IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2024 005330

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
Section 67 of the ***Coroners Act 2008***

Findings of:	Sarah Gebert, Coroner
Deceased:	James Thomas Reilly
Date of birth:	27 February 1938
Date of death:	9 September 2024
Cause of death:	1(a) Left haemothorax complicating rib fractures (not operated), sustained in a fall
Place of death:	West Gippsland Hospital, 41 Landsborough Street, Warragul, Victoria

INTRODUCTION

1. On 9 September 2024, James Thomas Reilly was 86 years old when he died in hospital following a fall at home.

2. At the time of his death, James lived in Drouin.

THE CORONIAL INVESTIGATION

3. James' death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

4. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

5. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

6. As part of my investigation, I obtained a statement from West Gippsland Healthcare Group and asked the Coroners Prevention Unit (**CPU**)[1] to review the medical care James received proximate to his death.

7. This finding draws on the totality of the coronial investigation into James' death. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[2]

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[1] The CPU was established in 2008 to strengthen the coroner's prevention role and to assist in formulating recommendations following a death. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health. The CPU may also review the medical care and treatment in cases referred by the coroner as well as assist with research into public health and safety.

[2] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

Background

8. According to Ambulance Victoria records, at the time of his fall James was independent with his activities of daily living and used mobility aids.

9. His medical history included pacemaker, bypass surgery, high cholesterol, gastric reflux, chronic neck pain, emphysema, pseudomonas, hypertension, and depression.

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

10. According to the E-Medical Deposition completed by Dr Wewalage Perera, Medical Registrar, James presented to West Gippsland (Warragul) Hospital at 12.21pm on 8 September 2024. The following history was provided.

11. James experienced (unspecified) visual disturbances on 7 September 2024.

12. James woke up at about 2.00am on the morning of 8 September, feeling unsteady and disoriented. He subsequently had a fall with no head strike or loss of consciousness.

13. At about 2.30am, emergency services were contacted and Ambulance Victoria paramedics attended. At the time, James was not transported to hospital.

14. The Ambulance Victoria records are unfortunately not entirely legible due to being a handwritten carbon copy.[3] It is however apparent the outcome of James' fall included minor injuries (skin tear to back of the right hand) which paramedics dressed. His GSC was 15,[4] there was no shortness of breath, and there was no dizziness whilst sitting but there was dizziness on standing. Pupils were equal and reactive to light. James reported new onset of pain to the left lower side of his back (worse on palpation and movement), and new onset of pain to the central thoracic region, but he was able to ambulate. His chest sounded clear at the upper airways but there was consolidation in both lower lungs. James declined the offer to be taken to hospital. He was advised to attend a Priority Primary Care Centre for proper wound dressing of his hand and assessment of his back injury with possible referral for x-ray and pain relief. James stated he would attend later that day. Paramedics also advised James to take his own oxycodone for symptom relief. If there was any deterioration, James was advised to call

[3] Due to the Protected Industrial Action in 2024 no electronic case sheets were available from this time, only paper.

[4] The Glasgow Coma Scale (**GCS**) is the most common scoring system used to describe the level of consciousness in a person following a traumatic brain injury. A score of less than 8 indicates a severe brain injury; a score of 9 to 12 indicates a moderate injury; and a score of 13 to 15 indicates a mild injury such as concussion.

emergency services again. James also stated he would follow-up with his general practitioner the following Monday.

15. At about 9.00am later that morning, emergency services were contacted due to new onset of right-sided facial droop, which had resolved by the time Ambulance Victoria paramedics re-attended. James also reported continued back pain post the fall. Paramedics queried possible transient ischemic attack and transported James to hospital.

16. At the emergency department, James was triaged as Category 2 and a Stroke Code was subsequently called. A CT brain scan was undertaken, which did not reveal anything obvious, with all neurology resolved by the time of review. It was therefore recommended to treat James for transient ischemic attack.

17. At about this time, James' Goals of Care were updated indicating he was not for cardiopulmonary resuscitation or intubation.

18. A clinician made a note on the medical record that James was to be provided *"only aspirin + clopidogrel + clexane for tonight".*

19. At 5.00am the next morning, 9 September 2024, James was reviewed for worsening back pain.

20. At 8.20am, there was a MET (medical emergency team) call for *"GCS, hypoglycaemic 3.1, tachycardic, hypotensive, tachypnoeic and hypoxic".* James was noted to be profoundly hypoglycaemic and once this was corrected with 50ml 50% dextrose, there was some general improvement. Borderline hypotension (SBP (systolic blood pressure) ~90) improved initially with dextrose and further following administration of 500ml 0.9% NaCl (sodium chloride). Sinus tachycardia (on ECG (electrocardiogram)) responded to a 500ml bolus although he still had ongoing tachycardia (HR (heart rate) ~110). Hypoxia assessment was difficult due to poor trace but sats (saturation) of ~75-80% was corrected with bag-valve mask before being swapped to non-rebreather mask. Hypoxia improved to sats 90-92% on 6-8 litres via non-rebreather with persisting tachypnoea above 30. Initially James' altered GCS was thought to be secondary to marked hypoglycaemia.

21. During the MET call it was identified that James had been administered 100mg clexane at approximately 8.00pm the night prior without reasons specified in the records.

22. At 8.55am, a chest x-ray was undertaken and revealed a large tension haemothorax. A plan was made to contact the surgical team for advice regarding urgent insertion of an intercostal catheter (**ICC**) for suspect tension haemothorax.

23. In the meantime, James' observations were semi-stabilised (approximately 9.00am). He still had mild ongoing tachycardia (HR 110), his blood pressure normalised, but he was still hypoxic (sats ~90-92% on NRB (non-rebreather mask)) and he was tachypnoeic.

24. James was transferred to the High Dependency Unit where he was seen by the surgical team to determine whether the ICC should be inserted on the ward or in theatre. James then rapidly deteriorated becoming increasing pale, and diaphoretic with worsening dyspnoea.

25. A Code Blue was called with staff from the emergency department and anaesthetics attending with the surgical team already present. James subsequently arrested during the Code with complete unresponsiveness and loss of output. A decision made by medical staff to attempt chest drain insertion with the hope of reversing the potentially reversible tension haemothorax.

26. The ICC was subsequently inserted with slow drainage. Unfortunately, this procedure did not prevent James' death, which was verified at 9.40am on 9 September 2024. Dr Perera indicated the possible cause of death was haemopneumothorax.

Identity of the deceased

27. On 9 September 2024, James Thomas Reilly, born 27 February 1938, was visually identified by his daughter, Teresa Williams.

28. Identity is not in dispute and requires no further investigation.

Medical cause of death

29. Forensic Pathologist, Dr Gregory Young, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an external examination on 11 September 2024 and provided a written report of his findings dated 18 September 2024.

30. The post-mortem examination revealed evidence of medical intervention, but no unexpected signs of trauma.

31. A post-mortem CT (computed tomography) scan confirmed the presence of a left haemothorax associated with mediastinal shift but no residual left pneumothorax. Posterior fractures of the left 9th – 10th ribs were also seen. The heart showed coronary artery

calcification and a pacemaker. There was no intracranial haemorrhage or midline shift/swelling in the brain.

32. Dr Young noted that haemothorax (bleeding in the pleural space around a lung) and pneumothorax (air in the pleural space) are known complications of rib fractures which, in this case, were likely to have been sustained from the fall.

33. Dr Young provided an opinion that the medical cause of death was *“1(a) Left haemothorax complicating rib fractures (not operated), sustained in a fall”*.

34. I accept Dr Young’s opinion.

FAMILY CONCERNS

35. Shortly after James’ death, his family verbally advised Coronial Admissions and Enquiries staff at VIFM that they had concerns that paramedics had dressed James’ hand but left him at home following his fall. Once in hospital, the family were concerned clinicians had missed a punctured lung from a broken rib and had increased blood thinning medication.

36. In March 2025 James’ daughter, Teri Williams, wrote to the Court outlining the family’s further concerns. In summary, these included:

    (a) she reiterated that paramedics chose not to take James to hospital despite complaining of pain and displaying signs of a stroke;

    (b) in hospital, treatment focussed on stroke but James also complained of chest pain;

    (c) James was administered blood-thinning medication;

    (d) the family were not informed that James was *“bleeding into his cavity, emphasising the seriousness of his condition and the need for an incision”;* and

    (e) following James’ death, the family received new information from clinicians, including that an expectation of bleeding was present.

37. The role of the coroner is limited and I can only examine matters that are significantly proximate and causative, or contributory, to a death. I have therefore focussed my investigation on the factors that contributed or may have contributed to James’ death.

38. Issues of poor communication or suboptimal care that have not contributed to death are best addressed directly by the health facility involved or the Health Complaints Commissioner.

39. The Ambulance Victoria records indicated that James declined transport to hospital at their initial attendance. My investigation has therefore focussed on the care he received once he was transported to hospital.

FURTHER INVESTIGATION

Statement from West Gippsland Health Group

40. Dr Letitia Maree Clark, Chief Medical Officer, provided a statement on behalf of West Gippsland Healthcare Group.

41. Dr Clark noted that James had presented to the emergency department following a fall at home after which he developed facial droop. He was suspected of having a stroke, but a CT scan of his brain did not show any significant abnormalities. A review by the Victorian Stroke Telemedicine (**VST**) team was conducted and advised to treat the symptoms as a transient ischemic attack. James also complained of some left-sided back pain.

42. Dr Clark stated that prior to his transfer to the medical ward, he was prescribed Dual Anti-Platelet Therapy (**DAPT**) (aspirin and clopidogrel) as per VST, despite a known sensitivity to aspirin. He was also prescribed a therapeutic dose of enoxaparin in error. James was administered these three medications in the evening on the medical ward.

43. At midnight James complained of back pain, which settled with repositioning.

44. At 5.00am he was reviewed by the medical registrar for back pain, given analgesia, and commenced on oxygen therapy as his saturations were dropping, which was presumed to be as a result of his increasing pain.

45. At 8.19am, James' consciousness level dropped, he was acutely short of breath, and his oxygen levels dropped significantly. A MET call was called, and a chest x-ray was completed which showed a large haemothorax. The surgical team proceeded to insert an ICC to drain the haemothorax and relieve any possible tension pneumothorax. Unfortunately, shortly after this, James deteriorated and passed away.

Examination of back and chest

46. Dr Clark stated that James' chief complaint was stroke-like symptoms and the main priority was stroke management. Neither the Medical Registrar nor Emergency Department Hospital Medical Officer (**HMO**) could recall examining James' back pain, nor could they recall whether his chest was auscultated. The admitting Medical Registrar did not examine James' back and was unaware of his complaint of pain. There was nil chest auscultation documented – the Medical Registrar presumed that it would have been completed as part of the routine assessment.

47. James complained of back pain overnight and was initially treated with simple analgesia and repositioning by the nursing staff. When the back pain had not subsided at a later time, he was reviewed by the overnight Medical HMO and prescribed stronger analgesia (same was administered). The overnight HMO made a note for the home team to follow up the back pain in the morning. Unfortunately, James deteriorated prior to review by the home team in the morning.

48. Dr Clark noted that the report of James' initial chest x-ray did not report on the rib fractures and they were also not identified clinically. The fractures were subsequently identified as part of the investigation following his death.

Incorrect prescription of therapeutic dose of enoxaparin

49. Dr Clark explained that the Emergency Department HMO prescribed enoxaparin which was meant for another patient. It was thought the HMO has not 'clicked' on the other patient correctly and that James' record was selected in the Electronic Medical Record. Prior to accepting the prescription in the system, the HMO did not double check the patient that it was being prescribed for. The HMO reported that they were likely distracted by other priorities and was in a hurry.

50. Regarding the dual anti-platelet therapy, Dr Clark indicated this was recommended by the VST given James' stroke-like symptoms on presentation and was prescribed by the Medical Registrar.

51. The Medical Registrar had documented that the enoxaparin was to be given when James was admitted to the ward. The dose or indication was not reviewed at this stage, and an assumption made that it was a prophylactic dose only (40mg daily).

52. The nursing staff who prepared, checked, and administered the enoxaparin did not recall checking the indication for prescribing prior to administration.

Internal review

53. Dr Clark confirmed that James' death was notified to Safer Care Victoria as a Sentinel Event under Category 7 (Medication error resulting in serious harm or death). The sentinel event investigation was then conducted as per Safer Care Victoria guidelines and included a full Root Cause Analysis.

54. The Sentinel Event review panel made the following findings:

    (a) the Emergency Department HMO incorrectly prescribed therapeutic enoxaparin for this patient when it was intended for another. It is likely that the HMO has not correctly selected or double checked the patient identification;

    (b) the nursing staff did not question the enoxaparin order, despite the wrong indication and also a high dose documented;

    (c) management of this patient was focused on the transient ischemic attack and did not consider other potential injuries from his fall such as possible rib fractures or other causes for his back pain;

    (d) training for locum and rotational junior medical staff, on electronic medical records system, is insufficient;

    (e) the nursing staff on the medical ward did not correctly follow the process for monitoring a patient who is on telemetry cardiac monitoring;

    (f) chest x-ray report did not mention any rib fractures, despite showing an old fracture and a potential new one; and

    (g) no documentation that patient's chest was auscultated, despite this being a requirement to be completed 'once per shift', as per the stroke/transient ischemic attack pathway.

55. The recommendations made by the Sentinel Event panel were as follows:

    (a) investigate the ability of current Electronic Medical Record (**EMR**) system to include: double check facility and improve lag. Medical staff to develop a process of

developing their own patient list. Any future EMR system to be checked for compatibility with double checking systems and filtering patients by doctor;

(b) all nursing staff will complete case study education around the six rights of medication,[5] especially related to high-risk medications. The training should include information around confirmation bias;

(c) investigate the possibility of implementing a 'red vs blue' team challenging system. The Red Team / Blue Team Challenge aims to test the hierarchical model and provides tools for team members to safely question and challenge the diagnostic decision-making process within the team environment;

(d) all locum or rotational junior medical staff must receive formal and structured training on EMR, medication prescribing, and checking. Align with similar processes as the Emergency Department;

(e) the current telemetry system should be reviewed to identify if additional data storage can be added, or if an upgraded system is required. Review the current process for telemetry monitoring, including policy, responsibilities of staff, etc;

(f) develop a process to ensure suspicious findings on all x-rays are discussed with the on call radiologist to review the films; and

(g) re-education of all medical ward nursing staff to enforce the requirement of chest auscultation, as part of the stroke/ transient ischemic attack pathway. Education to be provided for medical ward nursing staff on chest auscultation, including indications, technique, clinical indicators etc.

56. As at the time of Dr Clark's statement, 28 January 2025, not all of the recommendations had been implemented. The timeline for implementation was noted to be by 7 March 2025, with follow up in 12 months if not all recommendations had been implemented fully.

57. Dr Clark indicated that the events surrounding James' death were also reviewed at the relevant clinical stream morbidity and mortality meetings. The West Gippsland Healthcare Group committee and Board sub-group responsible for Clinical Governance were briefed to provide governance over the implementation of the recommendations.

[5] Checking: 1. Right patient, 2. Right medication, 3: Right dose, 4: Right time, 5: Right route, 6. Right documentation.

58. The incident was also reported to WorkSafe, which has now been closed with no follow-up required by WorkSafe.

Coroners Prevention Unit review

59. As part of my investigation and in light of the medical issues involving James' death, I obtained advice from the CPU.

60. The CPU considered that there were two contributory factors led to James' intrathoracic haemorrhage and subsequent demise:

(a) his rib fractures which were not diagnosed despite his complaint of back pain post fall. From the records, it appeared the delayed presentation of the fall and the presenting symptoms that suggested stroke (which is a time-critical diagnosis supported by processes – 'code stroke' designed to expedite care) resulted in cognitive fixation,[6] premature closure,[7] and systems related diagnostic momentum.[8] Staff were so focussed on the stroke aspect of James' presentation, that it appears no one assessed his complaint of back pain to find rib fractures; and

(b) the prescription of dual anti-platelet agents (aspirin and clopidogrel) as recommended by VST in addition to the accidental prescription of full-strength anticoagulation therapy (100mg enoxaparin/clexane). This error was not detected by nursing staff.

61. Regarding the rib fractures, the CPU noted that the internal review relied on the concept of improved reading of the chest x-ray as a means of improved detection. However, the CPU noted that chest x-rays only have at best a 50% sensitivity for rib fractures when compared to CT scanning[9] (this is also illustrated by the hospital's own review where even with the benefit of hindsight that an autopsy review gives regarding the number of broken ribs, the review saw only a single 'potential' fracture).

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[6] Cognitive fixation is a mental state where a person is unable to see beyond a single way of thinking about a problem or object. It can limit a person's ability to be creative and solve problems

[7] Premature closure is a cognitive error that occurs when a diagnosis is made too early, or before all relevant information has been gathered.

[8] Diagnostic momentum is a type of cognitive bias that occurs when a diagnosis is accepted and passed on without adequate evidence. This is a predictable consequence of all processes designed to expedite care; there is always an 'efficiency-thoroughness trade-off' (ETTO) – expediting the efficiency of stroke care risks less thoroughness in the assessment/treatment of other potential conditions. While our hindsight tells us they should have been more thorough, at the time it seemed that it was more important to be efficient.

[9] Bansidhar BJ, Lagares-Garcia JA, Miller SL. Clinical rib fractures: are follow-up chest X-rays a waste of resources? Am Surg. 2002 May;68(5):449-53. PMID: 12013289.

62. The CPU noted that the number of fractured ribs is clinically important as current statewide guidelines state that three or more fractured ribs is an indication to refer to a Major Trauma Centre as it is associated with an increased death rate from uncontrolled pain and secondary pneumonia.

63. In the CPU's experience, standard assessment[10] of chest wall trauma in the elderly is to compress the ribs (front to back, side to side from top to bottom). If the patient has no pain, no imaging is necessary. However, if the patient winces in pain a CT chest is ordered (with no chest x-ray ever being ordered). This assessment is usually performed by the Emergency Department, particularly in cases like this where the receiving team will not have trauma experience.

64. The CPU also advised that accidental prescription of a drug using electronic prescribing is not uncommon in the literature[11] nor in the CPU's experience. The combination of simultaneously having multiple patients and multiple interruptions causing task-switching between patients *and* a user interface that has very small signifiers identifying for which patient the clinician is prescribing unfortunately occurs in every electronic prescribing system.[12] [13]

65. While the CPU commended West Gippsland Healthcare Group for involving EMR vendor improvements to the user interface to decrease the chances of such errors, the CPU suggested that the solutions themselves should be developed and tested by the vendor using iterative design by human computer interaction specialists assessing not only the interventions success/failure in real world environments (multiple concurrent patients, multiple distractions, suboptimal training) but also detecting unintended consequences of the changes (e.g. double checking will slow process and likely result in workarounds[14]).

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[10] Karlson, K. A., & French, A. (2025). Initial evaluation and management of rib fractures. *UpToDate*. Moreira, M. E., & Gammons, M. (Section Eds.), Ganetsky, M. (Deputy Ed.). Retrieved from https://www.uptodate.com

[11] Baysari, M. T., & Raban, M. Z. (1 August 2019). The safety of computerised prescribing in hospitals. *Australian Prescriber*. https://australianprescriber.tg.org.au/articles/the-safety-of-computerised-prescribing-in-hospitals.html#r14.

[12] Sopan A, Plaisant C, Powsner S, Shneiderman B. Reducing wrong patient selection errors: exploring the design space of user interface techniques. AMIA Annu Symp Proc. 2014 Nov 14;2014:1056-65. PMID: 25954415; PMCID: PMC4420010.

[13] Taieb-Maimon, M., Plaisant, C., Hettinger, A. Z., & Shneiderman, B. (2017). Increasing Recognition of Wrong-Patient Errors through Improved Interface Design of a Computerized Provider Order Entry System. *International Journal of Human–Computer Interaction*, *34*(5), 383–398. https://doi.org/10.1080/10447318.2017.1349249.

[14] *American Medical Association*. (20 April 2025). The hidden dangers of EHR pop-up fatigue. https://www.ama-assn.org/practice-management/digital/hidden-dangers-ehr-pop-fatigue .

Final submission from West Gippsland Healthcare Group

66. In line with procedural fairness principles, West Gippsland Healthcare Group was provided with an opportunity to respond to the CPU's advice outlined above and my proposed recommendations (see further below).

67. On 31 March 2026, West Gippsland Healthcare Group advised that they considered the proposed recommendations were highly constructive and the health service was *"already working on a protocol for trauma in the older person"* which would address the first recommendation.

FINDINGS AND CONCLUSION

68. Pursuant to section 67(1) of the Act I make the following findings:

    (a) the identity of the deceased was James Thomas Reilly, born 27 February 1938;

    (b) the death occurred on 9 September 2024 at West Gippsland Hospital, 41 Landsborough Street, Warragul, Victoria, from left haemothorax complicating rib fractures (not operated), sustained in a fall; and

    (c) the death occurred in the circumstances described above.

69. Following a fall on the morning of 8 September 2024, James developed facial droop and was transported to West Gippsland (Warragul) Hospital where he was treated for presumed transient ischemic attack. He was prescribed antiplatelet medication on this basis.

70. It appears that differential diagnoses were not considered at this time, despite James' complaint of back pain and possible chest pain (according to his daughter's account).

71. During his admission, James was also erroneously prescribed and administered clexane.

72. Following his deterioration the following morning, the erroneous clexane prescription was identified, along with a large tension haemothorax. Fractured ribs were not identified at this stage.

73. Whilst an urgent plan was made to insert an ICC, James deteriorated further and passed away.

74. Reviews following James' death identified multiple contributing factors to the outcome. In response, a number of recommendations have been made to address these issues so that similar deaths do not occur in future. These recommendations are reasonable.

75. I convey my sincere condolences to James' family for their loss.

RECOMMENDATIONS

76. Pursuant to section 72(2) of the Act, I make the following recommendations:

77. I <u>recommend</u> West Gippsland Health Group implement the following:

    (a) the West Gippsland (Warragul) Hospital Emergency Department introduce a process of clinically assessing elderly trauma patients to determine if any imaging of the chest (CT scan) is indicated (as outlined by the CPU above); and

    (b) the health service approach their EMR vendor regarding user interface improvements to address 'wrong patient' prescribing as outlined by the CPU above.

DIRECTIONS

78. Pursuant to section 73(1A) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

79. I direct that a copy of this finding be provided to the following:

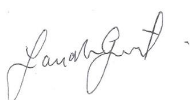
Irena Reilly, senior next of kin

West Gippsland Health Group

Ambulance Victoria

Senior Constable Liam Johnson, Victoria Police, reporting member

Signature:



Coroner Sarah Gebert

Date: 14 April 2026

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.