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, Madeleine Wilson, Coroner, having investigated the death of Beverley Jane Cox

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

a) The identity of the deceased is Beverley Jane Cox, whose date of birth is 26 January 1936;
b) Mrs Cox died in the circumstances set out below;
c) Mrs Cox's cause of death was cardiac failure; and
d) Mrs Cox died on 6 April 2024 at Launceston, Tasmania.

In making the above findings I have had regard to the evidence gained in the investigation into Mrs Cox's death which includes:

- The Police Report of Death for the Coroner;
- The Hospital Report of Death for the Coroner;
- Affidavits confirming identity;
- Prospect Medical Centre records;
- Launceston General Hospital records;
- Regis Aged Care Records;
- Forensic Pathology Report of Dr Donald Ritchey; and
- Medical Report of Dr Anthony Bell, MD, FRACP, FCICM Coronial Division medical consultant.

Background

Mrs Cox was 88 years of age and resided in Launceston in Tasmania. She was a retired Art Gallery Director and had a keen interest in art and reading. She was a widow, her husband Steven had died in 2014. She had two children, a son who had also died and a daughter from whom she was estranged. She maintained contact with her cousin, Susan Peters who was an executor of her will and resided interstate.

In recent years, Mrs Cox had become increasingly lonely and depressed. She had moved into Regis Aged Care in Norwood, where she preferred her own company and avoided participating in large group activities.

The records at the facility contain a summary of her medical history. Relevantly, it was noted that Mrs Cox had a pacemaker and that her cardiovascular vital signs were to be regularly recorded and her general practitioner informed if there were any concerns.

Mrs Cox was assessed as a medium falls risk, but until her death she had not suffered any falls at the facility.

Circumstances of Mrs Cox's death

On 6 April 2024 Mrs Cox was in her room at Regis Aged Care when she had a fall. At the time she resided in a dementia ward with full care. Ambulance Tasmania were called and a registered nurse assessed Mrs Cox for head injuries, of which none were noted. Upon arrival at the scene, Ambulance Tasmania paramedics observed Mrs Cox to be confused and to be exhibiting signs of delirium with fluctuating behaviour. She was noted to have hypertension and to be hyperglycaemic. Her baseline Glasgow Coma Scale score was 14. Mrs Cox was taken to the Emergency Department at Launceston General Hospital (LGH). On examination, there were no signs of injury from fall or any upper or lower limb tenderness. In particular, a Computed Tomography (CT) scan of her brain indicated no skull fracture or intracranial or parenchymal haemorrhage (i.e. no bleeding inside the brain tissue or within the skull) or intracranial mass. It was noted that Mrs Cox experienced "periods of vacancy" which became more pronounced and appeared to coincide with "poor output/ ventricular standstill/asystole lasting 5-10 seconds". When Mrs Cox came around, she was observed to gasp for breath and say, "I want to die." On the monitor it was apparent that she was experiencing longer periods of asystole/ventricular standstill despite the pacemaker functioning. As the episodes became more prolonged it became clear that she would require cardiopulmonary resuscitation (CPR), however she had a very clear Advanced Care Plan indicating that she did not want CPR or any life prolonging treatments. In consultation with her next of kin, a decision was made to withdraw life prolonging treatment and to respect Mrs Cox's wishes. Mrs Cox was kept comfortable and died a short time later.

Medical records related to pacemaker

Mrs Cox's medical records from Regis Aged Care, Prospect Medical Centre and LGH were reviewed. The Prospect Medical Centre (PMC) medical records disclose that a pacemaker was fitted in 2008 following a complete heart block in 2007. The general practitioners who saw Mrs Cox, regularly discussed her pacemaker and the need for

regular cardiac and pacemaker reviews with her, however none of the PMC records refer to any discussions regarding a cardiac or pacemaker review after 2019, despite her remaining a patient of the practice up until her death.

The records indicate that in 2012 the pacemaker was “working ok”, based upon a report imported from the Pacemaker Clinic which stated, “all aspects of pacemaker function were satisfactory”. No further reports were received or imported from the Pacemaker Clinic regarding subsequent check-ups.

The PMC records show that on 29 January 2015 her general practitioner was advised that Mrs Cox attended the Pacemaker Clinic every 9 months.

Mrs Cox was a Veterans Card holder and was eligible for the Coordinated Veteran’s Care (CVC) Program. The CVC contacted PMC on 24 March 2017 and advised that during their annual home visit, Mrs Cox had told them that she had not had the pacemaker checked in a few years and it was suggested that she may benefit from a pacemaker review. On 17 July 2017, Mrs Cox attended PMC for a consultation where consideration was given to her undergoing a pacemaker review as part of her CVC care plan. On 23 August 2017 she attended a further surgery consultation where she expressed that “she feels like she has had a heart attack, seeing Dr Croft today” The notes record “need to follow up if she has been seeing pacemaker clinic or Koshy[1]- no correspondence with either. Organise with Dr Tinson next visit.”

On 6 December 2017 the medical notes of a surgery consultation record, “due for pacemaker/cardiac rev. Dr Tinston will refer”. Mrs Cox attended surgery consultations on 21 March 2018, in which an appointment with the cardiologist was made for 15 May 2018; and 17 May 2018 which noted “has had cardiac rev re pacemaker”. On 24 June 2018 “appointment cardiology 15/5/2018” was marked in the system as “performed” and a new “action” was entered as follows; “Annual cardiology/pacemaker review on 1/5/2019”. On 24 April 2019 the surgery contacted Mrs Cox to advise that an appointment had been made for her to attend the LGH cardiology and neurology clinic on 10 May 2019 for her yearly pacemaker check. Following a surgery consultation on 11 September 2019, it was recorded that “Annual cardiology/pacemaker review marked as performed”. The medical records do not indicate that any further discussions were had with Mrs Cox about attending further cardiac or pacemaker reviews.

[1] Dr Koshy, a Cardiologist in Launceston, Tasmania.

Tasmania Health Services provided the medical records for Mrs Cox's attendances at the Launceston General Hospital "LGH," however, they did not contain any records of any attendances at the Pacemaker Clinic.

The Hospital Report of Death provides a summary of Mrs Cox's relevant history and records that a pacemaker device was implanted on 1 October 2013 for complete heart block.[2] The last device check in the Pacemaker Clinic was on the 10 May 2019. At that time the battery life was estimated to be 4.2 years. Pacemaker Clinic records indicate that they wanted to review the pacemaker in another 12 months and "return appointment" was selected in the visit's "outcome choice", however no follow up appointment appears to have been generated. Further interrogation of the records showed that there were no further device checks or downloads in the hospital's record system and the device history had not been "reset" (a standard practice after a check for most clinics) since 2019, indicating that device check-ups elsewhere were unlikely.

Following Mrs Cox's death, the pacemaker data was downloaded and reviewed. The "Alerts section" records that a patient notifier was triggered on 24 January 2022 for Elective Replacement Indicator "ERI", signifying that the battery life was nearing completion and the device may need to be replaced. The device is guaranteed for at least 3 months of normal operation between ERI and End of Service "EOS". The EOS for the device was reached on 11 November 2023, after which point correct operation of the device is not guaranteed.

The battery voltage was assessed at 2.10 volts which placed it in the extremely low range. The very low battery voltage is likely to have resulted in inconsistent operation from the point of EOS until the time of Mrs Cox's death.

Forensic pathology report

Dr Ritchey,[3] Forensic Pathologist, conducted a forensic medical review of the medical records and concluded that Mrs Cox had died of cardiac failure secondary to pacemaker failure and pacemaker battery exhaustion. He observed that Mrs Cox "presented to the LGH in cardiac failure and interrogation of her implanted pacemaker indicated extremely low voltage and was not functional. She died in the DEM[4] prior to admission. The reasons that she was lost to follow-up pacemaker maintenance/evaluation are unclear."

---

[2] No reference is made to the implantation of a pacemaker in 2008 or the pacemaker clinic review in 2012 which appear in the Prospect Medical Centre records.
[3] Dr D. Ritchey MD MSc FRCPA, Forensic Pathologist.
[4] Department of Emergency Medicine.

Pacemaker clinic

I directed that enquiries be made of the Pacemaker Clinic at the LGH to ascertain when Mrs Cox ceased attending the Pacemaker Clinic and what systems were in place in 2019 to ensure regular pacemaker reviews were undertaken, and whether the systems had changed since 2019.

The Director of the Department of Medicine at LGH, Dr Matt Lee-Archer confirmed that Mrs Cox was last seen by a pacing technician on 10 May 2019 in the clinic and following the review, she was directed to the cardiology department reception to book another appointment. Despite the inpatient management system (IPM) recording her status as "return appointment", Dr Lee-Archer was unable to explain why an appointment was not scheduled for Mrs Cox. He said at the time, following their consultation, patients were given a slip of paper indicating the timeframe for their next appointment, to be taken to reception so that an appointment could be scheduled. The patient received printed confirmation of the appointment time, and if their mobile phone was recorded in IPM they would receive a text message reminder about the appointment. If the patient did not attend the appointment, they were contacted and rebooked. Patients were counselled at each appointment that they needed to be reviewed regularly and to contact the cardiology department if their device alarmed. The IPM and LGH cardiology unit's in-house database did not have the capacity to identify patients that were overdue for review, where a follow up appointment had not been scheduled.

Dr Lee-Archer stated patients are instructed that if the ERI alarm is activated, they should contact the clinic for review. Mrs Cox did not notify the clinic that her device had alarmed. Had they been informed that the ERI alarm had activated, the patient would have been booked for a replacement battery as soon as possible. Although some contemporary devices can be remotely monitored, Mrs Cox's device did not have that capability. As such the Pacemaker Clinic was unaware that the ERI had activated.

Dr Lee-Archer stated that since 2019 (when Mrs Cox last attended the Pacemaker Clinic), there had been a change in practice and cardiac technicians now escort patients to reception following their pacemaker review and observe them receive their appointment. He also stated that reception staff routinely rebook all patients that do not attend their appointments. In the case of multiple non-attendance, the case is escalated to the cardiac technician and if necessary, the cardiologist. He stated that every visit the patient is educated about the need to have regular reviews and to contact the cardiology department if their device alarms.

Medical review of records

Dr Anthony Bell[5], conducted a review of the medical records to ascertain whether there were any issues with the care or treatment of Mrs Cox. He concluded that there were no significant signs of injury from the fall earlier in the day, noting that a CT of the brain showed no acute injury. He observed that Mrs Cox continued to deteriorate and died.

Advanced care plan

The LGH records contain a signed Advanced Care Directive dated 16 February 2018, purportedly written and signed by Mrs Cox Under the heading "My values and beliefs", the directive states: "I don't want to linger, I want to be let go. I don't want to be resuscitated; I don't want to be kept alive on life support. I don't want IV feeding if I am unaware of things, I don't want medical treatment such as antibiotics to keep me going if I know nothing, I want to be let go". The Goal of Care Plan recorded; "not for CPR or intubation."

The Regis Aged Care records show that a Care and Wellbeing Review Form was updated on 27 March 2024, in consultation with Susan Peters. The records state "Advance Care Plan in place and current."

Conclusion

I find that Mrs Cox last attended the Pacemaker Clinic on 10 May 2019, at which time no follow up appointments were arranged with her. In September 2019, Mrs Cox's general practice recorded that she had attended the Pacemaker Clinic for review but thereafter did not have any discussions with her about attending further cardiac or pacemaker reviews at the Clinic.

I find that Mrs Cox's pacemaker triggered a patient notifier for ERI on 24 January 2022, signifying that the pacemaker needed to be replaced but she did not act upon that notification. Given Mrs Cox's history of depression and that Mrs Cox had expressed a desire to die, I cannot exclude the possibility that Mrs Cox had earlier, made a deliberate decision not to consult the Pacemaker Clinic in response to the notification. Alternatively, her dementia diagnosis may have been a factor in her failure to act upon the notification.

I find that Mrs Cox died as a result of cardiac failure. At the time of her death, her pacemaker was non-functional due to severely depleted battery voltage and was unable to provide effective cardiac support.

[5] Dr A Bell MD FRACP FCICM, the Coroners Court Medical Consultant.

The decision not to administer CPR or life prolonging treatment was in accordance with longstanding Advanced Care Directives prepared by Mrs Cox. In particular, I find that Mrs Cox's fall earlier in the day was not causative of her death.

Consultation with stakeholders

A copy of the draft findings was circulated to Ageing Australia, Australian Medical Association Tasmania (AMA) and Royal Australian College of General Practitioners (RACGP) Tasmania. A focus of the draft comments and recommendations was to encourage general practitioners and aged care facilities to implement systems to notify patients when further reviews were due.

Ageing Australia responded saying that they did not wish to provide any formal comment.

A lengthy and helpful submission was received from AMA. While supporting the objective of reducing the risk of patients becoming lost to follow up for important device surveillance and review, the AMA highlighted that the circumstances of this case also raises broader system issues about how responsibility for ongoing specialist surveillance is allocated, communicated and monitored across specialist services, general practice and residential aged care. The AMA submitted that the central issue raised in this case, was not simply whether individual clinicians or facilities maintained reminders, but rather the absence of clear, consistent and documented arrangements regarding responsibility for ongoing follow-up. The AMA submitted that this reflects a broader challenge across the health system, with similar questions arising in many areas of care where specialist services recommended further surveillance. The AMA observed that there is often uncertainty regarding whether the specialist service retains responsibility for recalling and rebooking patients, or the specialist service should advise the general practitioner that future review is required and transfer responsibility for arranging that review to them. They observed that without explicit arrangements, there is a risk that each part of the system assumes another provider is responsible, creating the potential for patients to fall through the gaps.

AMA Tasmania submitted that health services should maintain clear and documented processes identifying who is responsible for future review and recall of patients requiring ongoing specialist surveillance. At a minimum, correspondence to the patient's regular general practitioner should clearly state that:

- The patient is due for review in 12 months and the specialist clinic will contact the patient and arrange this review; or alternatively,

- The patient is due for review in 12 months and a new referral should be arranged at that time by the general practitioner.

The AMA stated that specialist services must also have systems capable of identifying patients who have inadvertently become lost to follow up and of clearly communicating responsibility for ongoing surveillance to all parties involved in the patient's care.

The AMA observed that similar considerations apply within residential aged care as for general practice. Aged care facilities generally rely upon information provided by treating specialists and general practitioners regarding ongoing monitoring requirements. The AMA also noted that periodic clinical review processes should facilitate consideration of whether ongoing specialist surveillance remains appropriate in the context of a resident's overall health status, goals of care and expressed wishes. Importantly the AMA pointed out that in Mrs Cox's case, she had dementia and had longstanding advance care directives indicating that she did not want life prolonging treatment. They noted that in some cases, particularly where significant frailty, dementia or advanced illness are present, a decision not to pursue further intervention may be clinically appropriate, provided that decision is made consciously, documented, and communicated. Surveillance systems should support informed and documented decision making regarding ongoing care, rather than assuming that specialist monitoring will always remain appropriate indefinitely.

A response was received from the State Manager of RACGP Tasmania, who echoed the AMA's representation that effective communication and documentation are critical between healthcare providers. However, RACGP Tasmania recognised the value in encouraging a collaborative approach between aged care facilities, general practitioners and specialist pacemaker services over reliance on any single provider. RACGP Tasmania considered that aged care providers should maintain systems that identify residents with implanted cardiac devices and support timely liaison with the resident's general practitioner regarding ongoing monitoring requirements and specialist follow up arrangements.

They also considered that general practitioners are often best placed to provide continuity and oversight of a resident's healthcare needs and can play an important role in coordinating care between aged care facilities, specialist services and families. They considered that the inclusion of appropriate reminders within electronic monitoring records may provide an additional safeguard to ensure pacemaker reviews are not inadvertently overlooked, particularly where residents have complex healthcare needs or are no longer independently managing their appointments.

RACGP Tasmania also recognised that advancements in pacemaker technology increasingly enables remote monitoring and interrogation of many devices, which may reduce the need for patient transfers for pacemaker surveillance in the future.

Comments and Recommendations

Since Mrs Cox's death, the Pacemaker Clinic has implemented changes which address the shortcomings that existed at the time that Mrs Cox last attended the clinic, by ensuring that patients make a follow up appointment at the time of their consultation, thereby reducing the chances of patients losing contact with the service.

However, this case highlights that in cases where ongoing specialist surveillance is clinically required, responsibility for follow up should be documented and clearly communicated. Specialist services should either

- retain responsibility for patient recall and follow-up; or alternatively,
- clearly communicate to the patient's general practitioner that responsibility for arranging future review has been transferred.

Specialist outpatient services responsible for ongoing surveillance and medical devices must also maintain robust systems that:

- Generate follow up appointments where ongoing review is clinically required;
- Identify patients who become overdue for review;
- Escalate unresolved non-attendance where appropriate; and
- Clearly communicate responsibility for future follow-up to the patient's nominated general practitioner and where relevant, the patient's residential aged care facility.

Having reflected on the response from the AMA and RACGP Tasmania , I do not intend to impose any obligations on general practitioners or residential aged care facilities to initiate follow up of pacemaker reviews, in the absence of clear communication from the specialist service transferring the responsibility for arranging future reviews to them.

However, I note that the recording of pacemaker implantation and the use of reminders within electronic medical records is something which could be readily incorporated into systems already operated by residential aged care clinics and general practices which would provide an additional safeguard to ensuring that pacemaker reviews are not inadvertently overlooked.

The circumstances of this case are not such that require me to make any recommendations pursuant to s28 of the *Coroners Act* 1995.

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

Dated: 10 August 2026 at Hobart, in the State of Tasmania.

Madeleine Wilson
Coroner