IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2018 0680

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

Section 67 of the Coroners Act 2008 (Vic)

I, AUDREY JAMIESON, Coroner having investigated the death of MABEL GRACE ELLEN PRITCHARD

without holding an inquest:

find that the identity of the deceased was MABEL GRACE ELLEN PRITCHARD

born 8 February 1928

and the death occurred on 10 February 2018

at Box Hill Hospital – Eastern Health, 8 Arnold St, Box Hill, Victoria 3128

from:

1 (a) HOSPITAL ACQUIRED PNEUMONIA IN THE SETTING OF RECENT FRACTURES OF NECK OF HUMERUS AND NECK OF FEMUR (OPERATED) SECONDARY TO FALLS

Pursuant to section 67(1) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances**:

1. Mabel Grace Ellen Pritchard was 90 years of age at the time of her death. She resided in Elizabeth Gardens, an aged care facility, and had previously lived independently.

Mrs Pritchard's husband William Pritchard had died nine years prior to her death. They had two children: Pamela Pritchard and Greg Pritchard.

2. Mrs Pritchard had a significant medical history which included intrathoracic aneurysm, congestive cardiac failure, acoustic neuroma, superior semicircular canal dehiscence-right, trigeminal neuralgia, hypertension, dyslipidaemia and benign senescent forgetfulness. She was prescribed a number of medications in relation to these issues.

3. Mrs Pritchard was able to walk independently but due to her short term memory loss, it was considered unsafe for her to remain living independently. Elizabeth Gardens categorised Mrs Pritchard as a high falls risk.

4. On 17 January 2018, Mrs Pritchard was in her room at the aged care facility with her daughter. She attempted to sit on the bed but missed the edge and fell onto her posterior with her left leg bent beneath her body. She felt immediate pain, staff were called to attend, and emergency services were contacted. Mrs Pritchard was transported by ambulance to Box Hill Hospital where she was diagnosed with a broken hip and treated for her pain.

5. On 21 January 2018, Mrs Pritchard underwent surgery to have a pin inserted into her hip. During her stay at Box Hill Hospital, Mrs Pritchard contracted pneumonia and a urinary tract infection. On 24 January 2018, Mrs Pritchard was transferred to the Peter James Centre in Burwood for rehabilitation and treatment.

6. On 30 January 2018, Mrs Pritchard had an unwitnessed fall at the Peter James Centre. No injuries were recorded as a result of this fall. On 3 February 2018, Mrs Pritchard had a second unwitnessed fall and suffered fractured humerus and neck of femur as a result. The rehabilitation centre staff were advised to treat Mrs Pritchard conservatively.

7. On 6 February 2018, Mrs Pritchard was transferred back to the Box Hill Hospital for medical management and an orthopaedic review. On 7 February 2018, she was treated intravenously with Tazocin[1] for pneumonia.

---

[1] A combination medication containing the antibiotic piperacillin and the β-lactamase inhibitor tazobactam.

8. Mrs Pritchard became increasingly unwell and agitated throughout her treatment. On 8 February 2018, she required a syringe driver for analgesia and anti-anxiolytic. On 9 February 2018, Mrs Pritchard was found to have deep vein thrombosis.

9. At 1.00pm on 10 February 2018, Box Hill Hospital staff and Mrs Pritchard's family made a decision to cease active treatment and continue with only comfort management. At approximately 5.45pm, Mrs Pritchard was pronounced deceased.

INVESTIGATIONS

Forensic pathology investigation

10. Dr Mathew Lynch, Forensic Pathologist at the Victorian Institute of Forensic Medicine (VIFM), performed an external examination upon the body of Mabel Pritchard, reviewed a post mortem computed tomography (CT) scan and referred to the Victoria Police Report of Death, Form 83.

11. Dr Lynch commented that the external examination and CT scanning of Mrs Pritchard's body was consistent with her known, recent medical history. CT scanning also detected calcific coronary artery disease, cardiomegaly and bilateral pleural effusions. Dr Lynch formulated the medical cause of Mrs Pritchard's death as hospital acquired pneumonia in the setting of recent fractures of neck of humerus and neck of femur (operated) secondary to falls.

Police investigation

12. Victoria Police attended Box Hill Hospital shortly after Mrs Pritchard's death, as staff made a notification of a reportable death pursuant to the *Coroners Act 2008* (Vic).[2]

13. Senior Constable (SC) Paul Mayorkinos was the nominated Coroner's investigator.[3] At my direction, SC Mayorkinos investigated the circumstances surrounding Mrs Pritchard's death, including the preparation of the coronial brief. The coronial brief contained, *inter alia*, statements made by Pamela Pritchard, facility manager of

---

[2] *Coroners Act 2008* (Vic) s 4.

[3] A Coroner's Investigator is a police officer nominated by the Chief Commissioner of Police or any other person nominated by the Coroner to assist the coroner with his/her investigation into a reportable death. The Coroner's Investigator receives directions from a Coroner and carries out the role subject to those directions.

Elizabeth Care Gardens Monica Krishnan, as well as medical records from Elizabeth Care Gardens and Box Hill Hospital.

14. During the investigation, police learned that Mrs Pritchard's children had some concerns in relation to her care and treatment. In a statement written by Pamela Pritchard on behalf of herself and her brother, she stated that they had some concerns in relation to, *inter alia*:

    a. the staffing ratios at the Peter James Centre;

    b. the capacity of the Peter James Centre to care for and treat their mother's condition, and

    c. the unwillingness of staff to make enquiries to the Department of Veterans Affairs (DVA) about Mrs Pritchard's entitlements as a Gold Card holder.

15. Pamela Pritchard wrote that she felt Box Hill Hospital staff's care and treatment of Mrs Pritchard had been exemplary. She acknowledged that all of her mother's care providers had acted with the best intentions and that many of her concerns were related to systemic issues, including understaffing and underfunding in healthcare.

Further Investigation

16. Upon reviewing the family's concerns, I requested that the Peter James Centre provide a statement responding to Pamela Pritchard's letter. A response was prepared by the Executive Clinical Director of Geriatric Medicine at Eastern Health Dr Peteris Darzins.

17. Dr Darzins stated that Eastern Health complies with staffing ratios required by legislation. He commented that the Peter James Centre is a sub-acute facility where there are more patients per nurse than in acute care facilities. Dr Darzins stated that the nurse to patient ratios are set by the government legislation. However, doctor and allied health staffing[4] to patient ratios are not set by legislation. Dr Darzins stated that ratios in the rehabilitation facility are in keeping with current practice in Victoria.

18. Dr Darzins acknowledged the many demands placed on all practitioners during working days. He stated that practitioners must strive to simultaneously meet pressing needs of

[4] Allied health staff includes physiotherapists, occupational therapists and social workers.

multiple patients. He also commented that this issue was particularly evident for the nursing staff who may be called upon to urgently respond to immobile patients' need to use the toilet and that this was compounded with the even more urgent response required for patients who were mobilising in an unsafe manner and were at risk of injurious falls. Dr Darzins stated that patients suffering dementia and delirium were at a particular risk as they may suffer both an unsafe gait and a lack of cognisance of their own inabilities. Dr Darzins stated that the many, pressing and simultaneous needs of patients can keep nursing staff extremely busy, even where the staffing ratios meet the legal requirements.

19. Dr Darzins apologised if the staffing resources were not adequate to meet Ms Pritchard's needs. He stated that Eastern Health simply did not have the resources to provide more staff than are currently employed to meet legislative requirements and those that are funded by the government.

20. Dr Darzins acknowledged the family's concerns that Mrs Pritchard had not immediately been transferred back to hospital after her second fall. He stated that acute hospitals, such as Box Hill Hospital, provide high-technology services and are best used for the care of people who need the expertise or technology that can only be provided in that setting. It was determined that Mrs Pritchard did not require these kinds of services until she developed hyperkalaemia[5] and was transferred to the acute setting.

21. Dr Darzins acknowledged the family's concerns in relation to staff reluctance to follow up Mrs Pritchard's DVA entitlements. He noted that DVA Gold Card holders do have a range of entitlements to supports which are not otherwise available, but that these supports are typically available in the community rather than the hospital setting. He stated that there is some DVA funding for hospital care, but this is rolled into the overall funding envelope with all other funds received from insurers, benefactors and government sources. These funds are used for the Eastern Health business as a whole.

22. Dr Darzins stated that hospital notes record that Pamela Pritchard informed staff of her mother's "Gold Card" status and potential entitlements at 7.25pm on 4 February 2018. A plan was made for the Nurse Unit Manager to follow-up. Additional staffing for 1:1 nursing of Mrs Pritchard was obtained from the DVA, pursuant to the registrar notes at 4.05pm on 5 February 2018. Dr Darzins acknowledged that this may lead Mrs

[5] High blood potassium level.

Pritchard's family to query why extra services were not obtained from the DVA before that date. He noted that it was an unusual arrangement, not routinely available to patients and that Mrs Pritchard had already received 1:1 nursing at various times at the Peter James Centre.[6]

COMMENTS

Pursuant to section 67(3) of the *Coroners Act 2008* (Vic), I make the following comments connected with the death:

1. I thank Pamela Pritchard and Greg Pritchard for their participation in the Coronial process. I note that Pamela Pritchard's statement referred to some concerns which did not directly relate to the cause of her mother's death and are therefore outside of my jurisdiction.

2. The investigation into Mrs Pritchard's death highlighted that despite staff ratios meeting legislative and / or current practice requirements, there may still be instances where staff members need to balance the urgent need of multiple patients. This issue appears to be particularly problematic in aged patients who have experienced cognitive and physical decline but are still mobilising.

3. I shall provide a copy of my Finding to the Honourable Richard Tracey AM RFD QC and Ms Lynelle Briggs AO, Commissioners of the Royal Commission into Aged Care Quality and Safety. I hope that this material will provide further insight and assist their activities.

[6] Please see the Peter James Centre Progress Notes, 3 February 2018.

FINDINGS

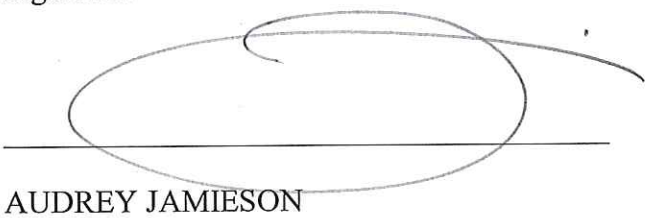
The investigation has identified that Mrs Pritchard was hospitalised subsequent to a fall in which she sustained multiple fractures. The investigation also identified systemic issues in relation to staffing and funding in healthcare. However, the care and treatment provided to Mrs Pritchard appears to be reasonable and appropriate in the circumstances.

I accept and adopt the cause of the death formulated by Dr Matthew Lynch, and I find that Mabel Grace Ellen Pritchard died from hospital acquired pneumonia in the setting of recent fractures of neck of humerus and neck of femur (operated) secondary to falls.

Pursuant to section 73(1A) of the *Coroners Act 2008* (Vic), I order that this Finding be published on the internet.

I direct that a copy of this finding be provided to the following:
Pamela and Greg Pritchard
Royal Commission into Aged Care Quality and Safety
Senior Constable Paul Mayorkinos

Signature:



AUDREY JAMIESON
CORONER
Date: **17 May 2019**