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 Dennis Ronald Clark

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

a) The identity of the deceased is Dennis Ronald Clark, date of birth 3 August 1940.

b) Mr Clark was 83 years of age and lived in Triabunna with his wife. He has two daughters and, before his retirement, worked for the Glamorgan Spring Bay Council. His medical conditions included heart failure and kidney failure. He had also previously had a right inguinal hernia repair. On 9 August 2023, Mr Clark was taken by ambulance to the Royal Hobart Hospital with pelvic pain. For several months previously, he had believed he had a hernia in his left groin but he had not experienced significant pain over that time.

Mr Clark had a peripheral intravenous catheter (PIVC) inserted by Ambulance Tasmania (AT) paramedics when they attended to him at his home. He was admitted to the Royal Hobart Hospital under the Emergency Surgery Unit for a left inguinal hernia repair. The operation occurred on 11 August 2023 and the AT-inserted PIVC was removed and covered with a dressing. In total, the AT-inserted PIVC was left in situ for 56 hours, and not removed within the first 24 hours after insertion as required by the existing protocol. Adherence to the protocol is important in preventing infection at the site. When a cannula is inserted in the “field”, the procedure is likely to be more difficult and more likely to produce infection due to contamination.

On 14 August 2023, the dressing was removed by hospital staff from the old PIVC site and staff found purulent discharge coming from the PIVC puncture wound. Swabs of the site and blood cultures were taken. Later that day, Mr Clark deteriorated and his condition triggered a Medical

Emergency Team (MET) call. Results from the blood cultures revealed that Mr Clark had a *methicillin-sensitive staphylococcus aureus* (MSSA) bacteraemia (blood infection). Sadly, he passed away that evening.

c) Mr Clark died as a result of sepsis due to *staphylococcus aureus bacteraemia* following infection of a left antecubital fossa intravenous access site puncture wound. His existing heart and kidney conditions worsened the infection.

d) Mr Clark died on 14 August 2023 at Hobart, Tasmania.

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

- The Police Report of Death for the Coroner;
- Tasmanian Government Death Report to Coroner;
- Affidavit as to identity;
- Opinion of the forensic pathologist regarding cause of death;
- Tasmanian Health Service records;
- Medical review by Dr Anthony Bell, Coronial Medical Consultant MD FRAP FCICM;
- Tasmanian Health Service Final Root Cause Analysis (RCA) Report;
- Affidavit from Rhonda Clark, wife of Mr Clark; and
- Correspondence to the Coronial Division from THS and AT regarding implementation of the RCA recommendations.

Comments and Recommendations

The main issue raised in this investigation relates to the failure of hospital staff to remove the AT-inserted PIVC within the required 24-hour period. If that had been done, it is most likely that the site would not have become infected and Mr Clark would not have died. This error was inadvertent, but most unfortunate.

I accept the analysis contained in the Tasmanian Health Service RCA report that the error occurred primarily for the following reasons:

1. That AT did not place a sticker on the line when inserted stating words to the effect of *"Ambulance Cannula – Remove within 24 hours"*.
2. Following Mr Clark's hospitalisation, his AT-inserted PIVC was not removed within the appropriate time; and subsequently the condition of the site was not monitored, reviewed or documented.

3. There was a lack of clear instruction in the existing protocol regarding who was responsible for the PIVC; this lack of guidance resulted in the PIVC and the site not being appropriately monitored.

In his report for the investigation, Dr Anthony Bell, coronial medical consultant, commented that PIVCs are the most commonly used invasive medical device in health care, with an overall failure rate of 35-50%. He stated that most instances of complications do not involve infection, although it is important that comprehensive protocols should be in place to address all aspects of the use of this device.

Following the death of Mr Clark, both AT and THS have implemented the recommendations made in the RCA report. The following measures were taken:

1. By May 2024, AT had fully implemented the requirement that paramedic staff utilise a new PIVC dressing marked with the word *"EMERGENCY"* to signify that the PIVC was inserted by AT personnel.
2. By November 2024, AT had launched both a new Clinical Work Instruction and a mandatory educational program for all operational paramedics concerning peripheral cannulation practices.
3. By June 2024, THS had developed and implemented a comprehensive *Statewide Vascular Access Device Management Protocol* providing instruction concerning PIVCs, including addressing the deficits identified in this case.

I would expect that both organisations have procedures in place to review the efficacy of these measures at an appropriate time interval.

In light of the above significant developments which address the issues raised by the evidence, I do not consider that I am required to make any recommendations.

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

Dated: 28 November 2025 at Hobart, in the State of Tasmania.

Olivia McTaggart
Coroner