MAGISTRATES COURT TASMANIA

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 Doreen May Grimsey

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

a) The identity of the deceased is Doreen May Grimsey, date of birth 4 September 1932.

b) Mrs Grimsey was 91 years of age and had resided in the Hawthorn Village nursing home in Blackmans Bay since 2022. She had a history of dementia and was fully dependent for all activities of daily living. She had a number of other significant medical conditions and her health had been slowly declining. She had also had a number of falls. During the morning of 28 June 2024, Mrs Grimsey had an unwitnessed fall in her room and was found on the floor by staff next to her bed. She had pain in her hip and thigh and was taken by ambulance to Calvary Hospital Emergency Department with a suspected fracture. Shortly after her arrival in hospital, she had an acute deterioration and a MET (medical emergency team) call occurred. As she was apnoeic, oxygen was administered via a mask. She remained only minimally responsive. Following discussions with the family, she was not intubated and was not given CPR. A palliative approach was adopted and she was made comfortable in a ward. Her oxygen was withdrawn and she passed away that evening.

c) The forensic pathologist conducting post-mortem investigations determined that Mrs Grimsey died of natural causes, being congestive cardiac failure. I accept this conclusion. Hospital x-rays from the Emergency Department suggested that Mrs Grimsey may have suffered a possible pubic ramus (pelvic) fracture. However, a post-mortem CT scan revealed that she did not suffer any acute injury in her fall. Therefore, I find that the consequences of her fall in the nursing home did not play a significant part in her death.

d) Mrs Grimsey died on 28 June 2024 at Lenah Valley, Tasmania.

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

- The Police Report of Death for the Coroner;
- Affidavit confirming identity;
- Opinion of the forensic pathologist regarding cause of death;
- Medical records from Calvary Hospital; and
- Review by the Coronial Nurse.

Comments

An issue arose in this case whether Mrs Grimsey's Advance Care Directive (ACD) was complied with following her fall. Mrs Grimsey specified in her ACD that if her condition deteriorated, she wished to have comfort care at Hawthorn Village and that she should not be sent to hospital.

I am satisfied that it was not contrary to her ACD to transport her to hospital after her fall, at least for assessment. Mrs Grimsey suffered an acute injury and a fracture was suspected. I do not consider that this situation could be classified as a *deterioration,* which is intended to refer to a decline in health. It is quite possible that an injury or fracture might be corrected so that there is a return to baseline function. It was reasonable for a hospital assessment to take place to ascertain the nature of the injury. As it transpired, Mrs Grimsey did in fact deteriorate in hospital. In accordance with her ACD, she was not intubated or given CPR and was allowed to pass away.

I make no criticism of the nursing home or hospital regarding this matter.

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

Dated: 22 October 2024 at Hobart, in the State of Tasmania.

Olivia McTaggart
Coroner