest held in the Hobart Coroners Court on 7 February 2020, find that:

a) The identity of the deceased is Margaret Ann Whitney;
b) Ms Whitney died in the circumstances set out below;
c) Ms Whitney died as a result of hypovolemic shock due to a haemorrhage during orthopaedic repair of a femur fracture as a result of a fall from standing height; and
d) Ms Whitney died on 30 June 2019 at the Royal Hobart Hospital, Hobart, Tasmania.

In making the above findings I have had regard to the evidence gained in the investigation into Ms Whitney's death. The evidence comprises the Police Report of Death; the Royal Hobart Hospital Death Report; an opinion of the State Forensic Pathologist who conducted the autopsy; an opinion of the coronial medical consultant regarding the care and treatment of Ms Whitney; identification and life extinct affidavits; and medical and nursing home records and reports.

Background

Margaret Ann Whitney was born on 23 April 1938 and was aged 81 years at the time of her death. She was the youngest of four children growing up in a reportedly happy home. Her past employment included working as a machinist in a factory. Unfortunately, later in life Ms Whitney found herself socially isolated, and had no contact with family members.

On 3 February 2019, Ms Whitney was found in a delirious state wandering the street naked shouting at her neighbour. The neighbour reported a decline in Ms Whitney's health over a six month period. Ms Whitney was admitted to the emergency department at the Royal Hobart Hospital. Geriatrician, Dr Janina Skelton, assessed Ms Whitney as having dementia, most likely the vascular type, as Ms Whitney's symptoms included short-term memory loss, self-neglect and disinhibition. Dr Skelton suggested that Ms Whitney would benefit from a therapeutic

environment, namely, the Jasmine Ward at the Roy Fagan Centre, for further assessment of her cognition and for appropriate discharge planning.

On 14 February 2019 an emergency guardianship order under the *Guardianship and Administration Act* 1995 was made appointing the Public Guardian as Ms Whitney's emergency guardian. Under that Act, an emergency guardianship order is made for a maximum period of 28 days unless extended for a further period of 28 days or until a full guardianship order is made. The emergency guardianship order applicable to Ms Whitney was expressed to be limited to the Public Guardian making decisions concerning:

i. Where Ms Whitney was to live, whether permanently or temporarily; and
ii. Providing consent to any reasonable measures required to convey Ms Whitney to, and cause her to remain at the place of residence as determined by the guardian.

On 15 February the Public Guardian, pursuant to her powers under the order, consented to transferring Ms Whitney to the Roy Fagan Centre to a secure unit and to her remaining at the unit whilst undergoing assessment for her cognitive capacity. Dr Alison Cleary, geriatrician, diagnosed Ms Whitney with moderate stage vascular dementia. Dr Cleary reported a decrease in Ms Whitney's delirium since being accommodated at the Roy Fagan Centre as a result of supportive care and management. Dr Cleary reported *"…Although she is able to manage simple activities of daily living now, she is still disoriented, lacking insight into her condition and unable to make any complex decisions for herself. Hence, Margaret needs a permanent Guardian to make decisions regarding her accommodation and healthcare."*

An application was filed with the Guardianship and Administration Board to appoint a full guardian. As a result, a full guardianship order was made on 21 March 2019 appointing the Public Guardian as Ms Whitney's guardian for a period of three years. The terms of that order were limited to decisions concerning:

i. Where Ms Whitney was to live either permanently or temporarily; and
ii. Providing consent to any medical treatment in the best interests of Ms Whitney and to refuse or withdraw consent to any such treatment.

On 1 April 2019, the Public Guardian arranged for and consented to the transfer of Ms Whitney from the Roy Fagan Centre to reside with Respect Aged Care at St Ann's Nursing Home in Hobart. The nursing home notes indicate that during Ms Whitney's three month residency at St Ann's, her behaviour was very difficult to manage. She was routinely aggressive, offensive and socially inappropriate towards other residents and was threatening to staff when she became particularly agitated. Although measures were put in place to assist her in

mobilising, she often refused help and wandered aimlessly. Significantly, it is apparent from the nursing assessments and records that Ms Whitney did not have self-awareness or insight into her behaviour and actions and that her cognition was impaired. She was unable to make reasonable decisions in respect of her own person and circumstances.

Circumstances Surrounding the Death

At 2.35am on 29 June 2019, Ms Whitney was found by nursing home staff sitting on the floor near her bathroom with her left leg twisted outwards and complaining of severe pain in her thigh. She stated that she had slipped on the floor. She could not move her leg or get off the ground and so staff made her comfortable and called for an ambulance. By 4.00am she was transported to the Royal Hobart Hospital.

In hospital an x-ray was performed which showed a left mid-shaft spiral fracture of the femur of Ms Whitney's left leg. The Public Guardian was contacted and subsequently provided consent for surgery to stabilise the fracture. A femoral nerve block was performed and the leg placed in traction. Due to the need to cease Ms Whitney's apixaban (prescribed anticoagulant medication), her surgery was delayed. The last dose of apixaban was taken at 8.29am on 28 June (day before her fall) and surgery was performed two days later on 30 June 2019 at 3.30pm. The surgery was to insert an intramedullary nail (metal rod forced into the medullary cavity of the bone) to stabilise the fracture. Although the intramedullary nail was inserted, the fracture was still displaced. The decision was made to proceed to open cabling of the spiral fracture. During the procedure, a substantial bleed occurred and despite resuscitation efforts, Ms Whitney passed away.

At autopsy, the State Forensic Pathologist, Dr Donald Ritchey, formed the opinion, which I accept, that Ms Whitney's cause of death was due to hypovolemic shock due to a haemorrhage during orthopaedic repair of a femur fracture as a result of a fall from standing height. I accept Dr Ritchey's opinion.

Medical Review

Dr A J Bell, coronial medical consultant, reviewed the evidence concerning Ms Whitney's treatment and care. Dr Bell stated in his report:

> *"**Consideration of management***
>
> *From the initial presentation on the 03.02.2019 to death the patient received good standard medical and nursing care. Note should be made of the significant difficulties associated with nursing management of the patient. These difficulties were managed very well.*

The post-mortem significant contributing factors were not apparent on the clinical assessment of the patient. Of note the electrocardiogram was normal, the kidney function was normal and the liver function tests were normal. A chest x-ray was noted to show intimal calcification of the aortic arch. An iron deficiency anaemia had developed in the 3 months for unclear reasons. The cause was not identified.

The delay of surgery to allow apixaban to wear off was according to usual practice.

The patient, due to pre-existing conditions (as above) had poor physiology to cope with a significant bleed, thus the failure of resuscitation was to be expected.

Conclusion

The care provided was appropriate and of good standard."

I accept the opinions of Dr Bell.

Comments

Ms Whitney was unable, by reason of her dementia and impaired cognition, to make reasonable judgements in respect of her person and circumstances and was subject to a long term guardianship order under the *Guardianship and Administration Act* 1995. It is also apparent that she did not have decision-making capacity as defined in section 7 of the *Mental Health Act* 2013. By satisfying this criterion, Ms Whitney met the definition of a "person held in care" under the *Coroners Act* 1995 because she was, at least, *liable to be detained* in an approved hospital within the meaning of the *Mental Health Act*.

Being a *"person held in care"* immediately prior to her death, I was required by section 24(1)(b) of the *Coroners Act* to hold a public inquest into Ms Whitney's death. I am also required, by section 28(5), to comment upon her care, supervision and treatment whilst held in care.

I comment that, for the reasons set out in this finding, the care, supervision and treatment of Ms Whitney while she was held in care at the Roy Fagan Centre and then at St Ann's nursing home was of a good standard. I am satisfied that the Public Guardian was appropriately consulted and involved with Ms Whitney's care and made appropriate decisions on her behalf in accordance with the terms of the order.

Dated 14 February 2020 at Hobart Coroners Court in the State of Tasmania.

Olivia McTaggart
CORONER