MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Robert Webster, Coroner, having investigated the death of Wesley Paton Courtney

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

a) The identity of the deceased is Wesley Paton Courtney (Mr Courtney);

b) Mr Courtney died as a result of injuries sustained in a fall;

c) Mr Courtney's cause of death was head and neck injuries; and

d) Mr Courtney died on 13 May 2020 at Hobart, Tasmania.

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Mr Courtney's death. The evidence includes:

- The Police Report of Death for the Coroner;
- The Tasmanian Health Service (THS) Death Report to Coroner;
- Affidavits as to identity and life extinct;
- Affidavit of the forensic pathologist Dr Christopher Lawrence;
- Affidavit of Mrs Margaret Courtney;
- Affidavit of Constable Matthew Reardon;
- Electronic patient care record obtained from Ambulance Tasmania;
- Medical records obtained from the Royal Hobart Hospital (RHH);
- Medical records obtained from Mr Courtney's general practitioner;
- Records obtained from the Ningana residential aged care facility (RACF) operated by Uniting AgeWell (UAW);
- Specific response to Mrs Courtney's concerns received from the RACF; and
- Report of the coronial medical consultant Dr Anthony Bell MB BS MD FRACP FCICM.

Background

At the date of his death Mr Courtney was 84 years of age (DOB 31 August 1935), married, retired and he resided at the Ningana RACF at Sorell which is operated by UAW.

Mr Courtney was the second of four children born to his parents in Tallangatta Victoria. Mr Courtney was a builder by trade. He undertook his apprenticeship at Beechworth Technical College. He excelled at sport. He played football for Albury as a teenager and he was a very good runner and cyclist.

Mr Courtney completed his National service when he was in his early 20s. He also moved to New Zealand for approximately five years in the 1950s.

Mr Courtney met his future wife Margaret in 1968. Mrs Courtney was married to John Lovett who passed away in 1996. Over a number of years Mrs Courtney managed and worked in plant nurseries while Mr Courtney was a manufacturer's agent who would supply stock to those nurseries. In 1996 they were working together at Harmony Nursery in Lauderdale. Mrs Courtney suffered a heart attack after which Mr Courtney indicated he wished to look after her and so he built a house at Carlton where they lived together until 2003. They were married in 1999. Thereafter they purchased 10 acres at Penna where Mr Courtney built the house in which they resided. Mr and Mrs Courtney also operated a wholesale nursery business from that property.

Mrs Courtney says that in or about 2015 her husband was having difficulties with his short-term memory. She says her husband also had difficulties with dysphasia and he started to have falls in the green house and garden. Mrs Courtney says her husband became very frustrated with the treatment he was receiving so he stopped going to see the neurologist. Then in 2017 while he was driving in Hampden Road, Battery Point, he stopped the vehicle and asked his wife to drive. He was confused about the route to take to a wedding they were attending. He never drove after that point. Over this period of time his role in the nursery business reduced and in about 2018 he ceased his physical roles in the nursery; for example making and bagging up potting mix. Sadly Mrs Courtney watched her husband gradually decline.

In December 2019 Mr Courtney was diagnosed with a bladder and chest infection and was taken by ambulance to the RHH where he was treated as an inpatient for about 10 days. His treating general practitioner wanted Mr Courtney to receive respite care from the Lillian Martin RACF at Mornington but Mr Courtney did not wish to go. Neither he or Mrs Courtney ever wanted to go into a nursing home and Mrs Courtney intended to look after Mr Courtney for as long as she could but she realised by that stage she could not look after him anymore. To her surprise after being told a few days earlier Mr Courtney was in no fit state to return home and the facilities at his home were unsuitable and that he needed to go into care Mr Courtney was discharged from the RHH. During the next week he had 2 falls at home and Mrs Courtney could not lift him. She rang a helpline to an ambulance

service which assisted getting Mr Courtney back into bed. The general practitioner agreed Mr Courtney could not remain home and as a result he was transported to the Lillian Martin home in Mornington for respite care where he remained between 23 December 2019 and 20 January 2020 during which time he was assessed with a view to becoming a permanent resident. Mrs Courtney says he sustained quite a number of falls during that period.

Mr Courtney's name was placed on a waiting list for the Ningana RACF and he was able to move into that facility on 27 February 2020. Mrs Courtney is aware, due to the phone calls she received from the RACF, that Mr Courtney had a number of falls in that facility. After his admission Mrs Courtney contracted pneumonia and that made it difficult for her to visit him and then restrictions were placed on visitation rights due to the COVID-19 pandemic. It was not until 5 May 2020 that a carer at the RACF managed to connect a video call so that they could speak for a short period of time. It was not until 11 May 2020 that the restrictions on visits to the nursing home were removed and as result Mrs Courtney saw her husband that day.

Circumstances Leading to Death

On 9 May 2020 at approximately 7:30 am staff entered Mr Courtney's room and found him lying on the floor still holding a walking frame. He was immediately assessed for injury. A head to toe assessment was completed and it was determined there was no injury and he was not in pain. He was assisted to bed and then he wished to stand up and when he did so he showed no signs of discomfort. He was showered and dressed and he then went to the main lounge area where post-fall observations commenced.

On 10 May 2020 at 2:20 am a carer came into Mr Courtney's room and found him sitting on the floor. He said he had slipped. He was clinically reviewed and again it was determined no injury was sustained. Mr Courtney was assisted back to bed.

On 12 May 2020 at 6:50 am Mr Courtney was again found on the floor of his room. This time he was assessed as possibly sustaining a fracture to his nose. He had a laceration to the right side of the forehead above the right eye and he was suffering from hip pain. He was given medication for the pain, his wound was treated and an ambulance requested.
Mr Courtney was taken to the RHH at which x-rays were taken of his right hip and hand due to pain and swelling. His head wounds were cleaned and dressed and as no fractures were detected Mr Courtney returned to the RACF.

On 13 May 2020 Mr Courtney fell at approximately 10:15 am. He was found on the floor of his bedroom. It was believed he had hit his head on the doorway. He was assessed by a number of staff as it was believed he may have suffered a right arm fracture or a shoulder

injury. He was also bleeding from his nose and forehead. Those injuries were treated. He was taken by ambulance to the RHH where a CT scan of the brain showed multiple bilateral facial bone and interior calvarium fractures. A CT scan of the cervical spine showed a C1 left tubercle fracture, C3 interior end plate fracture and C2-C6 paravertebral soft tissue swelling. Neurosurgery staff considered Mr Courtney was not fit enough for neurosurgical intervention. It is noted in the RHH records there is an advanced care directive for Mr Courtney which indicates his preference was for treatment aimed at prolonging his life be withheld or stopped and that palliative care be provided. That document is dated 13 January 2020. Accordingly palliative care was commenced and Mr Courtney passed away some hours later.

Investigation

Mrs Courtney says she found small twigs and plant matter on the clothes that were returned to her after Mr Courtney passed away. She says *"I don't know if he was moving around in the garden with his walker when he fell – but I'd like to know."* She also says as far as she knew Mr Courtney did not have dementia or Alzheimer's disease or motor neurone disease. She says his main condition was dysphasia. She also says staffing was totally inadequate to care for people with his condition. She believed he needed one to one care. She believes that with proper care he would be alive now.

Dr Lawrence conducted a post-mortem examination of Mr Courtney on 14 May 2020. After conducting the examination and considering antemortem radiology which was undertaken Dr Lawrence says Mr Courtney died as result of head and neck injuries sustained in a fall; that is the fall which occurred on 13 May 2020. He says examination revealed injuries of the head and neck consistent with facial fractures and a cervical spine injury at C1. Dr Lawrence says the pattern of the injuries is consistent with a fall. Dr Lawrence seems to have accepted a history that Mr Courtney had motor neurone disease which would cause weakness and dementia and a tendency to wander. I accept Dr Lawrence's opinion about the cause of death but not that Mr Courtney was suffering from motor neurone disease.

I have considered the RHH records and the GPs records carefully and the only diagnosis I can find which was made after Mr Courtney was treated is the diagnosis of primary progressive aphasia. This condition is a language disorder caused by damage to a specific area of the brain that controls language expression and comprehension. People with this condition cannot communicate effectively with others. This is not to be confused with the condition known as dysphasia which means impaired language whereas aphasia means a lack of language. The terms are however often used interchangeably. There are a number of potential causes for this condition which include dementia which is perhaps why the records

mention this condition as well as aphasia. I can find no documentation in which motor neurone disease and/or Alzheimer's disease is diagnosed.

The records of the RHH indicate Mr Courtney was admitted for treatment between 6 and 16 December 2019, on 19 February 2020, between 17 March and 25 March 2020 and on 13 May 2020. In December 2019 he was treated for primary progressive aphasia. On 19 February 2020 he sustained a haematoma on his scalp after he fell from a chair at the Lillian Martin home. That wound was treated. Chest, humerus and shoulder x-rays cleared Mr Courtney from suffering any fractures. Then on 17 March 2020 Mr Courtney was taken to the RHH by ambulance after suffering a fall. He was diagnosed with a right neck of femur fracture and two days later he underwent a right hip hemiarthroplasty. In addition during that admission Mr Courtney was treated for hospital acquired pneumonia.

The records of the RACP record that from 27 February 2020 Mr Courtney fell on seven occasions which occurred on 9, 11 and 17 March 2020 and 9, 10, 12 and 13 May 2020. An incident report with respect to each fall was completed. Falls assessments were completed on 9, 25 March and on 9, 10, 12 and 13 May 2020. In the initial falls assessment it was noted Mr Courtney can be impulsive when ambulating at times and will not wait for assistance. Due to his cognitive function he may also forget to use his 4-wheel walker. He was assessed as a medium risk of falling up until 9 May 2020 after which he was assessed as high risk. The initial assessment indicated Mr Courtney required one-on-one assistance at all times and he required the use of a room sensor because he would not always wait until assistance arrives or he might forget to ring the call bell.

On admission on 27 February 2020 Mr Courtney underwent a physiotherapy review and a review by a registered nurse. That initial review by the registered nurse indicates Mr Courtney was a high falls risk due to dementia and impulsive behaviours. A bed sensor was placed on his bed in the early hours of 28 February 2020 and later that day it was checked and was in place and working. His call bell was also within reach. The next day Mr Courtney rang the call bell. Later that day his bed sensor was checked and it was in place but it was considered he needed a chair sensor. His room was rearranged the next day so that the chair was placed closer to the power socket so the chair sensor could be plugged in. It was checked to be in position and working. On 3 March 2020 Dr Matthews, Mr Courtney's general practitioner, conducted a review. The next day the bed sensor and chair sensor were checked to be in place and working. Later that day Mr Courtney rang the call bell.

On 9 March 2020 at about 9:39 am Mr Courtney was found on the floor. He had been attempting to mobilise to change his clothes. He was assessed and it was determined he suffered no injuries. His general practitioner and his stepson were advised of the fall. On

10 March 2020 a physiotherapy review was conducted because of the fall. At 3 am on 11 March 2020 Mr Courtney was found on the floor in the lounge room. He had only been checked 5 to 10 minutes prior to this and was at that time okay. A floor mat sensor was placed in Mr Courtney's room to alert staff when he got out of bed. On this occasion Mr Courtney suffered superficial skin tears which were treated. On 11 March 2020 at 6:04 am Mr Courtney pressed the call bell. By the time carers reached his room he was making his way out. On 12 March 2020 at approximately 6:23 am observations, which are conducted for 24 hours after a fall, ceased. He had been in his chair in his room since 3 am. The chair sensor was checked to be in position and working. Later that day his bed sensor alarm went off and he was found wandering. On 13 March 2020 at 1:37 AM he was found standing at his door with no walker. He was reluctant to return to bed so he was taken to the lounge next to the nursing station for monitoring. He was offered food which he ate and then he went to sleep in the lounge room chair. On 17 March 2020 Mr Courtney fell while using his 4-wheel walker. That fall was witnessed by kitchen staff who were in the vicinity of the dining room where it occurred. Mr Courtney was assessed by a registered nurse and a physiotherapist before he was taken by ambulance to the RHH. He was reviewed after his return from the hospital on 25 March 2020 and the treatment plan provided by the hospital was initiated. Mr Courtney's bed sensor was in situ. The next day a mobility assessment was conducted by the physiotherapist and Mr Courtney was also reviewed by a registered nurse. Mr Courtney was regularly checked over the ensuing days but he did not attempt to get out of bed at all because of what I suspect was immobility caused by the hip fracture. On 28 March 2020 he rang the call bell and on 30 March 2020 his room mat sensor was plugged in and working. A mobility assessment conducted by the physiotherapist on 31 March 2020 indicates Mr Courtney was only able to ambulate two to three steps with his 4-wheel walker and with two assistants. He was reviewed by a GP later that day. A further mobility assessment was conducted the next day.

On 6 April 2020 Mr Courtney was again reviewed by a GP. His sensor mat was in position. A note for 11 April 2020 indicates the sensor mat was insitu and plugged in. On 14 April 2020 Mr Courtney is again reviewed by a GP. In the early hours of 18 April 2020 he was found to be attempting to get out of bed. He was taken out to the lounge room and given a drink and some food. The next day he was found attempting to get out of bed so again he was placed in the lounge room so that he could be more closely observed. A further physiotherapy review was conducted on 20 April 2020. On 10 May 2020 at 5:55 am the out of bed sensor rang and he was then found sitting on the edge of his bed. Less than ten minutes later when he was checked again staff reached his room just as Mr Courtney fell. His bed and floor sensor did not ring until he had already gotten out of bed and the care assistant walked into his room.

Each incident report lists strategies that are in place to prevent Mr Courtney from falling. These include the use of appropriate footwear, reviewing his bedroom set up which includes his bed height and the accessibility of his possessions, ensuring his call bell is in reach, ensuring reviews by a medical officer and physiotherapist take place and that his walking aid is available and in good condition. Other strategies listed include reducing clutter in his room, reviewing of Mr Courtney's incontinence and toileting schedule and ensuring a sensor mat is in use. On each occasion the next of kin and GP is notified. The incident reports state staff continue to try and pre-empt Mr Courtney's needs and try and reduce his risk of falling but due to his cognitive deficit he forgets to ring his bell for assistance when he wishes to mobilise.

Having considered both the medical records and the nursing home records the coronial medical consultant Dr Anthony Bell has said in his report the RACF provided standard care for falls prevention including bed monitoring alarms. In so far as the medical treatment at the RHH is concerned he says in Mr Courtney's case palliation was a sound option and there are no medical issues. I accept Dr Bell's opinion.

Finally there is no evidence the fall on 13 May 2020 occurred while Mr Courtney was moving around in the garden. The records clearly show Mr Courtney was found in his room.

As to Mrs Courtney's other concerns I have considered further records obtained from Mr Courtney's general practitioner and also a response received from the residential services manager of Ningana which responds to those concerns. The response from Ningana indicates an assessment conducted on 19 December 2019 noted Mr Courtney had a three year history of progressive decline in speech and some mild cognitive decline. The main diagnoses were neurodegenerative disorder, cognitive decline, expressive dysphasia and glaucoma. As a result of the assessment it was recommended Mr Courtney be approved for a level 4 home care package which was the highest level of home care available at the time.

On 19 February 2020 the general practitioner, Dr Matthews, provided a form to UAW which confirmed Mr Courtney was experiencing primary progressive aphasia, expressive dysphasia, multiple falls, fatigue, urinary and faecal incontinence, rosacea, leg cramps and shoulder pain. Dr Matthews also outlined Mr Courtney was experiencing "Dementia/Alzheimer's disease." Finally a discharge summary from the RHH provided on 12 May 2020 suggested at that time Mr Courtney was suffering from Alzheimer's dementia, falls, NOF (neck of femur fracture), HAP (hospital-acquired pneumonia), dysphasia, he was non-verbal and there was a delirium alert. It was queried, although not confirmed, that he might be suffering from motor neurone disease.

As to he care provided UAW believe this was appropriate. His level of care was articulated in his care plan dated 27 February 2020 which was updated regularly including a review by a physiotherapist on 20 April 2020. All staff were appropriately qualified and required to undergo annual manual handling training and training on assisting residents with dementia. In addition UAW advised that organisation had no escalated complaints to the Aged Care Quality and Safety Commission with respect to staffing levels or falls prevention or management strategies or the environment at Ningana in the last five years.

UAW note Mrs Courtney believes Mr Courtney ought to have received one-on-one care. As to that UAW responded as follows:

"On occasion, there may be instances where this level of care is provided on a short-term basis for certain needs e.g. in the hours after returning from hospital, however these instances are not common at Ningana or any Commonwealth funded residential aged care nationally. Nursing and care hours are determined by the level of individual residents and the resident population as a whole with one immutable factor being UAW always has at least one registered nurse on shift at all times (currently and at the time of the Deceased's residence at Ningana). Further, various technologies mean that one-on-one care would now be inefficient. Mr Courtney also had a room sensor as he did not always wait for assistance to arrive, the room sensors were triggered in the event Mr Courtney became ambulant. Also, UAW feels it more important residents have sufficient time with expert staff eg appointments with physiotherapists where falls prevention might be a focus rather than simply one-on-one carers."

UAW make the point that even if this level of care was provided it may not prevent a fall where a resident has the behaviours exhibited by Mr Courtney which included him being prone to being impulsive while ambulating and, due to his dementia, forgetting to use walking aids. His dysphasia was being managed in accordance with his care plan. Instances where residents are non-verbal are not isolated in an aged care setting and all staff are experienced in dealing with non-verbal residents.

Having considered the further records mentioned above I find Mrs Courtney's concerns are not made out. This accords with the opinion of Dr Bell.

Comments and Recommendations

Given my consideration of the medical and nursing home records in this case together with Dr Bell's opinion I find Mr Courtney was a high falls risk with a propensity, due to his cognitive deficits, to attempt to mobilise without seeking assistance. This is something the RACF was well aware of. I find the RACF employed all reasonable strategies available to reduce that risk. I therefore find there were no issues with the standard of care provided by

the RACF. I agree with Dr Bell there were no issues with the care provided by the RHH on 13 May 2020.

The circumstances of Mr Courtney's death are not such as to require me to make any comments or recommendations pursuant to Section 28 of the *Coroners Act* 1995.

I convey my sincere condolences to the family and loved ones of Mr Courtney.

Dated: 22 May 2023 at Hobart in the State of Tasmania.

Robert Webster
Coroner