FINDINGS and RECOMMENDATIONS of Coroner Simon Cooper following the holding of an inquest under the *Coroners Act* 1995 into the death of:

Valma Ann Tweedie

Contents

Record of Investigation into Death (With Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Simon Cooper, Coroner, having investigated the death of Valma Ann Tweedie with an inquest held at Hobart in Tasmania, make the following findings.

Hearing Dates

12-13 April 2023

Representation

Counsel Assisting the Coroner: L Pennington, A Bassett

Ms M Tweedie (Senior Next of Kin) – R Glover

St Michael's Association– FV Moore

Introduction and background

1. Valma Ann Tweedie was born in Queenstown, Tasmania on 16 September 1948. At the time of her death on 22 August 2021 she was aged 72 years. Ms Tweedie was unmarried and her parents pre-deceased her. Ms Tweedie was very close to her older sister, Margaret Tweedie, and frequently spent time at Margaret's home at Scamander on the East Coast of Tasmania.

2. Ms Tweedie suffered an intellectual disability, attributed to an acquired brain injury. It is unclear whether that intellectual disability was caused *in utero* by a virus or was the result of an accident as a young child. In the context of the inquest, the cause of Ms Tweedie's disability was unimportant. What was important was the care she needed and the care she received. She also had a diagnosis of bi-polar affective disorder. Nonetheless, she was evidently an active and vibrant lady – living life to the full, interested in cooking, gardening and animals; disliking broccoli. She was a lifelong smoker.

3. Originally a National Disability Insurance Scheme (NDIS) client, following her 65th birthday she lost eligibility for participation in the NDIS. Funding was provided to St Michael's Association under what was described as a "continuity of support" model. I do not consider that her status as a client of NDIS or otherwise was a factor in her death.

4. Ms Tweedie received supervised care and lived in a supported independent living facility operated by St Michael's Association. She had been a resident of St Michael's since 1995. At the time of her death, Ms Tweedie was staying at the Desmond Wood facility, 22 Hobblers Bridge Road, Newstead in Tasmania. She was staying there because necessary renovations were being carried out at her ordinary home at Kenneth Court, Norwood. Ms Tweedie moved temporarily from Kenneth Court to Desmond Wood on 5 July 2021 and was due to return home on 14 July 2021.

What a coroner does

5. Before considering the circumstances of Ms Tweedie's death in detail it is necessary to say something about the general role of the coroner. In Tasmania, a coroner has jurisdiction to investigate any death that 'occurs after a medical procedure, and the death may be causally related to that procedure and a medical practitioner would not, immediately before the procedure was undertaken, have reasonably expected the death'.[1] I consider Ms Tweedie's death meets this definition.

6. In addition the evidence makes it quite clear that Ms Tweedie's death also resulted from an accident or injury. As such a coroner has jurisdiction to investigate it on that basis as well.

7. Some categories of death – those that occur when a person is in custody, of infants, or while someone is at work amongst others – are such that an inquest must be held. Other deaths, and Ms Tweedie's falls within this latter category, may be the subject of an inquest where a coroner, acting in his or her discretion, considers that it is appropriate. The *Coroners Act* 1995 defines an "inquest" as a "public hearing".

8. When conducting an inquest, a coroner performs a role very different to other judicial officers. The coroner's role is inquisitorial. An inquest might be best described as a quest for the truth, rather than a contest between parties to either prove or disprove a case. When conducting an inquest, a coroner is required to thoroughly investigate the death and answer the questions (if possible) that section 28(1) of the *Coroners Act* 1995 asks. Those questions include who the deceased was, how they died, the cause of the person's death, and where and when the person died. It is settled law that this process requires a coroner to make various findings, but without apportioning legal or moral blame for the death.[2] The job of the coroner is to make

[1] *Coroners Act* 1995, section 3.
[2] *R v Tennent; Ex Parte Jager* [2000] TASSC 64.

findings of fact about the death from which others may draw conclusions. A coroner may, if she or he thinks fit, make comments about the death or, in appropriate circumstances, recommendations to prevent similar deaths in the future.[3]

9. It is important to recognise that a coroner does not punish or award compensation to anyone. Punishment and/or compensation are for other proceedings, in other courts, if appropriate. Nor does a coroner charge people with crimes or offences arising out of a death that is the subject of investigation.

10. As was noted above, one matter that the *Coroners Act* 1995 requires, is a finding (if possible) as to how the death occurred.[4] 'How' has been determined to mean 'by what means and in what circumstances',[5] a phrase which involves the application of the ordinary concepts of legal causation.[6] Any coronial inquest necessarily involves a consideration of the particular circumstances surrounding the particular death so as to discharge the obligation imposed by section 28(1)(b) upon the coroner.

11. It is also important to recognise that a degree of caution must necessarily attend this aspect of the coroners function. Self-evidently, the analysis involves a consideration of all the circumstances involving the death including decisions that were made at the time that may or may not have impacted upon the ultimate outcome. Coroners enjoy the distinct advantage of knowing exactly what occurred when making that assessment.

12. The standard of proof at an inquest is the civil standard. This means that where findings of fact are made, a coroner needs to be satisfied on the balance of probabilities as to the existence of those facts. However, if an inquest reaches a stage where findings being made may reflect adversely upon an individual, it is well-settled that the standard applicable is that expressed in *Briginshaw v Briginshaw*, that is, that the task of deciding whether a serious allegation against anyone is proved should be approached with a good deal of caution.[7]

13. The final matter that should be highlighted is the fact that the coronial process, including an inquest, is subject to the requirement to afford procedural fairness.[8] A coroner must ensure that any person (and the term 'person' means legal person, which includes any legal entity) who might be the subject of an adverse finding or

[3] Section 28 (2) of the *Coroners Act* 1995.
[4] Section 28(1)(b) of the *Coroners Act* 1995.
[5] See *Atkinson v Morrow* [2005] QCA 353.
[6] See *March v E. & M.H. Stramare Pty. Limited and Another [*1990 – 1991] 171 CLR 506.
[7] (1938) 60 CLR 336 (see in particular Dixon J at page 362).
[8] See *Annetts v McCann* (1990) 170 CLR 596.

comment is made aware of that possibility and given the opportunity to fully put their side of the story forward for consideration.

14. In accordance with this requirement, all parties who were identified as having a potential interest in the outcome of the inquest were identified, apprised of the fact of the inquest and provided complete disclosure of all documentation relevant to the investigation. All interested parties were also afforded the opportunity to appear at the inquest and be represented by lawyers.

Issues at the inquest

15. In advance of the inquest a number of issues, in addition to those mandated by the *Coroners Act* 1995, were identified as being matters to be particularly considered at the hearing. Those matters included:

    a. The circumstances surrounding the death of Valma Ann Tweedie;

    b. The care supervision and treatment of Ms Tweedie whilst held in care at the Desmond Wood facility operated by St Michaels Association Inc. preceeding her fall on 14 July 2021;

    c. The adequacy of treatment provided to Ms Tweedie upon presentation at the Launceston General Hospital (LGH), including compliance with appropriate guidelines or best practice in the Emergency Department and upon her subsequent inpatient admission; and

    d. The connection between any failure to apply appropriate guidelines or best practice in the LGH and Ms Tweedie's death.

Evidence at inquest

16. A number of witnesses gave evidence at the inquest. Those witnesses, in order were:

    a. Ms Margaret Tweedie;

    b. Ms Jacqueline O'Shea;

    c. Ms Joanne George;

    d. Mr Roderick Campbell;

    e. Mr John Gilpin;

    f. Dr Christopher Lawrence; and

g. Dr Anthony Bell.

17. In addition to the witnesses who gave evidence at the inquest, a significant amount of other evidentiary material in the form of affidavits, recordings, medical records and the like was tendered. A complete list of the documentary exhibits received at the inquest is attached to the end of this finding and is marked Annexure 1.

18. Although the THS did not appear at the inquest, Ms Tweedie's complete treatment records were provided and tendered as evidence. In addition, the THS conducted a comprehensive review of the circumstances surrounding Ms Tweedie's death. That review – a Root Cause Analysis (RCA) – was also tendered as evidence at the inquest and helped inform this finding.

Ms Tweedie's medical history

19. Ms Tweedie's medical history was the subject of evidence at the inquest. Her medical history suggests that she may have been suffering from early onset dementia. The issue of dementia seems to have been first flagged in October 2014, when her ordinary GP, Dr Jane Strong, requested that Ms Tweedie be reviewed by the Older Persons Mental Health Team, seeking an "opinion and management of altered behavior and occasional aggressive mood". In the referral, Dr Strong describes the unusual behavior as "shoplifting, wandering away from home and becoming aggressive with other residents… [and being] withdrawn from her normal interests and activities and less active than she used to be".[9] Dr Strong made specific reference to Ms Tweedie's sister, Margaret, wondering whether she may be demonstrating signs of dementia. The referral makes the obvious point that given Ms Tweedie's intellectual disability, assessment for dementia was not without difficulty.

20. After another referral to Dr George Razay, Gerontologist, in November 2016, for "opinion and management of declining cognition and memory"[10], a conclusion was reached that Ms Tweedie had "features of dementia of probable Alzheimer's type".[11] Dr Razay recommended a conservative approach to her treatment and support, but did raise the potential for Ms Tweedie to be accommodated in a nursing home if difficulties did not resolve or her behavior worsened.[12]

[9] Exhibit C 21, Page 146.
[10] *Supra*, page 154.
[11] *Supra*, page 21, letter Dr Razay to Dr Strong, 11 February 2016.
[12] *Supra*.

21. The diagnosis of probable dementia was re-affirmed by Dr Strong in July 2017 and again in March 2019. On the latter occasion, Ms Tweedie was again referred to Dr Razay, with Dr Strong noting "increasingly agitated and abusive behaviour".[13]

22. Records of St Michael's Association tendered at the inquest include reference to a visit by Dr Strong on April 2021 in which the possibility of a dementia diagnosis was canvassed.[14] Although it does not appear that a formal diagnosis of dementia was ever arrived at, the possibility that Ms Tweedie was in fact suffering from it was clearly identified by her GP to St Michael's approximately three months before her fatal fall.

23. The other medical issue of significance was Ms Tweedie's well documented history of falls from standing or from chairs and general instability on her feet. She suffered falls which led to hospitalisation in April 2020, November 2020 (twice) and December 2020. In addition, she fell and likely fractured an ankle in December 2020, which was treated at the Launceston Medical Centre.

24. Other than falls which led to admissions to hospital and/or treatment of some type, her care records are replete with references to unsteadiness on her feet, including one on 6 July 2021 when she is recorded as having nearly fallen over while walking back from the smoking area, after having a cigarette.[15]

25. In short, as at 15 July 2021, it was clear that Ms Tweedie was probably suffering from dementia and was experiencing significant balance and mobility problems. These were things known to St Michael's. What St Michael's did in response to that knowledge is an issue I will return to later in this finding.

Circumstances of death

26. On the basis of the evidence at the inquest I find that just before 5:45 am on 14 July 2021 Ms Tweedie was found lying on her back, on pebbles and half under a lemon tree, in the garden near some raised garden beds outside the Desmond Wood facility. It was raining. She was wet and very cold. The care worker who found her, Ms Joanne George, said Ms Tweedie whilst awake and breathing, could not get up, had blood around her head and mouth, and was less responsive than she ordinarily would be.[16]

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[13] *Supra*, page 174.
[14] Exhibit C 17, page 47.
[15] *Supra*, page 72.
[16] Exhibit C14A.

27. Ms George called an ambulance. The call was made at 5:54 am.[17] In that call, Ms George told the operator that she first noticed Ms Tweedie was missing at 5:30 am and had been looking for her ever since.

28. Upon arrival, Ambulance Tasmania paramedics assessed Ms Tweedie as hypothermic (her temperature was 28.2 degrees centigrade). She was noted to have facial injuries, was bradycardic and she had a Glasgow Coma Scale score of 12.[18] Paramedics warmed her, applied a pelvic binder and took her by ambulance to the LGH.

29. At the LGH, Ms Tweedie was admitted immediately. She was gradually warmed in the Emergency Department and had her facial injuries sutured. X-rays showed that she had suffered fractures of her mandible. Ms Tweedie had also suffered a fracture of her cervical spine at C4-C6, but medical staff failed to identify that fact.

30. Her medical notes in the Emergency Department record "*minimal history available from patient at present. Reports she was out picking lemons when her legs went.*"[19] That note was recorded as having been made at 1:47 pm on 14 July 2021.

31. The following day, 15 July 2021, Ms Tweedie's LGH medical notes indicate she was having difficulty with grip and mobility. In relation to her grip, it was noted that Ms Tweedie was '*not moving her arms like she usually does'*.[20]

32. On 16 July 2021, Ms Tweedie was noted to have developed a cough, which was attributed to, potentially at least, pneumonia.

33. The next day, 17 July 2021, Ms Tweedie was transported to the Royal Hobart Hospital (RHH) by air for mandibular repair surgery. That surgery was performed on 18 July 2021, apparently successfully and without incident.

34. Ms Tweedie was returned to the LGH on 22 July 2021. Her C4-C6 injury remained un-detected, despite her having no grip strength in her hands and exhibiting '*significant functional decline'*.[21] It was not until 28 July 2021 following a full neurological team review and an MRI scan that the fact that Ms Tweedie had suffered injury to her C4-C6 vertebrae was detected. She was identified as an inappropriate candidate for spinal surgery. Ms Tweedie remained in hospital. Family visited and were allowed to

[17] Exhibit C25 – 000 call recording.
[18] The Glasgow Coma Scale is used to assess the level of consciousness after a suspected brain injury. It ranges from 3 (completely unresponsive) to 15 (responsive).
[19] Exhibit C 23, Part 2, section 2.14 (page 21).
[20] Exhibit C7, Precis of medical records,
[21] *Supra*.

take her outside the hospital in a wheelchair. However, her condition continued to deteriorate.

35. On 4 August 2021 a meeting was held between medical staff and Ms Tweedie's family. A decision was made to transition her care to palliative, end-of-life care and active treatment for pneumonia was ceased. She developed a urinary tract infection, began to show signs of tachycardia and was noted to have high temperatures.

36. At 4:10 am on 22 August 2021, Ms Tweedie passed away.

Investigation – forensic pathology

37. The fact of Ms Tweedie's death was reported in accordance with the requirements of the *Coroners Act* 1995.[22] Her body was formally identified[23] and then transferred to the RHH for autopsy. The autopsy was carried out by Dr Christopher Lawrence, a highly experienced Forensic Pathologist. Dr Lawrence's report was tendered at the inquest[24] and he gave evidence. He expressed the opinion that the cause of Ms Tweedie's death was pneumonia, following cervical spine injuries due to an apparent fall. I accept Dr Lawrence's opinion.

38. At the inquest he expanded upon his report. He thought the findings of injury to the cervical spine was consistent with central cord syndrome. He said that the spinal injury was a partial cervical spinal cord injury which meant that some nerve fibres in the spinal cord had been damaged. That type of injury, Dr Lawrence said, typically tended to affect the hands of the person injured more than their legs. I note that Ms Tweedie was observed suffering from problems with her grip.

39. Dr Lawrence also gave evidence that pre-existing degeneration of the spine can predispose person to suffering central cord syndrome. He saw, at autopsy, evidence of such a predisposition. He said that central cord syndrome is typically the result of a hyperextension injury, that is to say, that the head has been pushed up or that the body has been pushed back in a direction that is different to the head and neck.

40. Finally, Dr Lawrence said that pneumonia was caused by an inability to clear fluid from the lungs. He gave evidence that it was his opinion that Ms Tweedie's pneumonia may have been exacerbated by the spinal injury or her long term cigarette smoking or both.

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[22] Exhibit C1.
[23] Exhibit C3.
[24] Exhibit C5.

Ms Tweedie's treatment in hospital

41. The first issue that requires examination is the actual cause of Ms Tweedie's death. Both Dr Lawrence and Dr Bell (the Medical Advisor to the Coronial Division) expressed the opinion that the cause of Ms Tweedie's death was hospital acquired pneumonia, Dr Bell explaining that the term described pneumonia developed in the course of treatment in hospital, as opposed to the condition resulting from exposure to pathogens in the community. It is I think important to recognize that just because pneumonia developed in hospital it does not mean it was necessarily caused by treatment in hospital, although if it is hospital acquired it is frequently resistant to anti-biotic treatment.

42. The second point that needs to be noted is that someone with Ms Tweedie's cigarette smoking history is very much at risk of developing pneumonia, whether in hospital or in the community.

43. Dr Bell undertook a comprehensive review of Ms Tweedie's medical records subsequent to her hospital admission until her death. He produced a comprehensive report which was tendered at the inquest.[25] Like Dr Lawrence, Dr Bell also gave evidence at the inquest. His evidence at the inquest was focused in particular upon Ms Tweedie's spinal injury, whether it should have been detected earlier than it was and what relationship the injury had to the pneumonia which ultimately caused Ms Tweedie's death.

44. Dealing with the matters in reverse order, Dr Bell said in his evidence that the spinal injury could have caused paralysis of Ms Tweedie's diaphragm which, in effect, pre-disposed her, or at least made her more likely, to suffer a collapsed lung and hence pneumonia.[26] I accept Dr Bell's opinion. His evidence satisfies me that the spinal cord injury suffered by Ms Tweedie at least pre-disposed her to developing pneumonia, although noting her lengthy smoking history, as I have said, she certainly would have been at risk in any event.

45. The question as to whether the fact that Ms Tweedie had suffered a spinal injury should have been identified earlier than it was is also not without difficulty. Dr Bell explained that the injury she sustained – central cord syndrome – was a rare condition for which no treatment is available, causing quadriplegia necessitating mechanical

[25] Exhibit C6.
[26] Transcript.

ventilation and which 'almost certainly…leads to death'.[27] Dr Lawrence gave evidence essentially the same, particularly in relation to the rarity of central cord syndrome.

46. The tenor and substance of Dr Bell's evidence, which I accept, was that there was a delay in identifying the fact that Ms Tweedie had suffered an injury to her spine. His evidence was not challenged. There was no evidence to the contrary from the LGH. The conclusion that there was a delay was the only one open on the evidence at the inquest. The delay was one of approximately two weeks. It occurred against a background of well documented concerns about mobility problems experienced by Ms Tweedie, none of which resulted in a comprehensive neurological assessment. It also occurred against a background of paramedics having identified the possibility that Ms Tweedie may have sustained a spinal injury.

47. As I mentioned earlier, the LGH subsequently carried out a Root Cause Analysis (RCA), which was tendered at the inquest. That document identified a number of factors which potentially contributed to the delay in identifying the fact that Ms Tweedie had suffered a spinal injury. Those factors included deviations from protocols, limitations in relation to policy guidance and what were described as environmental pressures. [28]

48. The RCA identified that as early as during Ms Tweedie's presentation at the ED, neurological observations were not fully completed[29] and that 'support to clinicians in identifying the criteria and frequency of neurological observations' did not exist.[30] In addition, it was identified through the RCA process that neurological assessments are 'influenced by the subjective nature of observation taking'.[31] The RCA indicated that there were multiple systems issues "starting from presentation to the ED, initiation of the trauma call, transfer to medical ward, the misdiagnosis, the lack of escalation of fluctuating abnormal neurological observations and follow-up and review of [Ms Tweedie's] family input that [all] contributed to a delayed identification of [Ms Tweedie's] spinal injury.[32] I consider this to be a reasonable and objective assessment of the issues surrounding Ms Tweedie's treatment following her admission to the LGH. In addition to identifying multiple systems issues, the LGH and its RCA identified a number of areas for systems improvement.[33]

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[27] Transcript.
[28] Exhibit C8.
[29] *Supra*, page 9.
[30] *Supra*.
[31] *Supra*, page 10.
[32] *Supra*, page 14.
[33] *Supra*, pages 17-20.

49. However, the evidence satisfies me that even if Ms Tweedie's spinal condition had been identified earlier there would have been no change to the ultimate outcome for her. The medical evidence was that once sustained there was no treatment available to reverse or even ameliorate the effects of central cord syndrome.

50. Finally, in respect of her treatment within the Tasmanian Health Service, I am satisfied that the treatment Ms Tweedie received for the pneumonia she developed in hospital by the administration of intravenous antibiotics was both conventional and appropriate. Nonetheless, as pointed out above, hospital acquired pneumonia is frequently resistant to antibiotic treatment.

How did Ms Tweedie hurt herself?

51. This was an important issue at the inquest, perhaps the most important issue, because the medical evidence suggested that her physical injury sustained at the Desmond Wood facility was directly related to her death. In short, I am satisfied that Ms Tweedie would not have died without suffering the injuries she did in the fall in the garden of the Desmond Wood facility in the early hours of 14 July 2021.

52. Viewing the evidence as a whole, I am satisfied that there were no suspicious circumstances associated with Ms Tweedie's death. Specifically, I am quite satisfied that Ms Tweedie was not the victim of an assault and that the injuries which caused her death were the result of an unwitnessed fall by her, in the dark and the rain, in the grounds of the Desmond Wood facility. In excluding the possibility that she was a victim of an assault, I have specific regard to Ms Tweedie's own account in her discussion with Ms O'Shea, digitally video recorded, on 8 August 2021. In that account, Ms Tweedie stated that she fell over. In light of the close nature of the relationship between Ms Tweedie and Ms O'Shea, I am quite satisfied that the account given by Ms Tweedie and recorded by Ms O'Shea is likely to be accurate. I accept that it is. Put another way, it seems inherently unlikely that Ms Tweedie would have said something to Ms O'Shea about how she sustained her injury if it was not true.

53. The real question for me is how it was Ms Tweedie came to be outside the facility, unsupervised, in the early hours of 14 July 2021.

54. The evidence was that Ms Tweedie was one of three clients living at the facility as at 13 – 14 July 2021. Ms Joanne George was on duty that night. As I understood her evidence, it was only the second occasion she had worked a night shift at the facility. Her shift consisted of what was described in evidence as 'active support work' from 3:00 pm until 11:00 pm, followed by a 'sleep shift' between 11:00 pm and 7:00 am. She

had the assistance of another support worker during the afternoon. Her team leader, Ms Rosemary Brodie, was also on duty earlier. Ms Brodie left the facility at about 8:00 pm. Thus the only staff member on duty at the relevant time was Ms George.

55. Ms Tweedie, like the other two clients Mr Andrew Barnard and Mr Stephen Faye, had her own room at the facility. Ms Tweedie, Mr Barnard and Mr Faye lived together normally at Kenneth Court.[34] Mr Barnard and Mr Faye also suffered from intellectual disabilities which meant they too required care.

56. Prior to Ms Tweedie, Mr Barnard and Mr Faye moving to the Desmond Wood facility, a formal hazard identification and risk assessment was carried out. The assessment was undertaken by Mr Roderick Campbell. He consulted with Ms Abigail Theobald, the Senior Team Leader of the Care Team responsible for looking after Ms Tweedie and Ms Pauline Robson, the Disability Services Business Manager of St Michael's Association. The draft plan which resulted was reviewed and approved by Mr John Gilpin, then Chief Executive Officer of St. Michael's Association. The plan was tendered in evidence.[35] That document (which notably spells Ms Tweedie's first name incorrectly throughout) records, without saying how, that Ms Tweedie's risk was apparently assessed as being "*adequately controlled…[and that] no further action [was] required*."[36]

Ms George's evidence

57. Ms George said in her evidence that Ms Tweedie was restless that evening and was "*fixated*" upon a lemon tree growing near the smoking area at the back of the facility.[37] Ms George also said that Ms Tweedie was "*smoking a lot more than normal*" that night.[38] Smoking required her to leave the building and go to a designated smoking area at the back of the building near the lemon tree. To get to the smoking area it was necessary to go out the back door in the kitchen of the facility. Such events were recorded in a document described as a "cigarette log".[39] That document has an entry at 3:10 am on 14 July 2021 confirming that Ms Tweedie had a cigarette at that time.

58. Ms George's evidence was that Ms Tweedie was excited about the prospect of returning home to Kenneth Court the following day. She was difficult to settle. She managed to get her into her pyjamas at about 10:50 pm but Ms Tweedie still would

[34] Another man, Mr Nick Britton, also lived at Kenneth Court, but he was not staying at the Desmond Wood facility during the night of 13/14 July 2021.
[35] Exhibit C 17, Document 11.
[36] *Supra*.
[37] Exhibit C 14.
[38] *Supra*.
[39] Exhibit C11A, annexure C, page 2.

not settle. At a time unclear on the evidence, Ms Tweedie told Ms George she wanted a drink with lemons in it and that she wanted to pick lemons from the tree. Ms Tweedie then went outside to the lemon tree with Ms George and the pair picked approximately 10 lemons before using them to make a lemon drink.

59. Ms George gave conflicting statements in relation to the circumstances of Ms Tweedie's fall and injury. Her evidence is inconsistent with objective evidence, particularly in the form of the 000 call she made.

60. Mr Roderick Campbell, at the time of Ms Tweedie's fall and subsequent death, the State Manager of St Michael's Association swore an affidavit[40] which was tendered, and gave evidence at the inquest. He said he was told by Ms George that she had discovered Ms Tweedie missing at 4:10 am and had located her at 4:30 am, at which time an ambulance was called. He was told that the ambulance arrived at 5:00 am. In fact, the ambulance was called at 5:54 am.[41] Mr Campbell also said that he was given the impression that when Ms George informed other staff of Ms Tweedie's fall via an after-hours line at 6:01 am, the ambulance had been and gone. In fact Ambulance Tasmania records show that the ambulance arrived at the facility at 6:04 am and did not depart until 6:42 am.

61. Another aspect of Ms George's evidence that was, broadly speaking, unsatisfactory, was the timings provided by her in the sleep disturbance form completed for her shift.[42] In that document, completed by Ms George, the following appears:

> *"VT went to bed at 2230 and was up again at 2315 stayed up with VT as very restless. Got VT to bed at 0200. Checked on VT at 0410 wasn't in bed found outside stayed until the ambulance left at 6.50."*[43]

62. Similarly, Ms George's account to police contains anomalies with respect to time. When interviewed by police about the circumstances of Ms Tweedie's fall as part of the investigation into her death Ms George again said that she discovered Ms Tweedie was not there she thought at about 4:10 am. She told police it took her "*a little bit of time to find her*".[44]

63. I do not accept Ms George's evidence that she first noticed that Ms Tweedie was missing at about 4:10 am, nor that she found her at about 4:30 am. It is inconsistent

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[40] Exhibit C 12.
[41] Exhibit C 25.
[42] Exhibit C 11A, annexure D.
[43] Contextually 'VT' can only be a reference to Ms Tweedie.
[44] Exhibit C14.

with all objective evidence (in particular, as I have said, to the 000 call records and the records from Ambulance Tasmania), which evidence leads me to conclude that Ms Tweedie fell sometime after 3:10 am and before about 5:45 am, when I am satisfied Ms George found her. I am satisfied that Ms Tweedie went outside at about 3:10 am for a cigarette with Ms George and that Ms George, hearing Mr Barnard apparently needing attention inside the facility, returned inside. She left Ms Tweedie alone outside the facility. It seems more probable than not that Ms Tweedie fell shortly after Ms George left her alone outside. Certainly, her hypothermic condition when Ms George found her at about 5:45 am supports such a conclusion. In his evidence at the inquest Dr Lawrence expressed the opinion, which I accept, that if Ms Tweedie had only had 40 minutes exposure to the elements that it was too short a period to account for her having lost 9°C of body temperature.[45]

64. This conclusion is also supported by the account that Ms Tweedie gave to Ms O'Shea in which she said, in summary that she'd gone outside for a cigarette with Ms George, that Mr Barnard was screaming, that Ms George then "*ran inside*", that Ms George did not return and that she [Ms Tweedie] fell over.[46]

65. I am satisfied that when Ms Tweedie fell, it is more probable than not that she struck her head (her chin) on one of the raised garden beds. I note that those beds are made from galvanized steel.[47] The injuries to her face and the cervical cord syndrome, most likely the result of a hyperextension injury to her neck, are entirely consistent with such a fall, as is the evidence of where she was found from Ms George.

66. I am satisfied that Ms George did not check to ensure that Ms Tweedie had returned safely to the inside of the facility. Even if Ms George was unaware of Ms Tweedie's recent fall history, she still should not have left an elderly client outside in the dark after 3:00 am.

Ms Tweedie's care at St Michael's

67. I have set out this in detail earlier in this finding the health issues associated with Ms Tweedie relating to her exhibiting symptoms consistent at least with dementia and her history of falls and mobility problems. Significant evidence was heard and adduced at the inquest in relation to St Michael's Association's response, if any, to Ms Tweedie's deteriorating physical health. I am satisfied, after considering that the

[45] Transcript, page 168.
[46] Exhibit C 10.
[47] Exhibit C 21, scene photographs.

evidence carefully, that in fact in a practical sense St Michael's Association did nothing to review or assess Ms Tweedie's needs for care.

68. For example, there is no evidence of St Michael's Association initiating or participating in regular multidisciplinary reviews of Ms Tweedie's care needs. In fact a full review of the records kept by St Michael's shows that there was no substantive review of her care needs carried out at all after she turned 65 years old. That is a significant date because the evidence was after clients 65th birthday they no longer were eligible to access funding under the NDIS. At the very least, it seems to me that it was not unreasonable at that point to have initiated a review. It was certainly something required in my assessment as an ongoing consideration and it was particularly necessary in light of the fact that St Michael's were aware of concerns in relation to the onset of dementia and mobility issues. Both Mr Gilpin and Mr Campbell gave evidence at the inquest that there were concerns that Ms Tweedie was or may have been suffering from dementia. Her records also confirm this state of knowledge, particularly in relation to information from Ms Tweedie's GP, Dr Strong.

69. I accept readily that there was no actual formal diagnosis of dementia. I also accept that making that diagnosis given Ms Tweedie's intellectual disability may have proved problematic. I also accept Mr Campbell's evidence that if Ms Tweedie had been formally diagnosed with dementia it may or almost certainly would have resulted in her receiving a different level of care.[48] Nonetheless, at the risk of repetition, I consider that there was ample reason for St Michael's to have been alert to the potential for difficulties associated with Ms Tweedie and the need to at least review the level of care she was receiving.

70. I do not consider that the level of funding to which she was entitled under the continuity of care model nor the fact that she was no longer a participant in the NDIS impacted upon the need to undertake this assessment and review.

Conclusions

71. In summary, Ms Tweedie's death was, in my view, a direct result of her being left alone, outside, in the cold and the rain in the early hours of the morning completely unsupervised. I do not think it is unreasonable to observe that policies, procedures and protocols should not be necessary to tell anyone that an elderly lady with an acquired brain injury, symptoms of dementia and mobility and balance issues should not be left in such circumstances.

[48] Transcript.

72. I do not consider there are any suspicious circumstances, inconsistencies or anomalies associated with Ms Tweedie's death. Specifically, I am affirmatively satisfied that the injuries which caused her death were sustained by her accidentally and that she was not the victim of assault or any form of violence.

73. I do not consider NDIS funding arrangements had any causal connection in relation to Ms Tweedie's death.

74. I consider that her treatment whilst a patient of the Tasmanian Health Service was sub optimal in the sense that there was a failure to diagnose her spinal injury in a timely manner. Nonetheless, as I have already made clear, that issue did not change the ultimate outcome for Ms Tweedie because the injury she sustained when she fell in the garden of the Desmond Wood facility in the early hours of 15 July 2021 was irreversible and fatal.

Formal Findings

75. On the basis of the evidence at the inquest I make the following formal findings pursuant to section 28(1) of the *Coroners Act* 1995:

    a. The identity of the deceased is Valma Ann Tweedie;

    b. Ms Tweedie died in the circumstances set out in detail in this finding;

    c. The cause of Ms Tweedie's death was pneumonia following cervical spine injuries sustained in an unwitnessed mechanical fall from standing; and

    d. Ms Tweedie died, aged 72 years on 22 August 2021, at the Launceston General Hospital, Launceston, Tasmania.

Recommendations and Comments

76. A coroner has a duty, "wherever appropriate, to make recommendations with respect to ways of preventing further deaths and on any other matter that the coroner considers appropriate".[49] It is well recognised that there are limits to the making of recommendations; recommendations must arise out of, or enjoy a clear evidentiary nexus to, the findings at the inquest and avoid "*philosophical self-indulgence*".[50]

77. Having regard to the circumstances of the death, I consider that the following **recommendations** are justified:

[49] See section 28 (2) of the *Coroners Act* 1995.
[50] *Chief Commissioner of Police v Hallenstein* [1996] 2 VR 1 at page 7 per Hedigan J.

a. That the Tasmanian Health Service implement the recommendations contained in the RCA report (exhibit C8 at the inquest) and dated 21 December 2021, within the completion dates set out in that report; and

b. St Michael's Association Inc. undertake a review with respect to its risk identification and management systems relating to residents at increased risk of falls.

Conclusion

78. I acknowledge the assistance of all counsel at the inquest.

79. I wish to convey my sincere condolences to the family and loved ones of Ms Tweedie.

Dated: 2023 at Hobart in the State of Tasmania.

Simon Cooper
Coroner

Annexure 1 – List of exhibits

LIST OF EXHIBITS

Record of investigation into the death of VALMA ANN TWEEDIE

No.	TYPE OF EXHIBIT	NAME OF WITNESS
C1	POLICE REPORT OF DEATH	Cst Chloe Bowden
C2	LIFE EXTINCT AFFIDAVIT	RN Tanya Tyson
C3	AFFIDAVIT OF IDENTIFICATION	Cst Jorge Amaya
C4	DEATH REPORT TO CORONER	Launceston General Hospital
C5	AUTOPSY REPORT	Dr Christopher Lawrence
C6	MEDICAL REPORT	Dr Anthony Bell
C7	PRÉCIS	Libby Newman, Clinical Nurse Specialist
C8	ROOT CAUSE ANALYSIS REPORT	Morag McPheron
C9	STATUTORY DECLARATION	Margaret Tweedie (SNOK)
C10	CONVERSATION TRANSCRIPT	Jacqueline O'Shea
C10A	AFFIDAVIT 24.08.2021	Jacqueline O'Shea
C10B	AFFIDAVIT 24.03.2022	Jacqueline O'Shea
C11	AFFIDAVIT	John Gilpin, St Michael's Association
C11A	SUPPORTING DOCUMENTS A. WORK ROSTERS B. CVS C. SMOKING LOG D. SLEEP DISTURBANCE FORM E. INCIDENT LOGS	John Gilpin, St Michael's Association
C12	AFFIDAVIT	Roderick Campbell, St Michael's Disability Services
C13	AFFIDAVIT	Cst Emma Baker
C14	JOANNE GEORGE AFFIDAVIT SUMMARY	TASMANIA POLCIE
C14A	JOANNE GEORGE RECORDED INTERVIEW ON DISC X1	TASMANIA POLCIE
C14B	INTERVIEW TRANSCRIPT	TASMANIA POLCIE
C15	INVESTIGATION FILE NOTES	Roderick Campbell, St Michael's Disability Services

C16	**INCIDENT NOTIFICATION**	**WorkSafe Tasmania**
C17	**ST MICHAEL'S ASSOCIATION RECORDS ON USB X1**	**John Gilpin, St Michael's Association**
C18	**NDIS INVESTIGATION RECORD**	**NDIS**
C19	**PATIENT CARE RECORD**	**Ambulance Tasmania**
C20	**FORENSIC PHOTOGRAPHS**	**DPEM Forensic Register**
C21	**MEDICAL RECORDS**	**Dr Jane Strong (GP)**
C22	**PATIENT HEALTH SUMMARY ON DISC X1 & PHOTOGRAPHS**	**Launceston Medical Centre**
C23	**MEDICAL RECORDS & USB X1**	**Launceston General Hospital**
C24	**MEDICAL RECORDS ON USB &1**	**Royal Hobart Hospital**
C25	**000 CALL RECORDING – 05:54 AM 14/7/2021**	**Tasmania Police**
C26	**ePCR - TWEEDIE, Valma - 20210714**	**Ambulance Tasmania (VACiS)**
C27	**ePCR (IFT) - TWEEDIE, Valma - 20210717**	**Ambulance Tasmania (VACiS)**
C28	**ePCR AMR (FWA) - TWEEDIE, Valma - 20210717**	**Ambulance Tasmania (VACiS)**
C29	**PHOTOGRAPHS**	**Margaret Tweedie**