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 Laurence Keith Gray

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

a) The identity of the deceased is Laurence Keith Gray (Mr Gray);
b) Mr Gray died as a result of injuries sustained after a fall from standing;
c) Mr Gray's cause of death was traumatic closed head injuries; and
d) Mr Gray died on 21 February 2022 at Glenorchy, Tasmania.

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

- The Police Report of Death for the Coroner;
- Affidavits as to identity;
- Report of the forensic pathologist Dr Andrew Reid;
- Affidavit of Mr Laurence John Gray, the senior next of kin;
- Records of Glenview Nursing Home (the RACF); and
- Report of the coronial nursing consultant Libby Newman RN.

Background

Mr Gray was 96 years of age (date of birth 1 April 1925), widowed and he resided at the RACF at the date of his death. Mr Gray was one of eight siblings (four sisters and four brothers) to his parents Robert and Audrey Gray.

Mr Gray grew up in Gretna where he attended both primary and high school. The senior next of kin believes his father's highest level of schooling was somewhere around the middle of high school. Mr Gray met Dorothy Norris when they were in their early 20s and they married. They remained married until Mrs Gray passed away. Mr and Mrs Gray had two children; a son and a daughter.

Mr Gray lived in the greater Hobart area all his working life. He worked for Hydro Tasmania as a linesman and then at Cadbury's as a storeman/foreman until he retired at the age of 65.

In about November 2021 Mr Gray fell in his driveway at his home in Grove Road, Glenorchy and suffered a fractured skull and bleeding on his brain. He spent approximately three months recovering both in the Royal Hobart Hospital and the Repatriation Hospital. Once discharged he was moved to the RACF where he remained until his death.

The senior next of kin has advised his father had a previous fall in 2019 after which he spent two to three weeks rehabilitating at St John's Hospital before he returned home to Grove Road. He says his father's mental health was very good, for a man his age, and he was still very sharp.

Circumstances Leading to Death

Mr Gray moved into the RACF on 16 February 2022. He had a minor fall that day when he slipped from his chair but he sustained no injuries. He appeared to settle in well.

On 19 February 2022 Mr Gray was discovered on the floor of his bathroom at 6:40am. He was assessed by the registered nurse then assisted back to bed via a hoist. Neurological observations were commenced and these were initially normal. The general practitioner was notified. Although Mr Gray appeared well initially his condition deteriorated over the following few hours. His family requested he not be transferred to hospital but rather receive palliative care at the RACF. This request was carried out and palliative care was commenced. Mr Gray passed away on 21 February 2022.

Investigation

Dr Ritchey carried out a post-mortem examination on 22 February 2022. He considered the medical records, the Police Report of Death for the Coroner and he conducted an external examination. As a result he determined Mr Gray died due to traumatic closed head injuries sustained in the fall on 19 February 2022. It was noted Mr Gray suffered a skull fracture, frontal lobe contusion and a sub arachnoid bleed. Dr Ritchey also noted Mr Gray had type II diabetes myelitis with peripheral neuropathy, atherosclerotic and hypertensive cardiovascular disease and he was frail. I accept Dr Ritchey's opinion.

The senior next of kin has indicated in his affidavit that neither he or his family have any concerns in the way Mr Gray was cared for at the RACF or while he was being treated in hospital.

Because Mr Gray was a resident of an RACF I arranged for the coronial nursing consultant Libby Newman to inspect the records of the RACF and comment upon the adequacy of the care Mr Gray received. Ms Newman noted Mr Gray was a 96 year old man who had been managing to live independently (with family support) until November 2021 when he had a fall at his residence.

As a result of this fall he sustained a skull fracture and traumatic brain injury (anterior frontal lobe contusion with traumatic sub arachnoid haemorrhage extension, pneumocephalus [air within the cranium] and a middle ear effusion).

Mr Gray was cared for at the Royal Hobart Hospital initially before being transferred to a rehabilitation ward at the Peacock Building on 14 December 2021 with the aim of being discharged home eventually. Unfortunately Mr Gray did not recover/rehabilitate strongly enough to return to independent living and, as such, a bed was secured for him at the RACF.

Mr Gray did not have a diagnosis of dementia however he did have some cognitive impairment and he was known to be impulsive. He required a four wheeled walker for ambulation.

On the day of admission to the RACF on 16 February 2022 Mr Gray had a falls risk assessment and other assessments carried out as part of his admission process. Unfortunately, on this day, he had a minor fall when he slipped from his chair on one occasion. He did not sustain any injuries in this fall.

Mr Gray was not seen in person by his (new) general practitioner, Dr Monks, as she was a COVID19 close contact at the time and unable to attend the nursing home. Accordingly all consultations from date of admission until Mr Gray's death were carried out via Telehealth which was clearly appropriate.

Mr Gray's most recent Falls Risk Assessment prior to his fall was carried out on 16 February 2022 (day of admission). He was assessed as being at a high risk of falling. Falls prevention strategies as documented in the nursing home notes included the use of a sensor mat.

The RACF has not provided a description of the falls prevention strategies they instigated for Mr Gray other than the use of a 'sensor mat'. Ms Newman is unsure if this was a bed or chair or floor sensor. She says it was possibly all three. Documentation from the nursing home says: "*As he was in his initial days of his admission this was a period of observations and assessment to formulate his care plan*". Ms Newman understands this and presumes other falls prevention strategies (such as keeping the room clutter free, appropriate lighting and footwear, keeping a call bell within reach etc) would have been in place; however the nursing home has not provided this detail.

She says the RACF was fully staffed at the time of the fall. In addition, the policy for falls risk assessments appears to be that they are carried out on admission, then every three months as well as following any falls or near misses. In addition physiotherapy reviews occur following any fall.

Ms Newman reviewed other recent fall cases at this RACF and each time the Coroner's office has received a response from the RACF its documentation regarding falls prevention has been somewhat sketchy or needing to be requested more than once, but once reviewed the falls prevention strategies for these other residents have appeared sound and are consistent with strategies employed by other nursing homes. Ms Newman does not believe there is necessarily an issue with falls management at this RACF but its processes for supplying this information to the Coroner's office appears, to her, to be lacking.

Ms Newman did not identify any particular red flags with regard to Mr Gray's management at the nursing home. She notes what the senior next of kin has said about his father's care at the RACF and she agrees with his view. I accept Ms Newman's opinion.

Comments and Recommendations

The circumstances of Mr Gray'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 Gray.

Finally I remind the RACF it is obliged, as a matter of law, to provide all documents requested by a Coroner pursuant to a subpoena in a timely manner. A failure to do so can amount to an offence under section 65 of the *Coroners Act* 1995, which if established, is subject to a maximum penalty of a fine of $3900 or imprisonment for a term not exceeding 6 months.

Dated: 20 November 2023 at Hobart Coroners Court in the State of Tasmania.

Robert Webster
Coroner