

FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

Section 67 of the Coroners Act 2008

Court reference: 3133/07

Inquest into the Death of ELLEN PLYMIN

Delivered On:

Delivered At: County Court, Melbourne

Hearing Dates: 29th September, 2010

Findings of: CORONER HEATHER SPOONER

Representation: Mr Ron Gipp of Counsel appeared on behalf of
Westgate Aged Care and Ms Rosa Lam

Ms Deborah Foy appeared on behalf of
Western Health

Police Coronial
Support Unit
(PCSU):

Leading Senior Constable Antolini

Place of death: Sunshine Hospital, 176 Furlong Road, St Albans, Victoria 3021

FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

Section 67 of the Coroners Act 2008

Court reference: 3133/07

In the Coroners Court of Victoria at Melbourne

I, HEATHER SPOONER, Coroner

having investigated the death of:

Details of deceased:

Surname: PLYMIN

First name: ELLEN

Address: Westgate Aged Care Facility, 4 William Street Newport Victoria 3015

AND having held an inquest in relation to this death on 29th September, 2010
at County Court, Melbourne

find that the identity of the deceased was ELLEN PLYMIN
and death occurred on 27th June, 2007

at Sunshine Hospital, 176 Furlong Road, St Albans, Victoria 3021

from

- 1a. SEPSIS RELATING TO AN INFECTED RIGHT SHOULDER
WOUND (INCLUDING MRSA)
- 1b. SURGERY FOR A FRACTURED SURGICAL NECK OF HUMERUS
2. ISCHAEMIC HEART DISEASE, AORTIC STENOSIS, PERMANENT
PACEMAKER, CONGESTIVE CARDIAC FAILURE,
CEREBROVASCULAR ACCIDENTS

in the following circumstances:

Background

1. The death of Mrs Plymin was reported to the Coroner by the Registrar of Births, Deaths and Marriages.
2. Mrs Plymin was aged 85 when she died. She had resided at Westgate Aged Care Facility (Westgate) prior to her death. On 10 May 2007 Mrs Plymin fell and fractured her humerus. She was transferred to the Western Hospital and underwent surgery. Mrs Plymin had a significant past medical history that included ischaemic heart disease, permanent pacemaker, chronic cardiac failure, stroke, hypertension, depression and rheumatic fever.

Family concerns

3. Her post operative care and treatment at Westgate under the supervision of her general practitioner Dr Gavin Martyn from 14 May 2007 and, particularly during the last few days prior to her readmission to hospital on 6 June 2007, was the basis of family concerns and the focus of the coronial investigation and inquest.

Brief Chronology of Events

4. On 3 April 2007 Mrs Plymin was admitted to the Westgate.
5. On 10 May 2007 she fell and subsequently underwent a closed reduction and internal fixation with two rush nails K wire at Western Hospital.
6. On 14 May 2007 Mrs Plymin returned to Westgate after surgery for her fractured humerus. She was discharged on oxycontin for pain relief and a note to '*keep an eye on her rattly chest and cough*'. Mrs Plymin was allergic to some oral antibiotics. Westgate staff observed her elbow red and swollen when she returned and sought a medical review. Apparently she was withdrawn and depressed, not taking diet or fluids and was sometimes incontinent of urine.
7. On 15 May 2007 a locum prescribed rulide for elbow cellulitis, however, when later seen by Dr Martyn he disagreed thinking there was no cellulitis and ceased this medication.
8. On 21 May 2007 she ceased oxycontin.
9. On 28 May 2007 a wound swab was taken from Mrs Plymin's infected suture line and she was commenced on an antibiotic.
10. On 29 May 2007 '*methicillin-resistant staphylococcus aureus*' (MRSA) was identified in swab sample.
11. A 30 May 2007 outpatient review was rescheduled to 6 June 2007.
12. On 31 May 2007 it was noted '*that the doctor was going to contact hospital about treatment as it was resistant to all antibiotics*'. The pathology report located in Mrs Plymin's file indicated it was resistant to cephalothin. Westgate staff were directed to perform daily betadine dressings.
13. On 1 June 2007 Mrs Plymin's daughter, Miss Briar Tutor, asked for her mother to be transferred to hospital. Miss Tutor was unable on medical advice to visit her mother personally due to her own health issues however she was in telephone contact. Dr Martyn instructed Westgate staff that he did not want to send her to hospital unless her condition deteriorated.
14. On 4 June 2007 Mrs Plymin had brown ooze and an offensive smell emanating from her wound.

15. On 6 June 2007 she was readmitted to hospital following an orthopaedic outpatient appointment.

16. On 7 June 2007 Mrs Plymin went to theatre and had '*3 of the 4 pins removed the fourth was buried and unable to be retrieved*'.

17. On 16 June 2007, despite being '*a high risk*', her wound was washed out in theatre and the fourth pin removed.

18. On 27 June 2007 she received palliative symptom management following development of a chest infection and died later that day.

Evidence at inquest

19. Ms Rosa Lam, is a Registered Nurse Division One and was the relevant Director of Nursing at Westgate. In regard to the betadine treatment, Ms Lam told the inquest that she was content with Dr Martyn's advice that he had contacted other specialists to discuss the most appropriate treatment. In any event she did not feel that she could override his advice.

20. Ms Lam stated that Miss Tutor was 'adamant' that she should speak to Dr Martyn about her wish for her mother to go to hospital on 1 June. After discussing the situation and being advised by Dr Martyn that Mrs Plymin should remain at Westgate unless her general condition deteriorated, she contacted Miss Tutor to make her aware and check that she was agreeable. From that time Ms Lam felt that Mrs Plymin's condition had stabilised despite the slight deterioration with the offensive smell emanating from the wound. On 4 June 2007 Ms Lam did contact Dr Martyn about this but he felt that it represented an improvement. She had not asked Dr Martyn to visit Mrs Plymin as she felt that decision should be left to his discretion. Otherwise Mrs Plymin was febrile with nothing else to indicate a deterioration. It did not occur to her to suggest to Dr Martyn that Mrs Plymin should be hospitalised as she did not think that was necessary.

21. Dr Gavin Martyn told the inquest that when he received the biology results he rang St John of God and discussed the clinical situation with a microbiologist. They agreed that the best way to treat the infection was with betadine. As Mrs Plymin was in a nursing home intravenous treatment was not an option and that was why the microbiologist suggested betadine. Dr Martyn had informed the microbiologist that Mrs Plymin had undergone an orthopaedic procedure and told the inquest that he believed that he would have explained that she had suffered a fracture, had it pinned and now had an infection in the wound where the pins were. Mrs Plymin was in a single room and suffered allergies which narrowed the options to intravenous antibiotics or topical treatment via betadine. Dr Martyn had last seen Mrs Plymin on 28 May when he ordered swabs taken. He recalled that there was a pussy bubble at the site of the wound. He could not recall how he had directed the betadine to be applied. On 31 May when he received the results and decided not to send Mrs Plymin to hospital, he was hoping that the wound and not the bone was infected although he anticipated that the situation would become clear over the following week. He told the inquest that had he thought the infection was with the bone then he would

have decided on a different treatment plan including hospital admission and intravenous antibiotics. As it was, Mrs Plymin was off antibiotics from 31 May due to issues surrounding the most suitable medication and her allergies. Dr Martyn was referred to the notes of 4 June noting the ooze and offensive smell which he told the inquest indicated the drainage of pus and the smell of bug which was a good thing. In his conversations with nursing staff he had relied on the general principle that should Mrs Plymin's condition remains stable, there was no need to change her management and they should continue with the treatment plan in anticipation of her outpatient review. His thinking was that they should wait until 6 June however had he considered it necessary or been asked, he would have visited Mrs Plymin in the interim.

22. Miss Briar Tutor was Mrs Plymin's daughter. She told the inquest that after hearing the evidence a lot of her questions had been answered. Miss Tutor also agreed that concerns and deficiencies that she highlighted in the accreditation report had now been complied with.

Cause of Death

23. A review of the medical records was conducted by Dr Paul Bedford, Forensic Pathologist at Victorian Institute of Forensic Medicine (VIFM), who commented:

"The deceased died on the 27th June, 2007 at the Sunshine Hospital. A death certificate was completed as follows - 1a) sepsis (6th June), 1b) infected right shoulder wound (6th June), II cardiac and respiratory failure (between the 6th and 21st June, 2007.

This lady presented to Sunshine Hospital as a referral from the Western Hospital. She was admitted for removal of a rush pin from the right humerus. There had been a previous history of open reduction and internal fixation of the right humerus following a fall in May, 2007 which resulted in a fractured surgical neck of humerus. There was also a past history of aortic stenosis, congestive cardiac failure, permanent pacemaker and of cerebrovascular accidents. Following removal of three of four pins on the 6th June 2007 there was a rise in the troponin level consistent with a non-ST elevation myocardial infarction. There were continued problems with sepsis and on the 16th June, 2007 a fourth pin was removed out of four and the joint washed out. The infective process included a number of organisms but most importantly methicillin resistant Staph. Aureus. She died of complications of sepsis and deteriorating heart and lung function.

This report is based on information available to me as detailed above. I have not examined the deceased's body."

24. Following this review Dr Bedford formulated the cause of death as stated.

Findings

25. The circumstances surrounding the cancellation/rescheduling of Mrs Plymin's outpatient appointment on 30 May 2007 remain unresolved. The evidence and material presented post inquest was limited. Whilst it tended to indicate that the confusion emanated from Westgate, they deny any knowledge as does Miss Tutor and Dr Martyn.

26. The wound swab results taken on 28 May 2007, revealed that Mrs Plymin was suffering from an infection that was multi resistant and could be difficult to treat.

27. Dr Martyn apparently proceeded on the basis that it was a less serious infection, and not a deep infection of the joint which is much more concerning and far less common. He had sought and obtained advice from a specialist microbiologist and prepared a management and treatment plan based on Mrs Plymin's general condition not further deteriorating. It was not until Mrs Plymin attended her outpatient appointment at hospital on 6 June that a deep wound was suspected.

28. It is impossible to know whether an earlier admission to hospital would have changed Mrs Plymin's outcome, but given the evidence and the advice that was sought and obtained from a microbiologist, together with Mrs Plymin's clinical condition, the decision for her to remain at Westgate was not necessarily unreasonable.

29. Mrs Plymin had a complex medical history and unfortunately died from sepsis following surgery for a fracture neck of humerus that she sustained in a fall.

Signature:



Heather Spooner

Coroner

Date: 15 December 2011

