MAGISTRATES COURT TASMANIA

MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Olivia McTaggart, Coroner, having investigated the death of Irene Barbara Taylor

Find, pursuant to Section 28(1) of the *Coroners Act* 1995, that

a) The identity of the deceased is Irene Barbara Taylor;

b) Mrs Taylor was born on 20 April 1923 and was aged 99 years at her death. Since early 2021 she had been a resident of Fairway Rise (Southern Cross Care) nursing home in Lindisfarne. She suffered advanced dementia and had frequent falls because of her impulsivity and dementia-related cognitive decline. She was assessed as being at high falls risk and prevention measures were put in place by the nursing home. These measures included a bed sensor and close monitoring, full assistance with hygiene, crash mats around her bed, and assistance with mobilisation.

At 7.15pm on 11 July 2022 Mrs Taylor fell from standing onto her right side in an attempt to pick up an object from the floor. The fall was witnessed by a staff member, who noted that Mrs Taylor complained of pain to her right hip after the fall. An ambulance was called and ambulance officers transferred her to bed. However, later in the evening, she rolled from her bed onto a crash mat. I am satisfied that she did not suffer significant injury from this second fall but her right hip pain continued from her first fall. Mrs Taylor was transported to the Royal Hobart Hospital. In hospital, she was assessed as having sustained a fracture of the right neck of femur (hip) which was not suitable for surgery given her poor prognosis. A palliative approach to her treatment was taken and she passed away two days after her hospitalisation;

c) Mrs Taylor died as a result of pneumonia due to a fractured right neck of femur (hip) sustained in a fall; and

d) Mrs Taylor died on 14 July 2022 at Hobart, Tasmania.

In making the above findings, I have had regard to the evidence gained in the investigation into Mrs Taylor's death. The evidence includes:

- The police and hospital reports of death for the coroner;
- Affidavits confirming identification;
- An opinion of the forensic pathologist regarding cause of death; and
- Nursing home report to the coroner and associated records and correspondence.

Comments and Recommendations

There are no issues arising in this investigation regarding the falls risk assessments or the prevention measures specified in attempting to ameliorate Mrs Taylor's high risk of falling.

However, at the time of Mrs Taylor's fall resulting in her fractured hip, she was not wearing hip protectors as she should have been. It appears that the staff did not have hip protectors, or at least unsoiled hip protectors, available for Mrs Taylor at that time. Hip protectors may have prevented or reduced the severity of her injury.

I **recommend** that the Fairway Rise nursing home takes appropriate action to ensure, to the extent possible, that residents who are assessed as requiring hip protectors are fitted with them at all times when required.

I convey my sincere condolences to the family and loved ones of Mrs Taylor.

Dated: 14 April 2023 at Hobart in the State of Tasmania.

Olivia McTaggart

Coroner