MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995

Coroners Rules 2006

Rule 11

I, Olivia McTaggart, Coroner, having investigated the death of Alan Maurice Gray

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

a) The identity of the deceased is Alan Maurice Gray;

b) Mr Gray died in the circumstances set out in this finding;

c) The cause of death was traumatic closed head injury due to a fall from standing; and

d) Mr Gray died on 19 September 2020 at Hobart, Tasmania.

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

- Tasmania Police and Royal Hobart Hospital reports of death;
- Affidavits confirming life extinct and identification;
- Report of the State Forensic Pathologist regarding cause of death;
- Affidavit of Jennifer Schorta, daughter of Mr Gray;
- Mr Gray's telephone records;
- VitalCall and 000 calls in relation to Mr Gray;
- Ambulance Tasmania VACIS records;
- Ambulance Tasmania review reports;

- Ambulance Tasmania correspondence regarding contributory factors and recommendations; and

- Report of Dr A J Bell, coronial medical consultant.

Mr Gray was born on 9 September 1943 and was 77 years of age at his death. He was a retired botanist and lived by himself in Howrah. Mr Gray was a widower and had four children.

In February 2018, Mr Gray underwent spinal fusion surgery which resulted in an impairment in his gait. This caused him to have regular falls. He declined to use a walking frame to assist with his stability, but did use a walking stick and had various aids installed around his home to assist his mobility.

At 4.00pm on 16 September 2020, Mr Gray had a fall whilst putting air into his vehicle tyres at a service station in Bellerive. In the fall, he hit the back of his head and suffered bruising to his elbow and tailbone. He was assisted by a member of the public, who notified his daughter, and he drove himself home. When he arrived home, his daughter checked him and did not note any apparently serious injuries.

At about 7.30pm that same evening, Mr Gray telephoned an after-hours doctor for advice as he had developed a headache. At 7.54pm, acting upon the doctor's advice, Mr Gray called for an ambulance using his VitalCall personal alert. In response, Ambulance Tasmania (AT) paramedics arrived at Mr Gray's address at 12.09am on 17 September, this being 4 hours and 15 minutes after Mr Gray's call. Mr Gray was located on the floor next to his reclining chair, conscious and alert.

Mr Gray was transported by ambulance to the Royal Hobart Hospital (RHH). A CT scan was conducted and revealed an extensive intracranial haemorrhage. Due to his other underlying health conditions; the extent of the bleeding; and his poor prognosis, a palliative care plan was created in consultation with his daughter. He was transferred to the Whittle Ward for end-of-life care and passed away on 19 September 2020.

Comments and Recommendations

I have investigated the issue of the delay between Mr Gray's call for an ambulance and the arrival of the ambulance 4 hours and 15 minutes later. AT has also reviewed its delay in response. The documents provided by AT reveal that contributory factors were as follows:

- An error was made by the AT officer triaging the call, who initially entered the case in the Medical Priority Dispatch System as category "*>6hr*" meaning that the fall had occurred more than six hours previously. This was not the case and the correct entry should have been "*<6hr*", meaning that it had occurred less than six hours previously. This would have resulted in the case being allocated a higher response priority;

- Ambulance personnel called Mr Gray at 9.20pm with no answer from him. The case was then not upgraded in priority as it should have been when he did not answer the call;

- There was patient off-load delay at the RHH contributing to a lack of ambulances to attend to the call volume experienced at the time;

- There was insufficient ambulance crews at the time of the call; and

- The generally high AT caseload in the Southern Region.

AT, as a consequence, has implemented various measures, including: (a) provision of education and follow-up for staff in respect of the Medical Priority Dispatch System and; (b) introduction of a call-back procedure for AT's State Operations Centre, specifying rules around patient follow-up and call-back in the event of delays in attendance.

Unfortunately, Mr Gray suffered a serious head injury, with extensive bleeding. Based upon the expert medical opinion in this case, I am not able to find that the sad outcome for Mr Gray would have been different if he had been transported to the hospital at an earlier time. However, the delay meant that he had no chance of recovery.

The circumstances of Mr Gray's death are not such as to require me to make any recommendations pursuant to Section 28 of the *Coroners Act* 1995.

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

Dated 1 March 2022 at Hobart Coroners Court in the State of Tasmania.

Olivia McTaggart
Coroner