QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Cynthia Thoresen**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Brisbane
FILE NO(s):	2009/3
DELIVERED ON:	22 May 2013
DELIVERED AT:	Brisbane
HEARING DATE(s):	13 May 2013
FINDINGS OF:	Christine Clements, Deputy State Coroner
CATCHWORDS:	CORONERS: Inquest – fall at home, failure to get medical attention, elderly neglect

REPRESENTATION:

Counsel Assisting:	Ms Emily Cooper
Counsel for Marguerite Thoresen:	Ms C Morgan of Counsel I/B Legal Aid Queensland

Introduction

Cynthia Thoresen was born on the 10 January 1920. She died on the 3 January 2009 in the Royal Brisbane and Women's Hospital (RBWH). She was a week short of attaining her 89th birthday. Her death was reported to the coroner at the instigation of medical staff who were concerned that she had suffered neglect prior to her admission to hospital on the 17 December 2008. A coronial investigation and subsequent inquest was then convened.

Autopsy

A comprehensive autopsy examination was conducted by forensic pathologist Dr Nathan Milne on the 5 January 2009. Due to the requirement for specialist neuropathology examination and reporting, there was significant delay in completion of the autopsy report. Dr TE Robertson, the neuropathologist, completed his report on the 29 May 2009. Dr Milne incorporated this report into his final autopsy report, which was finalised after peer review on the 2 December 2009. Unfortunately, due to the pressure of workload, this is not an uncommon length of time to wait for an autopsy report where neuropathology is required.

Dr Milne determined Cynthia Thoresen died due to

1(a) Pulmonary thromboembolism, due to
1(b) Fractured right femur, due to
1(c) A fall.

He identified osteoporosis, Alzheimer disease and coronary atherosclerosis as underlying significant conditions which also contributed to her death. The pathologist's conclusions are accepted.

The autopsy report included a summary from the medical records of the patient at the RBWH. This included social history that she lived with her daughter, granddaughter and two great-grandchildren. Her daughter, Marguerite Thoresen, had informed the hospital Cynthia's past medical history included asymptomatic low blood pressure, right hip replacement surgery and dementia (although dementia had not been medically diagnosed). She was not taking any medication. Usually she was able to mobilise with a walking frame. She was said to have worsening confusion, was only sometimes lucid and did not speak often. Marguerite Thoresen received the Centrelink benefit as the 'carer' for Cynthia Thoresen.

Queensland Ambulance Attendance

Cynthia Thoresen was admitted to the RBWH on the 17 December 2008. Her daughter Marguerite had called the ambulance. The case history recorded by one of the two ambulance officers at the time is as follows – 'Patient lives at home with her daughter. Daughter states that her mother had been deteriorating for the past few weeks, and is now bedbound and unable to eat and drink. Daughter states that she had not been moved out of bed now for about one week. On QAS assessment patient was found to have a significantly shortened right leg. On questioning daughter, it was found that

this has been like it for approximately three weeks, and occurred after a fall. Daughter states they did not at the time think the two events were related. Patient on QAS arrival was screaming in pain and localising pain to the right hip area. Patient unable to talk, eyes screwing up in pain. Daughter states it has only been this bad for a couple of days. Patient has also been unable to eat and drink very much so the family have been feeding her chocolate ice cream. Patient has not been medically assessed for a long period of time, and is on no medication. Patient's daughter states that she has dementia, has had a previous partial hip replacement (right) and has previously had oedema in her legs.'

Rebecca Whiteley was the advanced care paramedic who attended the home where Cynthia Thoresen lived at Gap Creek Road, Kenmore Hills. She subsequently provided a statement to the police. She and her partner, Christopher Curtis, were met at the front door of the house by a woman subsequently identified as Marguerite Thoresen. Rebecca Whiteley detected a strong odour of excrement and urine coming from inside the house as soon as the front door was opened. She stated the odour did not smell fresh. The smell of urine was strong with ammonia and the smell of excrement was stale as if it had been there for some time.

I accept this experienced ambulance officer's evidence as accurate and reliable.

She observed the patient, Cynthia Thoresen, lying on her back on a bed to the right of the front door. The first thing she observed was that Cynthia was screaming in a painful scream which she described as having a 10 out of 10 pain ratio. She saw Cynthia's eyes were screwed up and she was holding her hands and arms in a decorticate position up against her chest. I accept the officer's recollection and description as accurate.

Rebecca Whiteley spoke with Marguerite Thoresen while her partner took the patient's observations. Marguerite was very vague. She indicated the patient was her mother and she had deteriorated over 'some' period of time. Marguerite told the ambulance officer that up until recently her mother had been alert, orientated and self-mobile. She said they were able to toilet her on a commode up until about a week ago but they had not been able to move her for a few days. She said she had not been able to move her mother so she did not know what her 'skin integrity' was like underneath.

The ambulance officer observed a brown substance on Cynthia Thoresen's lips and chin. Her daughter stated this was chocolate ice cream as this was all they were able to get her to eat. She showed the officer a small baby drinking container with water in it. She said her mother drank only one full container the day previous. She said she could not get her mother to swallow any pain medication.

Cynthia Thoresen continued to scream but was otherwise unresponsive to the ambulance officers' attendance upon her.

She was examined by Rebecca Whiteley who removed the doona covering her. She immediately noticed the right leg was markedly shorter than the left by about 10cm. Cynthia was continually trying to grab to the right hip area. The ambulance officer saw faeces stain around her leg extending down to her feet and toes. There was faeces stain on her right hand and under her fingernails. Cynthia's lips and oral cavity were very dry and her lips were peeling and cracked extensively.

The ambulance officer then asked more questions of Marguerite Thoresen about Cynthia's right leg. Marguerite said her mother had a partial hip replacement a long time ago. The ambulance officer asked her if she had observed the right leg was shorter than the other. She said she had been like that for a little while. When questioned further, she replied around three weeks or so. She confirmed this coincided with her mother's deterioration.

Rebecca asked her whether there had been any trauma in that three week period and she said no. Marguerite was asked whether Cynthia had fallen. She told the ambulance officer her partner had told her Cynthia had slipped off the commode onto the floor about three weeks ago but they did not think anything of it because it was a soft fall.

She confirmed this fall coincided with the shortening of the leg. Marguerite asked the ambulance officer whether she believed her mother had broken or dislocated her leg. She said she had not connected the fall with the shortening of her leg at the time.

Cynthia Thoresen continued to scream. She was restrained to enable the senior ambulance officer to gain intravenous access and administer morphine to alleviate pain.

The ambulance officer informed Marguerite it was necessary to place her mother on the scoop stretcher to extricate her from the house and transfer her to the ambulance. This process would cause her pain, but it was unavoidable. Marguerite said she had been moving her mother on a blanket that was underneath her by picking up the corners of the blanket. The ambulance officer explained to her that doing so would cause flexion in the hip and leg which would aggravate the injury further and cause extreme pain.

Cynthia's screaming increased when the ambulance officers used the scoop stretcher to move her to the ambulance vehicle. The ambulance officer told Marguerite she would give her mother more pain relief as soon as she was in the ambulance. Marguerite was becoming irate and wanted her mother's pain alleviated. She said her mother had got to 88 years without going into a nursing home and that they had done a good job.

The ambulance officer was able to communicate with Cynthia during the transport to the RBWH as the pain relief became more effective. She was able to identify she was experiencing pain localised in her right hip area.

Rebecca Whiteley stated she had been employed as a paramedic for seven years. She had never seen a person that could put up with the pain of a fracture and displacement of the magnitude evident in Cynthia Thoresen's x-rayed right femur for five minutes, let alone three weeks. Rebecca Whiteley expressed the view there was a deficit in the level of care provided with respect to hygiene. It concerned her that Cynthia had been left in this state for such a period of time.

The second ambulance officer in attendance, Christopher Curtis also provided his statement to police. This was consistent with respect to the odour of faeces and urine upon the front door of the premises being opened. He confirmed Cynthia Thoresen was screaming in pain and patting her right hip/leg area. He described her pain as 10 out of 10. He made this assessment on observation of Cynthia Thoresen's screwed up face and screaming.

Christopher Curtis observed the shortened right leg and apparent infections on the right foot and overgrown toenails curling towards the bottom of her toes. He also observed faecal matter on Cynthia Thoresen including down her legs, her feet, her arms and hands, as well as underneath her fingernails.

He went through the house to check for any easier exit route for the patient. In doing so he observed Marguerite Thoresen closing all doors before he could see inside and preventing his passage forward until she had closed off each doorway. In concluding his statement to the police, Christopher Curtis said he had never seen anything like this as a student paramedic over a two and a half year period. It disturbed him and he had never seen anyone, regardless of their age, that could withstand the level of pain inflicted by a fractured femur 'for five seconds let alone three weeks'.

Admission to hospital

The initial triage assessment recorded in the emergency department of the RBWH documented that Cynthia Thoresen had a shortened right leg following a fall three weeks ago. Ambulance officers reported she had been lying in bed for three weeks. She was distressed on arrival and had been given intravenous morphine enroute. On examination by the triage nurse it was observed the patient was 'covered in faecal matter, multiple pressure areas, very poor skin integrity'.

Examination by the doctor confirmed Cynthia was agitated, covered in faeces, had skin breakdown on the right buttock and an ulcer on her right heel. She was tender in her right hip and had a shortened, internally rotated right leg. Her right thigh was swollen.

X-Ray examination confirmed a fracture of the right femur distal to the pre-existing prosthesis. The fracture was assumed to be probably three weeks old.

The second ‘problem’ noted by the attending doctor was poor care at home. It was recorded she was dehydrated, had skin breakdown and faecal contamination.

The initial plan was for pain relief, intravenous fluid, insertion of an indwelling catheter and to be admitted under the orthopaedic consultant.

Nursing care administered to Cynthia Thoresen noted the edge of the right heel ulcer appeared to be necrotic and there were large areas of excoriation around Cynthia’s groin, lower back and thigh. She had pressure areas to her sacral region which was grossly excoriated. The nurse noted faeces smeared around her groin, down her legs, over her abdomen, and faecal matter on her feet and under her fingernails. The nurse also noted the patient was very distressed and appeared to be suffering significant pain. She was bathed in bed and cleaned as much as was possible given her pain.

Cynthia Thoresen was admitted to hospital at about 10:00am on the 17 December. At about 1:30 that afternoon a nurse from the Community Assessment and Referral Service contacted Cynthia’s daughter by phone. The nurse discussed Cynthia’s condition with Marguerite Thoresen. The daughter described her mother as usually capable of mobilising with a four wheeled walker. She stated she was very modest and did not like others helping her with showering. She said she had not accessed a general practitioner because she did not know any since the family had relocated from Perth. She showed some interest in installation of grab rails at the house. She said she would wait until her partner was at home before trying to visit her mother in hospital. That was on the 17 December.

A social worker rang Marguerite back later that afternoon and noted Marguerite appeared and sounded unconcerned with respect to her mother’s condition. She said her mother’s fall three weeks ago was not a big fall and she had just slipped. She explained her failure to do anything about this circumstance as relying on experience in Western Australia when ambulance officers attended but refused to take her mother to hospital. The social worker noted that even after detailed explanation of her mother’s serious condition her daughter remained oblivious.

The medical record from that point records a consistent effort by social workers and the treating orthopaedic team to engage Marguerite Thoresen in providing information about Cynthia’s medical history and involvement with her medical care. Collectively the medical team were concerned with the background care that Cynthia had been receiving at home. Her daughter did not visit her in hospital for days and the treating team could not gain a history from the patient. They were forced to seek advice from the Adult Guardian with respect to treatment decisions in the absence of appropriate communication from the daughter.

On the 19 December a notation in the record indicates the dietician had assessed Cynthia Thoresen as suffering moderate to severe malnutrition. It was noted she had no natural teeth or dentures. The information available

was that she had been consuming chocolate ice cream for the past three weeks. There was no initial concern about her capacity to swallow but food had to be minced due to her lack of dentition.

On the 19 December, the Adult Guardian consented to initial surgical intervention by way of traction to address the fractured femur. Marguerite Thoresen rang the hospital that day. She confirmed her mother had no regular general practitioner. She provided some background information and confirmed her mother had been refusing oral intake apart from ice cream in recent times. She confirmed her mother liked lemonade and tea but usually refused water.

It was noted when she visited her mother it was important to discuss obtaining consent to debride her mother's right heel and clarify the 'not for resuscitation' status with respect to ongoing care.

On the 22 December an operative procedure was commenced in an attempt to reduce Mrs Thoresen's fracture. The fractured femur was observed under an image intensifier. It showed no movement despite considerable effort by the surgeons assessing the fracture at the time. The bone was observed to be very osteoporotic, but the fracture was already substantially healed. In the expert opinion of the consultant orthopaedic surgeon, Dr Kevin Tetsworth, the immobility of the fracture and the degree of healing was consistent with a fracture age between three and six weeks. He went on to say the fracture could possibly be as old as 12 weeks.

Because of the stable nature of the fracture and Mrs Thoresen's general poor physical condition, it was determined that continuing the operation to an open reduction and internal fixation of the fracture would be too high a risk for Mrs Thoresen to withstand.

Generally, Dr Tetsworth was of the view that a fracture which was clinically stable to this degree of healing was unlikely to cause the degree of pain being demonstrated by Mrs Thoresen at this time. There was considerable uncertainty as to the continuing source of her significant degree of pain. Her altered mental state (advanced dementia) was considered to be a contributing factor to her distress.

Independent Medical Review

An independent medical overview of Cynthia Thoresen's injury and medical condition was provided by Dr Adam Griffin from the Clinical Forensic Medicine Unit. I note in particular Dr Griffin's statement, 'A person who suffers such a fracture (femoral shaft fracture) would have considerable pain in the area of the fracture, be unable to weight bear on the affected limb and have swelling and deformity of the leg. The leg itself would appear shorter than the other, and may be rotated.'

Dr Griffin also stated, 'Without alignment, the fracture must heal by secondary intention. That is, tissue bridges must be formed by the body to anneal the two ends of bone, and these are then calcified as part of the healing process.

This process had begun in Mrs Thoresen's case, which is why such difficulty was experienced by the surgeons in trying to realign the fracture.'

I accept Dr Griffin's report in full (Exhibit B5).

Of most weight was the independent expert review provided by the Director of Thoracic Medicine at the RBWH, Dr Stephen Morrison. His report is contained in Exhibit B7 and is attached in full because the document thoroughly outlines all of the relevant information sourced from the medical record at the RBWH. I note Dr Morrison was not involved in Cynthia Thoresen's medical care.

I accept Dr Morrison's expert advice and comment with respect to Cynthia Thoresen's initial presentation, condition and commentary regarding medical care. I also note and accept his comments with respect to conclusions which can be drawn from her presentation with respect to the level of care, or lack thereof prior to admission to hospital.

In particular I note and accept that although Cynthia Thoresen developed a pleural effusion during hospitalisation which required aspiration; this was *not* associated with the development of the pulmonary embolism on the opposite side of her chest. I further note Dr Morrison's reference to the pathologist's estimate of the age of the embolism as two days. This indicates the embolism developed after decisions were made that palliative care was the appropriate way in which to provide for Cynthia's circumstances by this stage. I reject any suggestion that fluid overload was causative or contributory to the development of the pulmonary embolism.

I also accept Dr Morrison's assessment that appropriate anticoagulant therapy to assist in the prevention of deep venous thrombosis was provided to Cynthia Thoresen during the hospital admission.

I will return to Dr Morrison's concluding paragraph with respect to the role of the patient's family in this clinical episode after consideration of Marguerite Thoresen's evidence at inquest.

Inquest

An inquest was convened in the public interest to examine how an 88 year old woman said to be 'cared for' by her family, particularly her daughter, in suburban Brisbane could present to a hospital in such a state. In making this statement I have regard to all of the information available prior to the convening of the inquest. All of the information has been tendered into evidence and was made available to Marguerite Thoresen.

Prior to convening the inquest it was considered that the police had concluded their investigation. It was noted that the investigating lead police officer had reached the conclusion that there was insufficient evidence to proceed with criminal prosecution of Marguerite Thoresen.

However, it remained a matter of public interest and concern that an elderly vulnerable woman suffering from dementia could remain without access for at least a three week period following a fall causing a fracture to the shaft of her femur whilst in the care of her family.

Marguerite Thoresen required the direction of the coroner and the protection of s. 39 of the Coroners Act prior to giving evidence before the inquest. It was considered she may be at risk of incriminating herself and she was therefore directed in the public interest to answer the questions put to her at inquest.

Marguerite Thoresen is not an uneducated or unintelligent person. Examination of the material available includes information she holds both a journalism and business degree. She did however present as an evasive and passively uncooperative witness. I note her counsel's submission that significant time has passed since these events occurred and she should be given the benefit of the doubt with respect to a failure of memory. I also have due regard to her personal circumstances with respect to an episode of stalking in Western Australia which appears to have damaged her confidence.

However, I also carefully considered the information of ambulance officers who attended her home, emergency department staff who examined Cynthia Thoresen on admission and her interaction with ambulance, hospital and police. In particular I note the transcript of record of interview between police officers and Marguerite Thoresen on the 17 January 2009 (Exhibit B15).

Marguerite Thoresen's evidence at the inquest was broadly consistent with the information she provided to police when they interviewed her in January 2009. She described her mother as previously being capable of mobilising with the assistance of her walking frame and the walking stick with four legs. She could wash herself and dress herself. She looked at magazines and watched television. She 'talked to us but only subjects she wanted to discuss'. She had occasional episodes of incontinence leading up to the time of the most recent fall.

Marguerite explained her aversion to drinking water based on childhood experiences in China. She drank tea, coffee and lemonade. She said she would call out if she needed anything and Marguerite was always around to assist.

She described the house as single storey with a long hallway with bedrooms and a toilet and shower around the corner next to the laundry. There were six bedrooms.

She described her mother as being modest and preferring to attend to her own hygiene needs. There was a shower chair for her assistance.

She confirmed no arrangement had been made to engage the services of a general practitioner in the 18 month period since the family had moved to Brisbane from Perth. She appeared to have relied largely on the services of

the ambulance whilst living in Perth and constantly quoted advice provided allegedly by those officers.

She had no cogent explanation of the Medicare records which indicated her mother previously attended general practitioners on a regular basis between 1984 (nine occasions), 1985 (six occasions), 1986 (four occasions), 1987 (once), 1988 (four occasions), 1989 (seven occasions), 1990 (once), 1991 (once), 1992 (five occasions), 1993 (six occasions), 1994 (12 occasions), 1995 (eight occasions), 1996 (seven occasions), 1997 (four occasions), 1998 (nine occasions), 1999 (five occasions), 2000 (two occasions), 2001 (four occasions), 2002 (one occasion), 2003 (10 occasions).

The last documented occasion recorded by Medicare when Cynthia Thoresen was attended by a doctor was in August 2003. Her daughter's only explanation of the cessation of medical overview was that her mother did not ask to be taken to the doctor and was not ill. She said there had been an adverse reaction at some time to influenza vaccine and therefore that was discontinued. Her last prescription of medicine was in August 2003.

I find Marguerite Thoresen's explanation of total absence of medical review to be unsatisfactory and implausible.

Marguerite made application for a carer payment in January 2001. A Dr Manuela Witte of Parkwood in Western Australia completed the health professional assessment on the 29 January 2001. Physical and intellectual disabilities were noted as well as general frailty and a tendency to wander and disregard danger. Blindness in the right eye was the only other sensory deficit. At the time of the assessment Cynthia Thoresen was assessed as independently functioning in all personal matters. The doctor assessed her as mildly cognitively impaired with symptoms fluctuating.

According to Marguerite Thoresen's evidence at the inquest she has not been required by Centrelink to submit any further medical assessment relating to her mother's condition.

Marguerite continually referred to attendance and a comprehensive assessment provided by ambulance officers in Western Australia. Again, this appears an unreasonable and inadequate reliance on a service not equipped to assess an elderly person's general medical wellbeing.

Marguerite referred to providing her mother with a good diet and giving her vitamin support. She was unwilling to identify what source of information she specifically relied upon to inform her assessment and decision-making with respect to her mother's overall health and wellbeing. She simply referred to reading a lot about health on the internet. Her evidence was contrary to the hospital dietician's assessment that Cynthia Thoresen was moderately to severely malnourished upon admission to hospital. I reject Marguerite's evidence that her mother was receiving adequate nutrition at home. Nor do I accept that this could be explained simply by a decline in appetite which

Marguerite said had occurred only over the last week prior to hospital admission.

Marguerite failed her mother entirely by not establishing a general practitioner to care for her ageing mother. She herself had attended a general practitioner on several occasions since arriving in Queensland including for tinnitus, sinus infection and removal of a tick.

Her explanation of her mother's fall was consistent with her earlier account to police in January 2009. She did not witness the event occurring but was informed her daughter Anita had found her grandmother (Cynthia) on the floor by the side of her bed. There was also reference to the possibility she had slipped on some paper placed on the carpeted floor by John Wegner (Marguerite's partner). This was in response to what appears to be Cynthia's problem of incontinence.

At the inquest Marguerite said her mother made a noise, she moaned or something when Marguerite and John (who had returned to the house) moved her from the floor back to the bed.

Marguerite simply took the view that it was a simple fall not unlike what had previously occurred in Perth. She said on this occasion ambulance officers had attended and declined to take her mother to hospital. Therefore she considered there was no need to seek medical assistance on this occasion.

She said her mother might have had a sore arm but did not refer to her leg at that time.

Marguerite gave evidence to the court that after the fall her mother got up on one occasion, out of bed. She said she grimaced a bit. She told her mother to stay in bed. She also referred to an occasion when she found her mother with her legs over the side of the bed, and again she told her mother to stay in bed to recover.

She said it was the day after the fall that she saw her mother stand up and grimace in pain.

Medical evidence from Dr Griffin of the Clinical Forensic Medicine Unit brings this account into some question. Dr Griffin said a person who suffers such a fracture (fractured shaft of femur) would have considerable pain in the area and would be unable to weight bear on the affected limb, .which would appear shorter than the other and may be rotated.

What is unforgiveable is the length of time Cynthia Thoresen remained completely bedbound, unable to access any medical attention and at the mercy of her daughter's deficient decision-making with respect to adequate or appropriate care.

When pressed, Marguerite explained that she provided a 'nappy' for her mother in the bed in which she was confined. She would roll her mother over

a bit and put the towel beneath her. The towel was not secured in any way. She said she changed it on multiple occasions and washed her mother daily.

She said her mother may have complained of a stomach ache at some stage and she may have had some sores on her back.

When spoken to in January 2009 she told police she had given her mother pain relief of nurofen and panadeine and that her mother was sleeping a lot.

As to nutrition, she said her mother was eating and drinking in the first two weeks after the fall. She referred to egg-based dishes, fruit cake, soft chicken, vegetables and toast. However she said in the last week prior to her calling the ambulance her mother was eating less and not drinking as much as before.

Marguerite said she assumed her mother had sprained her knee.

She was evasive with respect to observations she made of her mother's skin condition and the fact that one leg was shorter.

Despite the evidence of the ambulance officers, which I have no reason to doubt; Marguerite denied her mother was screaming out in pain when ambulance officers attended at her home.

However, at the time she was interviewed in January she did concede to police in hindsight that it was probably as a result of moving her mother from the bedroom to a bed immediately near the front door. She did this, she said, with her partner John by slinging her mother in a quilt. She acknowledged this caused her mother distress.

Marguerite's explanation of why she did this was totally unsatisfactory. She said she did this to assist access to the ambulance officers, which was unconvincing. I conclude her real motive was to avoid the ambulance officers observing the conditions in which her mother had been lying in bed for at least three weeks. I note in particular the ambulance officer's evidence that when he went to explore alternative avenues to remove Cynthia from the house; Marguerite went ahead of him down the hallway. She closed each door to rooms before he reached them thereby preventing him from seeing into the rooms.

With respect to the period of time her mother had endured after the fall and prior to the attendance of the ambulance, the evidence varies. Marguerite refers to a period of three weeks. However, there is reliable independent medical evidence which puts the range of time possible out to a period as long as 12 weeks. In Dr Tetsworth's expert opinion, the degree of healing evident in the fracture suggested the fracture had most likely occurred somewhere between three and six weeks prior to that day. That time was measured back from 22 December 2008 when the orthopaedic team attempted to realign the fractured bone.

There can be no greater degree of certainty about the fall. Suffice to say it is an appalling thought to consider the pain endured by Cynthia Thoresen during this period when she was totally at the mercy of her daughter's inadequate regime of 'care'.

The other evidence where Marguerite Thoresen provided more information to the inquest than previously detailed in her interview with police, related to the explanation for the smell of urine and faeces referred to by ambulance officers. Both officers remarked upon it and that the odour was stale, including a reference to ammonia rather than fresh urine.

At inquest Marguerite was quick to explain this odour as due to her grandchildren who were sometimes allowed to run around the house without nappies. I reject this explanation. It is far more consistent with the observation of the ambulance officers that indeed Cynthia Thoresen was significantly smeared and covered in faecal material on her legs, back, groin, and under her fingernails. The degree of excoriation on her back, and in particular in her groin area would be consistent with the presence of faeces and urine over time. Marguerite Thoresen considered the medical and ambulance description was exaggerated. I do not accept this. Nor do I find any credibility in the suggestion that some of the material was in fact chocolate ice cream.

When pushed on this issue at the inquest she did refer to sponge bathing her mother and that her 'upper body was clean'.

While it can be well understood that the care of an elderly demented person on a full-time basis is an extremely challenging task, it is incomprehensible that her daughter would not seek assistance in this task when it was clearly apparent she was unable to continue to provide to her mother the required degree of care. There was no explanation offered by Marguerite.

If the motive was the continuation of the carer's allowance, (which is unknown) it prompts me to suggest the necessity of an annual independent medical review of the person being cared for. This measure may assist in preventing such an appalling decline in another vulnerable elderly person.

In hindsight, Marguerite concedes perhaps she could have called the ambulance a week earlier, but still does not consider she might have sought medical review immediately after the fall.

She also denied the hospital assessment of her mother being moderately to severely malnourished. She said it was only in the last week that her mother was eating inadequately. She said she did her best and wanted to care for her mother in the home rather than place her in nursing accommodation, which her mother had expressed an aversion to at an earlier time. While this may be true, Cynthia did not receive adequate care with her family and is likely to have received a much better standard of care and access to adequate medical care had she been living in a formal aged care facility.

Conclusion

I refer back to the evidence of Dr Morrison and quote from the final paragraph of his report – 'When Cynthia Thoresen was brought to RBWH, her state of filth, faecal contamination and the existence of numerous pressure sores suggested a severe degree of neglect by family members, particularly by her daughter Marguerite Thoresen who is self described as the patient's 'carer'. The three week delay between the fall at home and the patient's presentation to RBWH for treatment, during which she was in pain, completely immobile and bedbound, I consider neglectful to the point of cruelty in a distressed, demented and totally dependent patient. Likewise, the claim that the family thought the injury to be minor (as recorded by the orthopaedic resident on the day of admission) lacks all credibility, particularly in the full knowledge that she had sustained a previous hip fracture.'

Dr Morrison goes on to say the failure of the family to involve a general practitioner in her care since coming to Queensland in 2007 was also an issue. In an 88 year old patient with previous hip fracture, the probability of osteoporosis is high, and had this been diagnosed and treated it is possible that the recent fall might not have resulted in a fracture. At the very least, Dr Morrison says a call to the GP surgery after the recent fall would have resulted in either a home visit, or alternatively arrangements made to take the patient to an emergency department immediately.

Finally, Dr Morrison stated 'A general clinical sense would suggest that a patient who is clean, well nourished and free from infected bed sores would be better positioned to withstand the risks of anaesthesia and surgery following a femoral fracture, particularly if brought to hospital in a timely manner'.

I concur with Dr Morrison's opinion and lament the last few weeks of Cynthia Thoresen's existence in her home environment.

Contrary to Marguerite Thoresen's suggestion, I consider the care provided at the RBWH was appropriate, compassionate and tailored in the best interests of Cynthia Thoresen.

Section 45 findings

(a) The identity of the deceased person was Cynthia Thoresen.

(b) Cynthia Thoresen was an 88 year old woman suffering from dementia and, osteoporosis. She had previously fallen and broken her hip requiring a partial hip replacement. She was socially isolated and totally reliant for her physical and medical care upon her daughter, Marguerite Thoresen, who had performed the role of carer over a number of years. Approximately three weeks prior to 17 December 2008, Cynthia Thoresen fell and sustained a fracture of her femoral shaft. Her daughter and other family members assisted her back to bed where she remained until evacuated by ambulance officers on 17 December. She experienced severe pain during this period and her physical condition deteriorated including the contamination of her body

with faeces and urine and the development or worsening of pressure sores. When admitted to hospital she was moderately to severely malnourished. Despite all medical efforts to reduce the fracture (which was abandoned due to the period of time since the fracture) and all other medical care, including prophylactic measures to reduce the risk of deep venous thrombosis, she deteriorated and died.

(c) Cynthia Thoresen died on 3 January 2009.

(d) She died at Royal Brisbane and Women's Hospital at Herston, Brisbane in Queensland.

(e) She died due to pulmonary thromboembolism, due to a fractured right femur, due to a fall.

Section 46 comments

The following comments are made in the interests of –

Public health and safety,
The administration of justice and
Ways to prevent deaths from happening in similar circumstances in the future.

In a time of an ageing population and pressure on access to services to care for the elderly, there is likely to be an increase in circumstances where families take on the care of their elderly relatives. The responsibility can be a difficult challenge for a family. Our society acknowledges and supports the efforts of family by providing carer's benefit to provide some limited assistance to the carer in discharging their responsibilities.

It is important to note an elderly person may be entirely dependent upon their family for provision of physical and medical care. This was the reality in Cynthia Thoresen's case.

The evidence in this inquest was that after acceptance of the initial application for the carer's benefit, the carer was not required to submit any further regular documentation evidencing the medical status of the person being cared for. . (I note some inquiry is underway to check this information from Centrelink and may require an addendum to this comment.)

(a) Having regard to the available evidence it is suggested a recipient of the carer's benefit should be required to submit an annual independent medical review of the person being cared for. This measure may assist in preventing such an appalling decline in wellbeing of another vulnerable elderly person.

The investigating police officer who appeared before this inquest considered there was insufficient evidence to support a successful prosecution in the circumstances and in the context of the existing law. He had regard to other recent prosecutions. He suggested a review of the legislative regime to create a new offence more akin to the offences relating to 'cruelty to children'.

(b I consider it is appropriate to refer the matter to the Attorney General, who may consider referring the issue of review of legislation to the Queensland Law Reform Commission.

Chris Clements
Deputy State Coroner

22 May 2013

[redacted]

Cynthia THORESEN

Royal Brisbane & Women's Hospital
Health Service District

Department of Thoracic Medicine
Dr Stephen Morrison, Thoracic & Sleep Physician (Director)
Dr David Fielding Thoracic Physician (Deputy Director)
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Detective Senior Constable G Skugor
Criminal Investigation Branch
Indooroopilly Police Station
343-347 Moggill Road
INDOOROOPILLY Q 4068

Dear Det Const Skugor

RE: Cynthia THORESEN UR: 1844552 DOB: 10/1/1920

Thank you for asking me to provide an expert medical opinion in regard to the admission of the above deceased patient to the Royal Brisbane and Women's Hospital from 17 December 2008 to 3 January 2009. I provide that opinion herewith. In compiling my report I have used as data sources the hospital chart, the autopsy report, the computerised PACS system for radiology and the computerised pathology system Auslab. I had no personal involvement in the case at any time. My report is subdivided into five sections, which are sub-headed.

1. SUMMARY OF THE CLINICAL CASE

Cynthia Thoresen, an 88-year-old lady, was brought in by ambulance to the Department of Emergency Medicine at RBWH at 9:45 am on Wednesday 17 December 2008. She was not able to give any history herself, but the ambulance officers had obtained background information from the patient's daughter, Marguerite Thoresen, with whom Cynthia lived. Further details of the history were obtained by clinical staff in telephonic conversation with Marguerite Thoresen subsequently. The background history is that Cynthia Thoresen was originally from Western Australia, and had moved to Brisbane some 18 months earlier because of inability to cope on her own. She had previously undergone a partial right hip replacement at Fremantle Hospital. Since moving to Brisbane Cynthia was able to ambulate around the home, with the aid of a walker, though on account of progressive dementia, she rarely went out or socialised. It was reported by her daughter that Cynthia had had a fall in the house some three weeks prior to admission. She had been found on the floor by her bed, and Marguerite claimed that she did not realise that the fall had resulted in a fracture. However, since the fall, Cynthia had been intermittently crying out in pain, and had not been able to get out of bed at all during the three-week period between falling and being brought to RBWH. She had also been reluctant to take food and drink, and had only managed to consume ice-cream during this period. Because of inability to mobilise to the bathroom, she had become progressively more soiled with faeces, and on arrival at RBWH was covered in faecal material over most of her body, including between the toes and under the fingernails, with much evidence of skin excoriation. On examination on arrival, she was in an agitated state, but afebrile and not haemodynamically compromised. Pulse rate was 85 bpm, and blood pressure 130/80. As mentioned, she was extensively soiled with faecal material, and in addition had evidence of a number of bed sores, including a 10 cm x 1 cm linear pressure sore on the right buttock, a 12 cm x 3 cm confluent pressure sore in the natal cleft area and a 3-4 cm diameter pressure sore with necrotic skin on the right heel. The right hip was tender on movement, and the right leg shortened and internally rotated. There was some swelling and tenderness of the right thigh. She

appeared generally malnourished, but examination was otherwise unremarkable, with normal cardiovascular, respiratory and abdominal examinations. She was admitted under the orthopaedic surgeons, having been assessed by the orthopaedic registrar in the emergency department on the day of admission. Because of concerns about her social background, a number of allied health professionals assessed her while still in the emergency department, including a detailed assessment by the social worker, Ms J Forest-Wyatt, who also noted that Marguerite Thoresen over the telephone seemed unconcerned about her mother's clinical condition, and gave a number of reasons why it was not possible for her to visit. On 18 December 2008, a Steinman pin was inserted for the purposes of traction. The plan was to proceed to internal surgical fixation when an operating theatre became available, probably early the following week. A medical consult was requested, and a consultant physician, Dr S Kanagarajah, saw her on 19 December 2008, assessing Cynthia Thoresen's prognosis as grave. Recommendations included obtaining a CT head scan on account of her uncommunicative mental state, and contacting the Adult Guardian to obtain surgical consent, since there had been no contact from family members since admission. Dr Kanagarajah recommended that hydration be optimised intravenously, and that antibiotics be given for probable urinary tract infection. The latter was subsequently confirmed by a positive urine culture growing pseudomonas. The CT head scan was relatively unremarkable, showing only a degree of cerebral atrophy. Blood tests revealed a normal full blood count, a slightly reduced eGFR suggesting mild renal impairment, and a low plasma albumin at 23. The chest x-ray and ECG were unremarkable. Plain x-ray taken on admission confirmed a fracture of the distal part of the right femur. The presence of the hemi-arthroplasty was also noted. Cynthia was taken to theatre on 22 December 2008, and under general anaesthesia it was discovered that there was minimal movement at the site of the fracture, consistent with the latter having occurred several weeks previously. On discussion with the director of orthopaedics, Dr K Tetsworth, the recommendation was that the internal fixation not be proceeded with, since there was high risk of infection and it was considered unlikely that the patient would ever walk again, given her overall condition. The traction pin was therefore resited in her tibia, away from the fracture site, to facilitate ongoing traction. No further definitive surgery was performed. Thereafter management in the orthopaedic ward was conservative, with continuing traction and administration of analgesics and antibiotics. The patient continued to be seen by the physician team, who expressed concern about her state of nutrition and requested gastroenterology review with a view to parenteral nutrition. The decision was that it would not be appropriate to offer parenteral nutrition, and that her nutrition could be maintained by means of a nasogastric tube. This was undertaken, while fluid management continued with intravenous normal saline. The patient received ongoing attention from a number of allied health professionals, including the occupational therapist, the dietitian and speech pathologist. In view of the overall gravity of the situation, medical staff requested a meeting with the patient's daughter to establish a Not For Resuscitation Order. Marguerite Thoresen, however, withheld consent for this, insisting that full resuscitation measures be applied, should the need arise. The Adult Guardian was unwilling to override this direction. The clinical course thereafter was one of gradual deterioration. By 25 December 2008, Cynthia was developing signs of fluid overload, with peripheral oedema, and by 28 December 2008, there was evidence of a left-sided pleural effusion, confirmed radiologically. It is likely that the fluid overload was in part the result of ongoing treatment with 2-3 L daily of normal saline, as well as the intravenous Timentin prescribed for the urinary tract infection. Diuretics were commenced intravenously, and a left-sided chest aspiration was performed following ultrasound confirmation. 400 mL of straw-coloured fluid were aspirated, and chemical analysis of this confirmed it to be a transudate with a protein level of <5 g/L. There was no growth on culture. The situation continued to deteriorate, and by 30 December 2008, the effusion had become bilateral, again confirmed radiologically, and the oxygen saturation had dropped requiring 10 L/min of supplemental oxygen to maintain saturation in the mid to high 90s. In view of the continuing deterioration, the case was discussed again with the director of the orthopaedic unit, Dr Tetsworth, who agreed with the recommendation of the general physician that palliative measures now be implemented, and recommended that the traction pin be removed. This was undertaken aseptically later that day. Also on 30 December 2008, the patient was assessed by the palliative care team, who recommended the cessation of nasogastric feeding, and the implementation of a palliative drug regimen consisting of morphine, midazolam and haloperidol. The proposal to implement palliative care was initially opposed by the patient's daughter Marguerite, who later that day changed her mind and agreed. Later again that same day, however Marguerite indicated that she wished her mother transferred to another hospital (Canossa). This was strongly opposed by the managing team, since the patient was considered close to death. In the event, there were no beds available at Canossa and the transfer did not proceed. The Adult Guardian was again consulted, who agreed with the implementation of palliative care and also with an associated Not For Resuscitation Order. By 31 December 2008, the patient appeared significantly less distressed after 24 hours on the above palliative regimen. Questions were raised by family members as to why Cynthia was

not being monitored more intensively. They were given the explanation that patients on a care of the dying pathway could find it onerous to be subject to frequent measurements. Then, somewhat unexpectedly, the patient's daughter Marguerite telephoned to say that she did not wish her mother to be touched at all by staff and threatened to call the police were this to happen. An urgent family meeting was therefore scheduled for 3 pm on 31 December 2008. Marguerite Thoresen declined to attend. The patient's son, newly arrived from Melbourne, attended this meeting instead and appeared accepting of the gravity of the situation, and of the appropriateness of the palliative treatment which had been instituted. From that point on, the patient's course was of gradual weakening, in a relatively undistressed fashion given the circumstances, until her death peacefully at 18:15 on 3 January 2009. After the death had been certified by the ward call resident, there is a nursing note in the chart indicating that the Graseby syringe pump used to provide the palliative medications had been found disconnected from the patient on a bedside table. It was presumed that this had been removed by family members, though that was not actually witnessed. Fortitude Valley Police were notified of this occurrence.

2. COMMENTARY ON POST-MORTEM FINDINGS OF PULMONARY EMBOLISM

The post-mortem finding of pulmonary embolism is common in elderly hospitalised patients, and in a high proportion of these, no clinical diagnosis of pulmonary embolism is made ante-mortem. This is likely to be at least in part because the clinical symptoms and signs of pulmonary embolism are notoriously unreliable. The most common (and classical) presentation of pulmonary embolism is with sudden onset of dyspnoea, with or without pleuritic chest pain, and usually associated with some degree of hypoxaemia. There may or may not be signs in the lower limbs suggestive of venous thrombosis. In some patients there is haemodynamic compromise, with tachycardia and hypotension. Given the unreliability of the clinical features, diagnosis usually requires some form of imaging, most commonly either a CT pulmonary angiogram or ventilation perfusion isotope lung scan. Having reviewed Mrs Thoresen's case records, there was very little to suggest the development of pulmonary embolism in this patient prior to death. A degree of hypoxaemia had been noted, but there are many causes of this, and among these causes are pleural effusions, which this patient had. While pleural effusion can itself be a feature of pulmonary embolism, I do not consider this patient's pleural effusions likely to be attributable to this cause. Her effusion presented on the left side, whereas the pulmonary embolus found at autopsy was in the right lower lobe. Moreover, the fluid aspirated from the chest was a transudate (low protein content) whereas pleural effusion in pulmonary embolism is usually attributed to pulmonary infarction (which was not found at autopsy), and is generally associated with a high protein content (exudate). At no time did her haemodynamic observations suggest the development of pulmonary embolism. For these reasons, I do not consider the absence of a pre-mortem diagnosis of pulmonary embolism surprising. Moreover, the pathologist's estimate of the age of the embolism was two days. This would have put the occurrence of the embolism during the time after which palliative care measures had been instituted. It would be completely contrary to the spirit and purpose of palliative measures to implement invasive investigations such as those mentioned above in a patient on a care of the dying pathway.

3. THE OCCURRENCE OF PULMONARY THROMBOEMBOLISM IN PATIENTS WITH FEMORAL FRACTURE AND ASSOCIATED SURGERY

Patients presenting with fractured femur commonly develop deep venous thrombosis of the lower limbs or pulmonary embolism, or both. Some surveys have suggested an incidence as high as 80% in such patients, especially those with additional high risk factors. These risk factors include oestrogen therapy, old age, prolonged immobility, the presence of cancer, the occurrence of a previous deep venous thrombosis or pulmonary embolism, obesity, or multiple medical comorbidities. It is evident that several of these high risk factors were present in this case. Current guidelines recommend prophylactic anti-coagulant treatment, usually with low molecular weight heparin for patients in this category. These guidelines are well known and widely practised, and I note that appropriate prophylactic therapy with the anti-coagulant Clexane was prescribed to this patient on admission, and continued until the decision to implement palliative care was taken.

4. OVERALL COMMENTARY ON CLINICAL MANAGEMENT

From the outset, the complex nature of this patient's presentation was recognised. Even while the patient was still in the emergency department, a holistic approach was being taken, with the participation of a number of allied health professionals, and a multidisciplinary approach was continued throughout the

patient's entire admission. During the last few days of her life, this included the participation of a palliative care team. As a respiratory physician, I am not fully qualified to comment on the orthopaedic aspects of the case, but the decisions taken to me appear sound, objective, and appropriate to the clinical and social circumstances of this patient. The possible impact of family and social factors was recognised early on, and it appears that family members were treated at all times with empathy and patience. Interaction with the Adult Guardian appears correct in the circumstances. A minor criticism of management would be that over-reliance on normal saline perhaps contributed to the fluid retention seen towards the end of the admission. However, the patient was severely hypo-albuminaemic from the time of admission, probably on the basis of prolonged malnutrition, and fluid retention is well known to be associated with this. Overall, I consider the clinical management this patient received at RBWH was appropriate, conscientious and thorough. Full usage of a wide range of resources was employed.

5. THE ROLE OF THE PATIENT'S FAMILY IN THIS CLINICAL EPISODE

When Cynthia Thoresen was brought to RBWH, her state of filth, faecal contamination and the existence of numerous pressure sores suggest a severe degree of neglect by family members, particularly by her daughter Marguerite Thoresen who is self described as the patient's "carer". The three-week delay between the fall at home and the patient's presentation to RBWH for treatment, during which she was in pain, completely immobile and bed bound, I consider neglectful to the point of cruelty in a distressed, demented and totally dependent patient. Likewise, the claim that the family thought the injury to be minor (as recorded by the orthopaedic resident on the day of admission) lacks all credibility, particularly in the full knowledge that she had sustained a previous hip fracture. The reason given for the delay, namely a previous failure by ambulance officers to deliver Cynthia to a hospital, some years ago, in Western Australia, and in circumstances which are not known, is patently ridiculous. Next, there is the failure of the family to involve a general practitioner in her care since coming to Queensland in 2007. In an 88-year-old patient with previous hip fracture, the probability of osteoporosis is high, and had this been diagnosed and treated it is possible that the recent fall might not have resulted in a fracture. At the very least, a call to the GP surgery after the recent fall would have resulted in either a home visit, or alternatively arrangements to take the patient to an emergency department immediately. Next is the apparent absence of concern by family members as to the seriousness of the patient's condition on admission. This is evidenced by their failure to accompany the patient on the day of admission, failure to visit for the next three days (and then for less than five minutes without speaking to any staff) and strongly suggests a lack of care for a vulnerable family member for whom they had taken responsibility. Indeed, the hostile remarks made by Marguerite Thoresen to various staff members (eg to the emergency medicine social worker over the telephone on 17 December 2008 that she had "no business" asking about home circumstances, and later on, the threat to call the police) suggests either a severe lack of insight or alternatively an element of guilt at allowing the situation to get so out of hand. This early lack of concern is in sharp contrast to later pressures brought to bear on clinical staff to persist with measures deemed futile. It is a matter of judgement whether the ultimate outcome for Cynthia Thoresen would have been different, had proper care and support been provided to her in the time leading up to admission. A general clinical sense would suggest that a patient who is clean, well nourished and free from infected bed sores would be better positioned to withstand the risks of anaesthesia and surgery following a femoral fracture, particularly if brought to hospital in timely manner. In compiling this report, however, I do not consider it my role to pre-empt the judgement of the Coroner's Court on this question.

I trust the above will meet your requirements. Please contact me if further information is required.

Yours sincerely

Stephen Morrison

Dr Stephen Morrison MA PhD FRCP FRACP
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Monday 29 August 2011
(dictated 26.8.2011)