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 Elizabeth Robertson Bell

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

a) The identity of the deceased is Elizabeth Robertson Bell (Mrs Bell);

b) Mrs Bell died subsequent to a fall at a Residential Aged Care Facility (RACF);

c) Mrs Bell's cause of death was pneumonia and a fracture of the neck of her right femur after a fall; and

d) Mrs Bell died on 26 May 2021 at Sandy Bay in Tasmania.

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

- The Police Report of Death for the Coroner;
- Affidavits as to identity and life extinct;
- Report of the forensic pathologist Dr Donald Ritchey;
- Affidavits of Mrs Bell's senior next of kin Mr Graeme Bell;
- Records obtained from the RACF – Guildford Young Grove; and
- An opinion of the coronial nursing consultant Ms Libby Newman R.N.

Background

Mrs Bell was aged 84 years (date of birth 4 July 1936), she was a widow and she resided at Guildford Young Grove which is a RACF in Sandy Bay at the date of her death. Her husband Mr George Bell predeceased her by nine years. Mrs Bell's parents, John and Christine Rankin died in 1986 and 2000 respectively.

Mr and Mrs Bell had four children three of whom live interstate or overseas. The senior next of kin Mr Graeme Bell (Mr Bell) resides in Hobart. Mr Bell says that for most of his

mother's working life she was a hairdresser. She also raised her four children and thereafter did some retail work.

Mr Bell says his mother was in good health but she developed dementia in or about 2015. He says with the help of Dementia Australia respite and a government home care package her family was able to look after her until July 2020 when she entered Mary's Grange RACF in Taroona for a three-week period of respite. When the 3 weeks passed it was decided, because she was receiving better care at Mary's Grange, she would remain at that RACF rather than come home. In December 2020 Mrs Bell was moved to Guildford Young Grove due to the closure of Mary's Grange.

Mr Bell says when his mother went into full-time care his family visited frequently and kept in touch with staff both in person and by email. He says his mother had a history of escaping and staff had to keep a close eye on her. She was very active during the night and would frequently stay up late but he found both homes adapted well to her routine. They would allow her to sleep during the morning, after a late night, to ensure she was still getting enough sleep. Mr Bell says, as a family, it was felt she was well cared for at both homes.

Circumstances Leading to Death

At 11.30pm on 19 May 2021 staff noted that Mrs Bell was in bed asleep. Sometime after that she has got out of bed to go to the toilet and she has fallen over near her bathroom.
At 12.10am on 20 May 2021 the same staff member went into her room to complete checks on her and located Mrs Bell on the floor and in some pain. A doctor attended and it was determined Mrs Bell had suffered a fractured right hip (fracture of the right neck of femur) as result of the fall.

As result of discussions between the family, the doctor and the RACF end-of-life care was implemented. This care continued until Mrs Bell passed away at approximately 5.25pm on 26 May 2021.

Investigation

Dr Donald Ritchey performed a limited autopsy, there having been an objection to a full autopsy, on 27 May 2021. The limited autopsy included an external examination of Mrs Bell, the taking of photographs and consideration of the relevant medical records and the police report of death for the coroner. As a result of conducting that examination and considering that material Dr Ritchey determined the cause of death to be a fracture of the right neck of the femur which was caused by a fall from standing. In addition, as result of' Mrs Bell's immobility after the fall, she developed pneumonia. I accept Dr Ritchey's opinion. It is not

uncommon for an elderly person to pass away after sustaining such an injury because their age and frailty results in them being unable to cope with the insult to the body caused by the fall and fracture. It is also not uncommon for elderly people who sustain such an injury to subsequently developed pneumonia because of an inability to move.

Because Mrs Bell fell over and sustained an injury which ultimately led to her death while in care I arranged for the coronial nursing consultant Libby Newman to examine the records of the RACF and to provide her opinion on the standard of care provided by the RACF. In addition to considering the records of the RACF she also considered the other documents listed on page 1.

Ms Newman noted Mrs Bell's past medical history included Alzheimer's disease, left eye blindness, a dual chamber cardiac pacemaker; previous syncopal episodes (prior to pacemaker insertion), carotid vascular disease, incontinence and vitamin D deficiency.

Mrs Bell had Alzheimer's disease but was physically quite well and she was able to independently mobilise. She did not need to use a mobility aid and only required supervision for her mobility. She did, however, have a somewhat unsteady gait and this, combined with her cognitive status, resulted in her being at a high risk of falling.

Mrs Bell had a movement sensor alarm in place by her bed at night. She wandered about her residence frequently and was noted to be confused. She would display disinhibited behaviour. She had previously been at risk of absconding although this did not appear to have been a major problem over the last few months of her life. She was noted to be impulsive, she lacked insight into her safety, could be intrusive towards other residents, prone to verbal outbursts, she often refused assistance and she was confused most of the time.

On 15 January 2021 Mrs Bell slipped from a chair to the floor when going to sit down in a nurse's station. This was a witnessed event. Mrs Bell was assessed and it was determined she did not sustain any injuries.

A mobility and transfer assessment was carried out on 1 March 2021. Findings and recommendations included that Mrs Bell was to be supervised but otherwise she was independent, no mobility aid was needed, her bed should be set at '*low low*' height, staff were to complete 30 minutes wanderer's checks, she was encouraged to join activities in the main lounge where she could be observed, a beam alarm was to be switched on when Mrs Bell was in bed and a crash mat was to be placed on the side. She was to be monitored frequently when in bed. A Falls Risk Assessment was also carried out on this day.

Mrs Bell was reviewed by her general practitioner (GP), Dr Monks, on 14 May 2021. Dr Monks noted:

> "*History*
> *Routine review today. Usual self. No absconding events of late*
>
> *No falls or incidents in the last week and bowels opening regularly*
> *Eating and drinking as usual – not dehydrated*
> *No pain or soreness*
>
> *Examination*
> *No non verbal signs of pain*
> *No new bruises or skin tears*
> *Looks clean and well looked after*
> *Well hydrated*
>
> *Management*
> *Continue current management*"

On 17 May 2021 Mrs Bell was noted to be removing her clothes while walking around the main lounge room. She underwent a physiotherapy review on that day which resulted in the following findings and recommendations: Mrs Bell is able to independently mobilise and transfer, she only needs supervision (as opposed to assistance) with day to day activities, however her safety is at risk (she is at risk of falling) due to psychological issues and cognitive decline. The goal at this time was stated to be '*minimise risk of falling*'.

On 19 May 2021 nursing notes state Mrs Bell was wandering around "*from one corner of the facility to another. She was redirected multiple times. Several non pharmacological nursing intervention*[s] *applied to keep her occupied nil success*…"

On 20 May 2021, just after midnight, a staff member discovered Mrs Bell lying on her bathroom floor. At this time it was noted the movement sensor alarm that should have been positioned next to her bed was neither in place nor turned on. Mrs Bell was transferred from the floor to her bed by a mechanical hoist. She was noted to be screaming in pain, alert and coherent. The staff noted shortening of her right leg. Apart from some hypertension her clinical observations were satisfactory. Mrs Bell's GP was contacted. She advised staff not to transfer Mrs Bell to hospital – rather she would come in to review her. An order for analgesic medication was made and administered.

Notes made by the nurse in charge at 1.35am include:

"…*Beam sensor was turned off and it was placed next to the cupboard*

…Pupils reactive to light

Has equal strength in bilateral arms

Shortening of the affected leg R) was evident and unable to move due to excruciating pain

…Dr Libby was notified, and brief handover was given regarding the clinical issue

RNIC was advised not to transfer the resident to the hospital and she will come to the facility to assess the resident…"

The mid-morning nursing notes state:

"*Went to see Betty after finishing handover @0720 hrs. Betty was found in her bed with large amount of vomit present on her clothing's (fresh vomit). When tried to make a conversation with her she was looking distressed. Phone order Morphine 2.5 mg s/c administered @ 0730 hrs with RN Charles as witness… Called GP for review and O2 administration again @ 0850 hrs, Dr Libby voiced not to continue O2 until review. NOK was called on the same time, NOK stated she wants to be in facility when GP is on site*

GP arrived in facility @ 0910 hrs same with NOK (Johan) [sic]*, after having a*[n] *extended conversation with family GP prescribed Betty with syringe driver order and PRN sedative orders. Betty is on End of Life Pathway. To maintain PAC 2 hourly. Maintain her dignity and manage pain*"

In the early evening Dr Monks noted,

"*Fall*

?#NOF

History

Fall overnight and pain in R leg since. Morphine settled it at time of fall in the night. Now not rousable, R leg shortened, swollen+++ over R upper thigh, tender to palpate R groin or move R leg

Assessment

Likely #NOF from fall

Plan

Long chat with multiple family member re options – hospital transfer pros and cons and staying at home pros and cons

Plan is to stay at home, comfort care and dignity

Star[t] *SD with 20 mg morphine, 5 mg midazolam*

Use morphine prn apc for pain

Use midazolam prn apc for agitation

Use glycopyrrolate prn for urt secretions

No neuro obs
Cease oral medications
Start EOLP
I will review mane
(Seen this morning)"

Mrs Bell continued to receive comfort/palliative care and died on 26 May 2021.

At the most recent falls risk assessment (prior to fall) on 1 March 2021 Mrs Bell was assessed as being at a high risk of falling (due to being severely affected by one or more psychological factors, severely impaired cognition, dementia and wandering behaviour).

Falls prevention strategies noted included: answering the call bell promptly, supervising Mrs Bell with transferring/mobilising, communicating risk status and strategies, not permitting her to isolate during the day, eliminating environmental hazards, ensuring bed brakes were on at all times, her bed was to be set at the lowest height, she was to use non slip footwear and a crash mat and movement sensor alarm was to be in place next to her bed at night.

Ms Newman says Mrs Bell was at risk of falling due to her impaired cognitive status, impulsive behaviours and frequent wandering. She had appropriate falls prevention strategies in place and had recently been seen by a physiotherapist and a GP. Her falls risk assessment was up to date and she was appropriately assessed as being at a high risk of falling.

Ms Newman concludes as follows:

> *"The circumstances of her fall on 19/20.05.2021 are important – it is well documented that the movement sensor alarm was not in place and not turned on. This was recognised immediately following the discovery of Mrs Bell on the floor. The nursing home has provided some documentation regarding their investigation and noted the following strategies/actions needed to occur: staff education regarding ensuring sensors are in place, turned on and working correctly; Clearer documentation and communications regarding resident care needs; Ongoing education for the registered nurse working that night regarding "not contacting family at the time of significant fall"; Clinical assessment; Ongoing education for nursing staff for responding to a significant incident, who and when to contact and appropriate follow up care delivery.*
>
> *Had the movement sensor been working and in place it presumably would have alerted staff to check on Mrs Bell and her fall potentially would have been avoided. This is, of course, not a certainty – but the likelihood of a fall would probably have been circumvented."*

Ms Newman notes she was hopeful the RACF had implemented the recommendations of its investigation to avoid this circumstance happening again. Other than this obvious circumstance Ms Newman says there are no other 'red flags' following a review of all the documentation provided.

I agree with and accept Ms Newman's opinions.

A copy of my draft findings was forwarded to Ms Charmaine Carter for comment. Ms Carter is the Executive Manager, Residential Care Services of Southern Cross Care (Tasmania) Inc. which is the organisation which operates the RACF. Ms Carter did not respond.

Comments and Recommendations

While there are no guarantees that had the movement sensor alarm been in place and been switched on Mrs Bell would not have fallen, the purpose of such a device is to alert staff so that they can attend to the resident thereby reducing the risk of a frail and vulnerable person from falling and injuring themselves. If falls are prevented in such circumstances then that reduces the risk of a resident of such a facility dying by the mechanism of death which occurred in this case. The risk of injury and therefore death cannot be reduced unless the alarm is in place and switched on. In this case had the alarm been in place and had it been switched on then assuming the alarm was attended to promptly the probability is the fall which led to Mrs Bell's death would have been avoided.

In these circumstances it is necessary to remind all RACFs that where a resident is assessed as requiring a movement sensor alarm, they are to ensure that alarm is in place and switched on when a resident is either resting and/or sleeping alone in his or her room or unit.

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

I convey my sincere condolences to the family and loved ones of Mrs Bell.

Dated: 8 August 2023 at Hobart Coroners Court in the State of Tasmania.

Robert Webster
Coroner