



MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION



Record of Investigation into Death (Without Inquest)

*Coroners Act 1995
Coroners Rules 2006
Rule 11*

I, Rod Chandler, Coroner, having investigated the death of Alan John McKenzie

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

- a) The identity of the deceased is Alan John McKenzie;
- b) Mr McKenzie was born in Launceston on 14 September 1925 and was aged 92 years;
- c) Mr McKenzie died on 15 April 2018 at Newstead, Tasmania; and
- d) The cause of Mr McKenzie's death was heart failure secondary to ischaemic heart disease/arrhythmia aggravated by a fall with cervical neck fractures.

Background

Mr McKenzie was married to Anne McKenzie. In June 2017, because of declining health, he became a resident of Fred French Nursing Home at Newstead (the Home). His wife visited him daily. He suffered from chronic obstructive airways disease, Alzheimer's Disease and dementia. At the Home he became increasingly debilitated and immobile. By November 2017 he was unable to stand or walk unaided and he was provided with a princess chair which he used exclusively. Such chairs are designed to provide pressure relief and are utilised by persons who are unable to manage their own pressure care. It became the practice for Mr McKenzie to spend most of his waking hours in this chair.

Circumstances Surrounding the Death

At around 9.00am on Saturday 14 April 2018, Mr McKenzie was attended by aged-carers Peta Apted and Danika Jones. They assisted with his toileting needs after which he was transferred with the aid of a quick-move hoist into his princess chair. Ms Apted then wheeled Mr McKenzie to the dining room and assisted him to eat his breakfast.

At about 9.45am Ms Apted wheeled Mr McKenzie to the lounge in the Churchill Wing where he joined other residents who were watching television. Shortly afterwards Mr McKenzie was seen to fall from his chair landing head first on the floor. Staff attended and an ambulance was called. Records show that paramedics arrived at 10.35am. Mr McKenzie was then conveyed to the Launceston General Hospital (LGH) arriving at 11.05am.

At the LGH Mr McKenzie was diagnosed with cervical spine fractures at C1 and C2 with an epidural haematoma and spinal cord compression. His radiology images were reviewed by neurosurgical staff at the Royal Hobart Hospital who advised that Mr McKenzie was not a candidate for surgical intervention because of the seriousness of the injuries, his age and poor state of health. Mr McKenzie's family was advised of this decision. He was then returned to the Home for palliation. That evening he was visited by his general practitioner Dr Stuart Guest who gave directions for pain relief. Mr McKenzie died at 5.45am on 15 April 2018.

Post-Mortem Examination

This was carried out by pathologist, Dr Terry Brain. In his opinion the cause of Mr McKenzie's death was heart failure secondary to ischaemic heart disease/arrhythmia aggravated by a fall with cervical neck fractures. I accept this opinion.

Investigation

This was overseen by Constable Christopher Jackson of Tasmania Police. A significant focus was upon Mr McKenzie's fall from his princess chair and how it came to occur.

CCTV footage recovered from the lounge shows Mr McKenzie sitting in the chair for several minutes. The chair's right arm is seen to move from the perpendicular when Mr McKenzie makes contact with it. Following this Mr McKenzie is later observed to lean to the right and the arm of the chair collapses downwards whereupon he falls from the chair onto the floor. The footage does not show Mr McKenzie releasing or in any way interfering with the locking mechanism on the chair's arm. This information led to an investigation of the chair which revealed that:

- The princess chair is built from a steel frame with air cushioned seating. It has drop-down armrests and adjustable wings which permits easy transfer of patients. It has a black knob at the front of each armrest which releases a spring mechanism when pulled and the armrest lowers. When the armrest is re-engaged in the upright position the spring mechanism locks it in place. The spring mechanism can be heard to 'click' when it's re-engaged.
- The princess chair was gifted to the Home by another resident and Mr McKenzie began using it after that resident no longer had a need for it.
- On the day of Mr McKenzie's fall Ms Apted states that she and Ms Jones were sure that the right armrest had been properly locked in its upright position after Mr McKenzie had been placed in the chair. Subsequent events suggest that Ms Apted's and Ms Jones' confidence that the armrest was securely locked in place was misplaced.
- In the days prior to the accident Ms Apted reports that she "*noticed issues with the arms of the princess chair, I believed the arms were not functioning properly as it was becoming harder for the sides of the chair to click into place.*" Ms Apted says that she made two maintenance requests for the chair to be looked at and repaired.

- Mr Rod Budsworth is the person responsible for the maintenance of all equipment at the Home. He says the usual practice, if an item requires maintenance, is for a written maintenance request to be lodged with the Home. He says that there is not any record of a written maintenance request being received with respect to the princess chair.
- Tasmania Police caused the princess chair to be examined by technician, Aaron Dillon of McLean Healthcare. He reports that the chair had these faults:
 - Its right rear castor brake was not working.
 - The right armrest release bolt had a stripped thread in the release knob making it difficult for the armrest to be released.
 - The spring mechanism for the right armrest was worn and not properly lubricated. Further he *“noticed when returning the armrest to the upright position the locking pin did not engage properly, it had to be physically pushed in and visually inspected to ensure it was locked in. There wasn’t a loud clicking noise until it was forced in, which required more effort than I would expect.”*
 - The left hand leg rest lever was missing a bolt.
- It was Mr Dillon’s opinion that the chair should have been removed from use until fully repaired.

Findings, Comments and Recommendations

The evidence makes it apparent that the princess chair was not fit for use and should have been removed from service prior to Mr McKenzie’s fall. The fact that it was not removed from use demonstrates very serious shortcomings in the Home’s systems concerning the regular inspection of equipment, the reporting of faults and the carrying out of repairs. It is my **recommendation** that the Home, as a matter of urgency undertake a review of its protocols surrounding the regular inspection, maintenance and repair of its equipment, coupled with its fault reporting procedures in the hope that it leads to the implementation of new and more effective processes which prevent a repeat of an event similar to that which befell Mr McKenzie.

I am satisfied that Mr McKenzie’s premature death was a direct consequence of the right armrest to his princess chair collapsing when he leaned on it causing him to fall to the floor. This fall and its resultant injuries had a cascading effect upon Mr McKenzie’s health leading to his heart failure and death. This tragic outcome would have been prevented had his princess chair been maintained in proper working order.

I have decided not to hold a public inquest into this death because my investigation has been sufficient to disclose the identity of the deceased, the date, place, cause of death, relevant circumstances concerning how his death occurred and the particulars needed to register his 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.

I convey my sincere condolences to Mr McKenzie's family and loved ones.

Dated: 10th day of December 2018 at Hobart in the State of Tasmania.

Rod Chandler
Coroner