MAGISTRATES COURT of TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

(These findings have been de-identified in relation to the name of the deceased, family, friends and others by direction of the Coroner)

I, Rod Chandler, Coroner, having investigated the death of Mrs F

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

a) The identity of the deceased is Mrs F;
b) Mrs F was born on 9 November 1924 and was aged 91 years;
c) Mrs F died at the Royal Hobart Hospital (RHH) in Hobart on 8 December 2015; and
d) The cause of Mrs F's death was a pelvic haematoma arising from a fracture of the neck of the left femur sustained in a fall.

Circumstances Surrounding the Death

Mrs F was a divorcee and resided by herself in her own home at West Hobart. It seems that she was strongly independent and resistant to a move to a nursing home. Family members visited daily to help with her care and domestic needs. Her medical history included emphysema and seriously impaired hearing. In recent times there had been a decline in her cognitive function. An assessment by a geriatrician in November 2015 included a recommendation that a guardianship order be obtained.

On 2 December 2015 Mrs F had a fall from her bed. The next morning she reported to family members that she had injured her left wrist. She was taken to her general practitioner, Dr Danny Rimmer. He was concerned that she may have sustained a fracture and recommended that she attend the RHH for an x-ray. The x-ray did not detect a fracture. A comprehensive assessment was undertaken involving a geriatrician and the Emergency Multidisciplinary Team. Mrs F's family members were also consulted. It was agreed that Mrs F did not have the capacity to care for herself and that it would be unsafe to allow her to go home. She was officially admitted to the Medical Unit at around 6.00pm on 3 December. The admission process included completion of a falls risk assessment; it showed Mrs F to have a high risk of falling.

The following morning Mrs F was reviewed by a Nurse Practitioner in aged care. It was considered that she would require residential aged care placement. This course was

discussed with Mrs F and family members later in the day. There was a referral made for her to have physiotherapy. However, it was recorded in the notes that: *"Due to limited resources, there will be a delay in physiotherapy services to see this patient. All referrals are being reviewed and prioritised daily. A physiotherapy assessment will occur as soon as a therapist is available…"*

In the early morning of 5 December Mrs F fell from her bed. She was found on the floor by hospital staff and said that she was *"rolling over in bed and fell out."* An x-ray showed a fracture of her left hip. It was decided, with family involvement, that surgery was not an option and to initiate palliative care. There were initial difficulties in managing Mrs F's pain and this was not satisfactorily achieved until the evening of 7 December. Mrs F died at 2.00pm the following day.

Post-Mortem Examination

This was carried out by forensic pathologist, Dr Donald Ritchey. In his opinion the cause of Mrs F's death was a pelvic haematoma arising from a fracture of the neck of the left femur sustained in a fall. Significant contributing factors were advanced atherosclerotic and hypertensive coronary vascular disease, emphysema and dementia. I accept this opinion.

Investigation

It has been informed by:

- An affidavit provided by the son of Mrs F.
- An affidavit provided by a granddaughter of Mrs F.
- A review of Mrs F's records at the RHH carried out by research nurse, Ms L K Newman.
- A report provided by Dr Annette Pantle, Executive Director for Patient Safety with Tasmanian Health Service.
- A report upon Mrs F's medical care at the RHH compiled by Dr A J Bell, as medical adviser to the coroner.

A focus of the investigation has been upon the circumstances surrounding Mrs F's hospital fall.

A falls risk assessment at the RHH necessitates completion of a document entitled Falls Risk Assessment Tool (FRAT). In Mrs F's case this document was completed by registered nurse, Ms Uma Kennedy. A portion of the FRAT is entitled 'Falls Risk Assessment' and requires the level of risk to be scored against four named criteria. Nurse Kennedy has left that part of the form blank. However, she has rated Mrs F to be in the High Risk category. Another portion of the FRAT is entitled 'Individualised Strategies.' It identifies a number of risk minimisation devices. Some of the options relevant to Mrs F's circumstances include 'Bed at Correct Height for Exit'; HI-LO bed/low bed'; 'Floor mat next to Bed'; 'Bed Rails Down'; 'Bed/Chair Sensor' and 'Supervise at all times in Bathroom/Toilet.' Again that portion of the form has also been left blank. I am informed that when interviewed by her employer, Nurse Kennedy advised that she was unable to recollect the reasons these parts of the FRAT were not

completed. Further, she says that she does not recall whether any of the strategies listed in the FRAT were put in place for Mrs F.

In his affidavit Mrs F's son says: *"It was very busy in the hospital that night. I think there was one nurse off, so the ward was running one short. One of the nurses explained to Mum that she was not to get out of bed. I think the nurse held up a sign telling her this. She also informed Mum of where the buzzer was. However 5 minutes later Mum would not have remember (sic) that."* Later he also says: *"The bed was quite high in the hospital, much higher than her one at home."*

Mrs F's granddaughter says in her affidavit: *"I do not understand why [the deceased] was placed in a bed so high from the ground and why the guard rails were not utilised. [The deceased] was only 34kgs and under 5 foot tall, it was a long drop for her to the ground. She had been medicated with heavy pain killers (morphine I believe), she would have been unsteady. It would have made sense for her to be lower (sic) the ground in case she fell."*

Findings, Comments and Recommendations

I am satisfied that it was a correct decision to admit Mrs F to hospital on 3 December 2015. This is because the evidence clearly shows that it would have been unsafe to allow her to resume caring for herself at home having regard to her physical and cognitive impairments. Instead she required assessment for admission to an aged care facility and it was quite feasible for this to be undertaken whilst she was an in-patient at the RHH. Obviously during this time the RHH had a duty to provide Mrs F with proper care and to keep her safe.

It is also clear from the evidence that Mrs F was a high falls risk. This was evident to nurse Kennedy when she assessed her on the day of admission. This circumstance required the RHH to take all reasonable steps to minimise the risk of Mrs F falling and causing herself injury. However, it seems that the only steps in fact taken were to advise Mrs F not to leave her bed and to utilise the buzzer if she needed to do so; presumably so that she could be assisted to attend the bathroom. This advice needs to be considered in context. In November 2015 geriatrician, Dr Blair Adamczewski, carried out an assessment of Mrs F and his subsequent report (a copy of which is in Mrs F's hospital records) stated, *inter alia*: *"[The deceased] has evidence on cognitive testing and collateral history of a probable dementia of Alzheimer's type. Manifestation of this seems to be not only marked short term memory loss but also reduced insight into the care that she requires day to day."*

Mrs F's cognitive state made it, in my view, highly unlikely that she would remember and hence comply with any directions given to her by nursing staff. It follows that it was insufficient, as a measure to minimise her falls risk, to advise Mrs F to remain in bed and to utilise her buzzer. Instead her safety demanded that other measures be taken and these, in the least, should have included a lowered bed, the provision of a floor mat and ideally the fitting of a bed sensor. The failure to employ any of these measures constituted a serious shortcoming in the standard of care required by Mrs F.

There were no witnesses to Mrs F's fall on 5 December and the circumstances which brought it about are not entirely obvious to me. Nevertheless it is clear that Mrs F did have a fall that morning which caused her to suffer a fracture to the neck of her left femur. I accept,

given all of the circumstances, that the decision to forego surgery and to implement palliative care was a reasonable course. It is most unfortunate that in the days following difficulties were encountered in managing Mrs F's pain which undoubtedly caused her and her family members extra distress.

In my view, Mrs F's fall and its fatal consequences would, in all likelihood, have been avoided if the RHH had ensured that her falls risk was comprehensively assessed and strategies put in place to respond to that risk. It follows that her death was preventable.

I am advised by Dr Pantle that following Mrs F's death these recommendations were made to avoid a recurrence:

- Increased use of the FRAT and its correct completion.
- Direct observations of patients with a high risk of falling.
- Regular auditing of FRAT.
- Education of staff in falls assessment and action plans for all patients.

It is hoped that these recommendations are implemented and sufficiently monitored.

There is a final matter upon which I wish to comment. The coronial investigation of a death in a medical setting requires the co-operation and assistance of those persons and institutions associated with the death. If that is not received in a timely manner the investigation is prolonged causing understandable frustration and distress to family members. In this instance, as part of the investigation, a report was requested from Dr Pantle concerning Mrs F's falls risk and the FRAT. That request was made on 24 February 2017. However, the report was not received until 8 September 2017 which date coincided with the day Dr Pantle had been summoned to appear at a case management conference to explain her unresponsiveness. I mention this matter with a plea that all persons from whom assistance is sought provide that assistance as promptly as is reasonably possible. By doing so unnecessary delay will be avoided and family distress minimised.

I have decided not to hold a public inquest into this death because my investigation has sufficiently disclosed the identity of the deceased, the date, place and cause of death, relevant circumstances concerning how her death occurred and the particulars needed to register her death under the *Births, Deaths and Marriages Registration Act 1999*. I do not consider that the holding of a public inquest would elicit any significant information further to that disclosed by the investigation conducted by me. The circumstances of this death do not require me to make any further comment or to make any recommendations.

I convey my sincere condolences to Mrs F's family and loved ones.

Dated: 5 February 2018 at Hobart in the State of Tasmania.

Rod Chandler
Coroner