MAGISTRATES COURT TASMANIA

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 Ronald Reginald Slatter

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

a) The identity of the deceased is Ronald Reginald Slatter;

b) Mr Slatter died following a fall in which he sustained a fracture of the neck of his right femur;

c) The cause of Mr Slatter's death was Alzheimer's Dementia; and

d) Mr Slatter died, aged 93 years, on 22 July 2022 at the Mersey Community Hospital, Latrobe, Tasmania.

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

- Police Report of Death for the Coroner;
- Medical Records – Tasmanian Health Service (including Medical Certification of Cause of Death);
- Report – Dr Andrew S Reid, Forensic Pathologist; and
- Report – Dr Anthony J Bell, Medical Advisor to the Coronial Division.

Circumstances of death

Mr Slatter died in the Mersey Community Hospital on 22 July 2022. He had been in that hospital since 10 May 2022 when he was taken for assessment due to his declining health. He never left. Whilst in the Mersey Community Hospital he contracted Covid 19, but that was not a factor in his death.

On 1 July 2022, Mr Slatter suffered a fall from a chair in the presence of a nurse.

In the fall, Mr Slatter sustained a fracture to the right neck of his femur. He was transferred to the North West Regional Hospital at Burnie where he underwent surgery to repair the fracture.

He was transferred back to the Mersey Community Hospital but he continued to decline and died on 22 July 2022. Regrettably, and in error, a Medical Certificate of Cause of Death (MCCD) was issued by a doctor at the Mersey Community Hospital. That MCCD identified the cause of Mr Slatter's death as Alzheimer's dementia, but completely omitted any reference to the fall on 1 July 2022 in which Mr Slatter had sustained a fracture of his hip. It is unclear why the doctor omitted that information. They may not have known about it, although that it had occurred and at least contributed to his death was something plainly obvious from even the most cursory examination of Mr Slatter's medical records.

The fact that Mr Slatter's death had not been reported as required by the *Coroners Act* 1995 was identified in late September 2022 following an internal review. The matter was duly reported. By then, of course, no autopsy could be carried out and other investigations were potentially compromised.

In any event, I asked Dr Andrew S Reid, the State Forensic Pathologist and Dr Anthony J Bell, the Medical Advisor to the Coronial Division, to review Mr Slatter's medical records and provide me with reports. Both did so and their reports are the basis of the formal findings pursuant to section 28 (1) of the *Coroners Act* 1995 that I made at the beginning of this finding.

Conclusion

I am satisfied that there are no suspicious circumstances associated with Mr Slatter's death. There seems to me no issue in relation to his care whilst an inpatient at the Mersey Community Hospital.

Nonetheless the failure on the part of the Mersey Community Hospital to report the fact of Mr Slatter's death in accordance with the requirements of the *Coroners Act* 1995 is to be regretted.

A reportable death in this state means, relevantly, a death:

> "That ***appears*** to have been unexpected, unnatural or violent or to have resulted directly or ***indirectly from an accident or injury***."[1] [Emphasis added].

[1] See section 3 of the *Coroners Act* 1995.

The obligation to report a death to the Coroner is a personal one and the failure to do so amounts to an offence.[2]

As things happened, the Coronial investigation in relation to Mr Slatter's death was not materially compromised by the failure on the part of the responsible staff at the Mersey Community Hospital to ensure his death was reported in accordance with the law. However, that was simply fortunate.

Comments and Recommendations

The circumstances of Mr Slatter's death to require me to **comment** pursuant to Section 28 of the *Coroners Act* 1995 that it is important all members of the medical staff of all hospitals familiarise themselves with the requirements under the *Coroners Act* 1995.

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

Dated: 2 August 2023 at Hobart, in the State of Tasmania.

Simon Cooper

Coroner

[2] Section 19 of the *Coroners Act* 1995.