MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Robert Webster, Coroner, having investigated the death of Ellis Newton Hughes

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

a) The identity of the deceased is Ellis Newton Hughes (Mr Hughes);

b) Mr Hughes died in the circumstances set out below;

c) Mr Hughes' cause of death was aspiration pneumonia; and

d) Mr Hughes died on 13 February 2020 at Hobart, Tasmania.

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

- The Police Report of Death for the Coroner;
- Affidavits as to identity and life extinct;
- An opinion of the forensic pathologist Dr Donald Ritchey;
- Affidavit of Mrs Elizabeth Hughes;
- Letter from Ambulance Tasmania (AT) together with supporting documentation;
- The medical records of Mr Hughes obtained from the Royal Hobart Hospital (RHH);
- The medical records of Mr Hughes obtained from his general practitioner; and
- Report of the coronial medical consultant Dr Anthony Bell MB BS MD FRACP FCICM.

Background

Mr Hughes was born on 4 January 1937 in Sheffield in England. He was a retired mining engineer. As at the date of his death he was 83 years old, married and retired from his employment. Mr Hughes had two children with his wife, Elizabeth, and 5 grandchildren.

Mr Hughes moved to Africa with his father who worked as a heavy machinist when he was 12 years of age. When Mr Hughes turned 18 years of age he joined the National Service in Kenya for 18 months. He then worked in a mine in Uganda before attending a mining school in England in 1959 at which time he met his wife Elizabeth. The couple were married in 1962 and they moved to Tasmania in 1965 first to Storeys Creek before later moving to a house they purchased in Orford.

In or about 1972 Mr and Mrs Hughes moved to far north Queensland where they purchased another house. They continued to live between Queensland and Orford, spending the summer months in Orford and the winter months in Queensland. Mr Hughes continued working until 2010 when he was aged 73.

Mr and Mrs Hughes sold their property in Queensland and continued spending time between their house at Orford and a home they purchased in Howrah.

Health

Mrs Hughes says her husband was in good health the majority of his life with no major issues until he was diagnosed with advanced prostate cancer in 2008. She says he had not shown any symptoms of the cancer prior to his diagnosis which was a shock to both of them. Mr Hughes' father had died from prostate cancer. Mrs Hughes says her husband responded to the treatment he received very well and he maintained a normal functioning life up until about late 2018 when the treatment "stopped working." As a result of the deterioration in Mr Hughes' health he was unable to maintain his weight which fell from approximately 72 kg down to 50 kg. He lost his appetite and struggled to eat.

In late January 2020 Mr Hughes was in the vegetable garden at the Orford property when he fell. He had trouble getting up and had to crawl over to a metal post and pull himself back up onto his feet. Mrs Hughes was present when he fell and she says he did not appear to sustain any injuries as he was able to walk around without any restrictions after he regained his feet. Mrs Hughes felt at the time the cause of the fall was the unevenness of the ground combined with his declining health as she had noticed Mr Hughes had become unsteady on his feet prior to this event which she says was his first fall.

Circumstances leading to Mr Hughes' death

On 5 February 2020 at approximately 2.30pm Mr and Mrs Hughes were at their home in Howrah and were packing their car to travel to their home at Orford. Mrs Hughes was inside the house and Mr Hughes had gone out to the car which was parked in the driveway. After Mr Hughes went outside Mrs Hughes could hear him yelling out. She went outside and saw him lying on the concrete path just before the driveway. She was unable to move him and he was calling out in pain. She called for an ambulance and waited with him for approximately 2 hours for the ambulance to arrive. Mrs Hughes called for an ambulance a second time one hour after the first call.

Mrs Hughes also contacted her next-door neighbour by phone and she came over to assist. She also telephoned AT for assistance.

Mr Hughes was transported to the emergency department of the RHH and after assessment he was admitted to hospital. After further assessment and discussions with the medical staff at the hospital it was decided Mr Hughes would be operated on and he underwent surgery to repair a comminuted fracture involving the lateral condyle of the right femoral shaft which extended to the lateral femoral condyle and joint. An open reduction and internal fixation of the right distal femur fracture was performed on 10 February 2020. He remained in hospital to recover.

Mrs Hughes visited him on 10 February 2020 and says Mr Hughes seemed fine. When she saw him on 11 February 2020 he was in the company of a physiotherapist and she says he still seemed to be recovering well. Mrs Hughes returned to Orford on 11 February 2020 and next intended to visit him on 13 February 2020 however she received a call from him at 8.30am that morning at which time he told her he had been ill during the night and had vomited a number of times. Mrs Hughes reached the hospital at approximately 12.00pm and as she was walking to see him she received a phone call from a doctor who advised her Mr Hughes was not very well. When she saw him his breathing appeared very heavy however he was still able to maintain a conversation. Both Mr and Mrs Hughes then had a discussion with the medical staff on how much treatment they would administer and they were advised Mr Hughes had contracted pneumonia. She says a short time later she was speaking to one of the doctors when the doctor said Mr Hughes had stopped breathing and after Mr Hughes had been checked they confirmed he had passed away.

Investigation

Dr Ritchey carried out a post-mortem examination on 14 February 2020 at which time he determined Mr Hughes died as a result of aspiration pneumonia which condition had

occurred after he had undergone surgical repair of a fractured femur which had been sustained in a fall. Dr Ritchey noted Mr Hughes was frail and had cancer of the prostate. I accept Dr Ritchey's opinion.

Mrs Hughes says she has no complaints with respect to the treatment Mr Hughes received while he was an inpatient at the RHH. She was however concerned at the length of time it took for the ambulance to arrive. She was advised by AT there was more life-threatening jobs for the ambulance service to be dealing with. She says when the paramedics finally arrived their treatment of Mr Hughes was excellent.

Given Mrs Hughes' quite legitimate concerns my office wrote to AT for an explanation. A response was received from the Director of Medical Services of AT. The records of AT show:

- 13:47: AT received the first 000 call from Mrs Hughes;
- 14:46: a second call was received from Mrs Hughes;
- 15:43: an ambulance crew was dispatched;
- 15:49: a third phone call was made by a neighbour who was informed a crew had been dispatched;
- 15:55: the ambulance crew arrived on scene;
- 16:31: the ambulance crew departed the scene with Mr Hughes; and
- 16:51: the ambulance arrived at the RHH.

The calls received at 13:47 and 14:46 were received by a team leader trained as an accredited quality improvement officer with the International Academy of Emergency Dispatch. Given the history taken from Mrs Hughes this officer categorised Mr Hughes as a priority 3 patient. A priority 0 patient is considered to have an immediately life threatening condition and the nearest available operational resource is to be assigned as early as possible and a clinician is to be on the scene in the shortest possible time. With a priority 3 patient the aim is to have a clinician on the scene within 60 minutes of a call being received where possible.

AT's state operations centre uses the Medical Priority Dispatch System (MPDS) to process incoming calls requesting an ambulance. This system is a triage system used by most ambulance services in Australia to dispatch appropriate resources to medical emergencies depending on a specified triage category. The call taking algorithm is based on a number of key questions. These questions allow the emergency medical dispatch support officers to categorise the call by chief complaint and set a determined level ranging from alpha (minor) to echo (immediately life threatening) dependent on the severity of the patient's condition.

The MPDS codes allow emergency medical systems to determine the appropriate response mode that is a routine response or a "lights and sirens" response and resources to be assigned to the event. The objective of this system is to ensure patients receive the most appropriate care.

It is acknowledged the response time in this case was 2 hours and 8 minutes which is well outside the aim of having a clinician on the scene within 60 minutes. AT however says the reasons for this delay are as follows:

- AT was experiencing high demand for services during this period. In the southern region there were 21 emergency calls for ambulances between 13:35 and 16:59 which included:
    - 1 priority 0 case;
    - 4 priority 1 cases;
    - 10 priority 2 cases;
    - 2 priority 3 cases;
    - 3 priority 4 cases; and
    - 1 priority 5 case.
- There was no extended care paramedic on shift on this day due to staff shortages;
- There was delay offloading patients at the RHH which impacted on crew availability. There was only one ambulance available during this period with all other ambulances tasked to incidents or ramped at the hospital;
- Priority 0 meal break windows also impacted on the availability of a crew to attend to a priority 3 incident. The Ambulance Tasmania Award 2020 at clause 5 provides for the management of meal breaks and where a meal break has not been completed by the end of the second hour after the start of what is called a window of opportunity the employee is only required to respond to a priority 0 case.
- The only vehicle that could have responded was a crew at Claremont who was clear between 13:50 and 14:47 however it is normal practice for emergency dispatchers to hold at least one crew to be available for the next emergency incident response and
- due to the information provided regarding Mr Hughes' injury and state of health he was categorised as priority 3 and not an emergency case.

The Director concludes by saying:

"As an emergency organisation, we take all calls for assistance seriously, however, due to staff and equipment limitations, AT, like all other emergency services, triages patients and responds to the most critical cases first as a matter of preserving life. An ambulance crew was dispatched to Mr Hughes as soon as was available considering the high demand, availability of crews, and the nature of other emergency cases at the time in question."

Dr Bell also considered this case. He noted Mr Hughes had hypertension, that in 2013 he underwent an abdominal aortic aneurysm repair, prostate cancer had been diagnosed in 2008 and by 2019 it had spread to his abdomen and lower spine. As at February 2020 the records indicate an estimated life expectancy of 3 to 6 months.

When examined at the RHH Dr Bell noted the clinical examination revealed cachexia[1], his vital signs were normal, his chest was clear, his heart had a systolic ejection murmur consistent with aortic stenosis, his abdomen was firm and his right leg was painful but his neurovascular system was intact. Blood tests showed anaemia and thrombocytopenia. There was a significant degree of renal failure and there was severe hypercalcaemia and hypophosphataemia. An electrocardiogram showed an old septal myocardial infarction. An echocardiogram showed reasonable heart function with aortic stenosis and left ventricular hypertrophy.

Appropriate investigations and consultations took place rapidly and there was a good response to therapy. He noted the distal right femur repair on 10 February 2020 and that Mr Hughes was stable after surgery.

On 12 February 2020 during the morning round it was noted Mr Hughes had a history of vomiting overnight, poor appetite for 2 months and minimal urine output. There had been multiple episodes of vomiting and he had not responded to antiemetics.

On the morning of 13 February 2020 Mr Hughes was short of breath. At 13:40 hours there was an acute deterioration with hypoxia and hypotension. A chest x-ray suggested aspiration. Renal function had deteriorated and Mr Hughes passed away.

Dr Bell says there was no relationship between Mr Hughes' death and the slow ambulance response. He says the medical care provided to Mr Hughes was of a good standard.

[1] A wasting syndrome that leads to loss of skeletal muscle and fat. This condition is estimated to occur in up to 80% of people with advanced cancer.

Comments and recommendations

Mr Hughes died of natural causes. His death was precipitated by the fall and need for surgery. He was also frail and had metastatic cancer. It is not necessary to comment upon the adequacy of the response by AT as it is clear that organisation's delay was not in any way related to the death of Mr Hughes.

The circumstances of Mr Hughes' 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 Hughes.

Dated: 30 November 2022 at Hobart in the State of Tasmania.

Robert Webster

Coroner