MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Simon Cooper, Coroner, having investigated the death of Peter Joseph Guy

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

a) The identity of the deceased is Peter Joseph Guy;

b) Mr Guy died in hospital where he was receiving treatment for injuries sustained by him in an unwitnessed fall from bed, whilst a resident in a residential aged care facility (or nursing home). In the fall, Mr Guy suffered a L2 compression fracture. Mr Guy's medical history included mixed vascular dementia and Alzheimer's disease, atrial fibrillation, congestive cardiac failure, ischaemic heart disease, PE and DVT, PTSD, depression, anxiety, incontinence and mobility difficulties. He had a documented history of falls in the RACF;

c) The cause of Mr Guy's death was hypostatic pneumonia; and

d) Mr Guy died, aged 82 years, on 23 April 2022 at the Repatriation Centre, Peacock Ward, 90 Davey Street, Hobart, Tasmania.

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

- Police Report of Death for the Coroner;
- Affidavits establishing identity and life extinct;
- Report – Dr Donald Ritchey, Forensic Pathologist;
- Affidavit – Ms Justine White, sworn 6 July 2022;
- Records – Masonic Care, Tasmania;
- Medical Records – Tasmanian Health Service; and
- Nursing Home Fall Review – Mr Kevin Egan, Forensic Coronial Nurse, Coronial Division.

Background

Mr Guy was admitted to the Freemasons Home on 12 September 2019 as a consequence of his deteriorating physical and mental health. From that date until his death, he had several recorded falls. On 14 January 2022 Mr Guy fell and suffered a compression fracture of his L2 spine. He had a series of falls after that date, culminating in an unwitnessed fall on 1 April 2022 which required his hospitalisation and led directly to his death.

The evidence indicates that the Freemasons Home do not appear to have used bed alarms or any other sensory or mobility type alarms for Mr Guy, despite repeated falls, clear evidence of wandering and well documented evidence of worsening confusion in the wake of each fall. A bed alarm would not have prevented Mr Guy's fall on 1 April 2022 but it would have led to a quicker response. Moreover there is no evidence of bed rails being used by the nursing home. Bed rails would almost certainly have prevented the fall.

Finally, an audit conducted not long before Mr Guy's death makes it clear that Freemasons Home was non-compliant in relation to 7 of 8 standards assessed in that audit. Relevantly, Freemasons Home could not demonstrate that residents receive safe and effective care that was best practice.

Investigation

When Mr Guy's death was reported it was the subject of an investigation pursuant to the provisions of the *Coroners Act* 1995. As part of that investigation, Freemasons Home was sent a series of questions. Those questions included:

> "*Has Peter Joseph Guy fallen before 1 April 2022. If so:*
>
> *i. On how many occasions?*
> *ii. The date of education?*
> *iii. Nature of any injuries related to these falls?*
> iv. *When was the last fall prior to 1 April 2022 event?*"

By way of reply, in a letter dated 4 July 2022, Masonic Care Tasmania (the operators of Freemasons Home) only provided details of falls for the three months leading up to 1 April 2022 – amending the question and omitting information in relation to the fall in which Mr Guy suffered a compression fracture of his spine, and omitting any information in relation to any earlier falls.

It is apparent that the response was deliberate. Whether it was deliberately misleading is unclear.

This finding was sent, in draft, to the management of the Freemason's Home for comment. In reply Respect Group Ltd pointed out that it had assumed management of Masonic Care Tasmania in December 2022 and was 'disappointed that the response provided by Masonic Care [as part of this investigation] appeared to be misleading and omitted certain facts'.

Conclusion

Mr Guy's care at Freemasons Home was substandard.

The level of cooperation of Masonic Care Tasmania in respect of the investigation into Mr Guy's death was poor.

Comments and Recommendations

The circumstances of Mr Guy's death are such as to require me to **comment** pursuant to Section 28 of the *Coroners Act* 1995 that there is a legal (and one might add moral) obligation on the part of the operators of RACF's to cooperate fully and openly with any Coronial investigation.

I convey my sincere condolences to the family and loved ones of Mr Guy.

Dated: 27 June 2023 at Hobart in the State of Tasmania.

Simon Cooper
Coroner