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 Aubrey Charles Reeve

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

a) The identity of the deceased is Aubrey Charles Reeve;

b) Mr Reeve died as a result of injuries sustained in an unwitnessed mechanical fall on 24 July 2023 whilst resident in a Residential Aged Care Facility (RACF). At the time of his fall, Mr Reeve was suffering osteoporosis, ischaemic heart disease, hypertension and dementia. After the fall, he was taken by ambulance to the North West Regional Hospital (NWRH). The attending paramedics noted his body temperature was 34.7°C. At the NWRH, Mr Reeve was assessed and noted to be suffering from hypothermia. He was returned to his RACF for palliative and end of life care;

c) The cause of Mr Reeve's death was a comminuted pertrochanteric fracture of his left hip; and

d) Mr Reeve died, aged 98 years, on 28 July 2023 at Umina Park Nursing Home, 22 Mooreville Road, Shorewell Park, Tasmania.

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

- Police Report of Death for the Coroner;
- Affidavits confirming identity;
- Report – Dr Andrew Reid, Forensic Pathologist;
- Medical Records;
- Residential Aged Care Facility Records;
- Report (RACF fall review) – Mr Kevin Egan, RN, Forensic Medicine Coronial Nurse;
- Letter (and supporting documentation) – One Care, 12 November 2023.

Mr Reeve had been living at Umina Park Nursing Home since 2018. He suffered from numerous comorbidities in the lead up to his death.

It is evident that Mr Reeve had experienced an escalating number of falls in the last year of his life, including a fall in October 2022 when he suffered a fractured pubic ramus.

Clearly, steps needed to be taken to ensure, to the extent possible, that he was protected from the risk, and consequences, of falls.

Unfortunately, I am not satisfied that the care he received in the final weeks of his life at his RACF was of an appropriate standard.

Although Mr Reeves' room at the RACF was apparently fitted with movement detectors, it appears those detectors did not operate appropriately. I reach this conclusion because he was found near the door of his room, indicating to me that he did not fall out of bed, but rather had mobilised from his bed. If that is so, correctly working sensors would have alerted staff to the fact that Mr Reeve was mobilising in his room. This in turn may have allowed staff to assist him before he fell. This finding was sent to Umina Park in draft for comment. Umina Park confirmed that the room sensor was not functioning at the time of the incident.

In addition, the fact that Mr Reeve was diagnosed as suffering from hypothermia suggests to me that he may have been on the floor of his room for some time. It is unclear from his records when he was actually last seen by staff before he was found on the floor of his room. It is also unclear from the records provided by the RACF whether, and when, overnight checks occurred on Mr Reeve.

Next, there is only a limited amount of information on Mr Reeves file. For example, the file from the RACF does not contain progress notes, falls assessment or care plans. As I have said Mr Reeve was obviously a high falls risk. Although the RACF asserted in answer to questions asked as part of this investigation that his fall risk assessment was "up-to-date" no actual fall risk assessment (or similar) was provided to support that assertion or assist with this investigation. Although those deficiencies were rectified by the RACF when this finding was sent in draft for comment, I observe it essential that all relevant information is provided immediately it is requested by the coroner.

I am satisfied that the care and treatment he received at the NWRH was of an appropriate standard.

Specifically, the decision to not actively treat his fracture and to palliate Mr Reeve was, in all of the circumstances, appropriate in my assessment.

Comments and Recommendations

The circumstances of Mr Reeve's death require me to **comment** that the care he received at Umina Park Residential Aged Care Facility was not of an acceptable standard and likely contributed to the fall that caused his death.

It is essential that Residential Aged Care Facilities ensure that movement detectors, in addition to being fitted and appropriately installed as and when required, actually operate correctly.

I acknowledge the steps taken by the Residential Aged Care Facility to attempt to ensure mechanical deficiencies in relation to movement detectors and similar are identified and rectified by staff in a timely manner. I also note the various measures taken by Umina Park to enhance overall quality of care since Mr Reeves fall.

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

Dated: 18 December 2023 at Hobart in the State of Tasmania.

Simon Cooper

Coroner