OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Therese Josephine TILSE**
TITLE OF COURT:	Coroner’s Court
JURISDICTION:	Townsville
FILE NO(s):	COR338/06(1)
DELIVERED ON:	13 May 2009
DELIVERED AT:	Townsville
HEARING DATE(s):	12 – 13 May 2009
FINDINGS OF:	Ross Mack, Coroner
CATCHWORDS:	CORONERS: Inquest – death at Townsville Hospital, excessive paracetamol ingestion, fall from bed

REPRESENTATION:

Council Assisting the coroner:	John Tate
QLD Health: Lawyers	Kate McIntyre – TressCox
Becky Crozford, Deborah Hunt, Toni Griffiths:	Roberts & Kane Solicitors

In January 2006, Therese Josephine TILSE was a lady 91 years of age living at home at 34 Werona Street, Mundingburra. She was able to live at home as a result of the significant assistance she received from her family, in particular her daughter, Dorothy Patricia Tinsley.

On the 7th January 2006, Mrs Tilse suffered a fall at home during the night and suffered an injury above her left eye as well as hurting her right knee. Mrs Tilse did not receive any medical treatment for that fall. Her daughter Mrs Tinsley on Monday the 9th January 2006 took a supply of paracetamol to her mother's house and administered an appropriate dose at about 8 o'clock in the morning. Subsequent to Mrs Tinsley's departure, Mrs Tilse located the *panamax* tablets and from all accounts continuously ingested them during the day.

When Mrs Tinsley became aware of her mothers ingestion of the *panamax* she immediately contacted Dr Markwell who indicated that Mrs Tilse should be taken to hospital – she was taken to hospital by her daughter Mrs Tinsley.

Mrs. Tilse's treatment at the hospital commenced on the basis the major threat to her health was the ingestion of paracetamol and her treatment followed the protocol in place for the treatment of excessive paracetamol ingestion. Notwithstanding the immediate concern about the ingestion of paracetamol, Dr Williams was concerned about Mrs. Tilse's behaviour. Dr Williams' concern was that something other than paracetamol was causing the symptoms being exhibited by Mrs Tilse. Dr Williams was suspicious about the fall Mrs Tilse had suffered on the 7th January 2006 and arranged for a CT scan in an attempt to discover an underlying cause.

A CT scan was performed and an assessment was made by Dr Amos, the Radiology Registrar on duty on the night. Dr Amos concluded there was no fracture involving Mrs Tilse's head nor was there any intra cranial bleeding. However there was some evidence that suggested a recent infarction in the right occipital lobe.

Subsequent to her return to the accident and emergency department, attempts were made to settle Mrs Tilse and they seem to have been successful enough to enable her daughter to finally leave the hospital to go home for a well earned rest.

Subsequent to Mrs Tinsley leaving the hospital, Mrs Tilse vomited and she was assisted by nursing staff who suctioned the residue of the vomit from her mouth. There appeared to be blood in the vomit and subsequent tests confirmed this to be the case. Treatment was administered in the form of medication to mitigate the vomiting and to address the prospect of intestinal bleeding.

At about 10:00pm Mrs Tilse, who had been observed to be "fidgety", made her way to the end of the bed and, according to Dr Withnall, manoeuvred into a squat position and fell forward from the foot of the bed with one hand on the bedrails which he confirms were in the upright position.

Mrs Tilse landed head first on the floor at the foot of her bed.

Mrs Tilse was taken for another CT scan which was performed at 10:30. The injuries revealed in the scan were devastating. Mrs Tilse had suffered an acute sub-dural haematoma together with a number of fractures of the face and head.

She was subsequently moved from the emergency department to the oncology ward which was a more peaceful setting because her prognosis was very poor.

At 4:35pm on the 10th January 2006 Mrs Tilse passed away.

A post mortem examination was conducted by Professor Williams who determined the cause of death to be:

1(a) Sub-Dural Haemorrhage, due to
1(b) Head Injury, due to
1(c) Fall.

In terms of Section 45 of *The Coroners Act* I make the following findings:

(a) The deceased person was Theresa Josephine TILSE
(b) Mrs Tilse died as a result of injuries she received in a fall she suffered at the Townsville General Hospital in the circumstances I have just described.
(c) Mrs Tilse died on the 10th January 2006.
(d) Mrs Tilse died at the Townsville General Hospital.
(e) The cause of Mrs Tilse's death was:

1(a) Sub-Dural Haemorrhage, due to
1(b) Head Injury, due to
1(c) Fall.

The findings I have outlined above would seem to indicate a simple train of events and, although the outcome was tragic, there was nothing controversial in the treatment of Mrs Tilse that would raise any concerns on my part.

As mentioned during the course of the proceedings, there was a concern on the part of Mrs Tinsley that her mother may have fallen from the bed whilst she was vomiting or otherwise unwell and she could only have fallen from the bed if the bed rails were not raised. In that regard the evidence from Dr Withnall is conclusive – he says his recollection is clear, in fact he says the image is "*indelibly imprinted*". His recollection with respect to the positioning of the rails is corroborated by each and every one of the nurses and doctors who gave evidence. I am able to make a finding that the rails on Mrs Tilse's bed were in fact raised and she in fact fell from the end of the bed as a result of her deliberate efforts to leave the bed.

The fact Mrs Tilse has fallen from the bed in hospital would generally give rise to some concern as to the nature and adequacy of the care and supervision during her stay in the emergency department. In this case those concerns have been eliminated by an appreciation of the evidence of the staff involved in the emergency department on the 9th January 2006. The efforts of the medical and nursing staff who were involved in the care of Mrs Tilse have been described by Dr Spain, an emergency medicine specialist, as excellent. I agree with this assessment.

Initially Dr Williams correctly suspected an underlying issue not related to the ingestion of paracetamol and she acted appropriately to address that concern.

The nursing staff, who were operating under some pressure as a result of the number of patients in their care, executed their duties professionally and compassionately.

Dr Spain who had the benefit of reviewing the procedures adopted on the night has concluded there is no reason to suggest an alternative care regime should have been adopted.

I cannot identify any aspect of the care of Mrs Tilse that warrants criticism.

That being said, the logical question that arises is how, if the care was appropriate, did such an adverse outcome eventuate? I think the answer to that is that the death of Mrs Tilse is a tragic accident. She did not exhibit any signs or give any indication to her daughter, the doctors or the nurses that she would engage in the behaviour that led to her fall. In fact the opposite is probably the case, she had been medically restrained prior to her having the first CT scan, she returned from that scan in a calm state. I accept that the medication was not long lasting. Mrs Tinsley was confident her mother was resting well enough that she, Mrs Tinsley could leave, and significantly Mrs Tilse was 91 years of age and could not have been regarded as being particularly mobile. She gave no warning she was about to leave the bed.

During the course of the Inquest Mrs Tinsley made some suggestions, at my invitation, that may prevent a similar tragedy and mitigate the heartache that follows such an event. Those suggestions were:

> *That a liaison officer should follow up with the next of kin and a meeting should be held to, in effect, de-brief the family. This is a suggestion with merit and Mr Luchich has indicated that this type of arrangement is available to families.*
>
> *That beds should be a lot lower and the floor around the bed should be padded in some way. The effect of this would be to reduce the impact on a patient who falls out of bed. This concept was raised with Dr Spain who indicated the concerns that such measures would address were matters that specialists such as him were alive to. He gave an example of the plans for the new Gold Coast Hospital that had accommodated those concerns.*

> *That cameras should be associated with beds in the emergency wards to capture the events that occur during a patient's course of treatment. I accept that there may be some benefit in such an innovation however I did not embark on this inquest with this type of recommendation in mind and I am of the view that it would be ill-advised of me to make such a recommendation without the benefit of expert evidence in the areas of health care, ethics and privacy.*
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> *Finally Mrs Tilse suggested that statements relevant to an Inquest such as this one should be made closer to the event that gives rise to the Inquest. That is a suggestion that is difficult to criticise however in this instance I am confident that the recall of the witnesses is accurate and the event is or was of such a nature that the recollection of the witnesses did not need a good deal of refreshing.*

That being said I am confident that even in the absence of such a recommendation the Patient Safety Centre will peruse these findings and the evidence adduced at the Inquest with a view to generating or refining a policy that may prevent accidents of the nature that claimed the life of Mrs Tilse.

It would be remiss of me to conclude this Inquest without some mention of the staff involved in the care of Mrs Tilse and the commitment exhibited by her daughter Mrs Tinsley.

It has become apparent during the course of the Inquest that the staff at the emergency department of the Townsville General Hospital discharged their duties as one would expect in a diligent manner. What one may not expect is the compassion they showed to the patient and next of kin. To a man and woman, each of the doctors and nurses displayed compassion to Mrs Tilse and Mrs Tinsley that was a credit to them and to that extent I commend them all.

With respect to Mrs Tinsley, I thank her for her contribution to this Inquest and I can say I hope that my children display the same commitment and compassion for my wellbeing if I am fortunate enough to reach the age her mother reached.

The Inquest is closed.

Ross Mack
Coroner
13 May 2009.