



MAGISTRATES COURT of TASMANIA

CORONIAL DIVISION



Record of Investigation into Death (Without Inquest)

*Coroners Act 1995
Coroners Rules 2006
Rule 11*

I, Stephen Raymond Carey, Coroner, having investigated the death of Maxwell Alfred Delaney

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

- The identity of the deceased is Maxwell Alfred Delaney;
- Mr Delaney died in the circumstances set out in these findings;
- Mr Delaney died as a result of hypostatic pneumonia due to a traumatic fracture of C7 and subluxation of C6/7, resulting in an unstable cervical joint;
- Mr Delaney died on 28 January 2015 at North West Regional Hospital, 23 Brickport Road Burnie;
- Mr Delaney was born in Ulverstone on 26 September 1923 and was aged 91 years;
- Mr Delaney was widowed and was a retired local government employee at the date of death; and
- No other person contributed to the cause of Mr Delaney's death.

Circumstances Surrounding the Death:

Mr Delaney was born with the surname Hudson, but was adopted into the Delaney family at age 4. When he was 21, he changed his surname by deed poll and his senior next of kin is his sister, Judith Delaney, who resides in Ulverstone. In 1983 he married Valerie Judith Delaney who passed away in 2008. Mrs Delaney had four children from a previous marriage.

When he retired, Mr Delaney and his wife were living at 113 Tarleton Street, East Devonport, living together until Mrs Delaney passed away in 2008. Mr Delaney continued to live at that address until 2014.

Mr Delaney had a complex medical history and at the time of his death suffered from atrial fibrillation, hypertension, angina, osteoporosis, vitamin B deficiency and Dupuytren's Contracture. He had also been diagnosed as suffering from Alzheimer's disease. He had impaired mobility and was also being managed for oedema, arthritic joints, chronic skin conditions and deep vein thrombosis.

Notwithstanding his medical conditions, Mr Delaney was quite mobile. However, in August 2014, he suffered a fall whilst at the home of his sister and as a result of which he was admitted to hospital on 17 August 2014. He remained in hospital until 1 September 2014 when he was transferred to the Eliza Purton Care Home in Elliott Street, West Ulverstone.

After his fall, Mr Delaney required a four-wheeled walker to assist his mobility. He was noted as unsteady on his feet and his manual dexterity was reduced. In the care home, he was usually supervised when moving from his chair to his bed or from chair to chair. However, he continued to maintain his independence in his activities. When admitted to the care home, an extensive care plan was compiled which outlined to staff his mobility limitations and guidance as to assistance to be offered to him. Clearly, as a result of his fall in August 2014, also noting that there had been other falls, the ongoing risk of a fall was high.

Mr Delaney enjoyed sitting in the sun and he spent most part of each day sitting in a courtyard outside his room. The courtyard was conveniently located and staff would normally find him seated in this courtyard if required. When the weather did not allow this, he spent time in the common lounge area or in his room.

The door to the courtyard was an internal door and therefore not alarmed. The area is accessed via a set of double doors and leads out to a small concrete slab and then opens up to a larger grassed area. On 24 January 2015, Mr Delaney has apparently opened the double doors and moved outside into the courtyard area which was part of his routine each day. However, rather than his usual practice of sitting on the concrete area, he has apparently moved his chair onto the grassed area and sat with his back facing an external wall of the building. He was sitting on a white moulded plastic chair, the type that is readily available from hardware stores and garden centres.

The grassed area where his seat was located slopes back to the building wall at an angle estimated at between 5 and 10 degrees. It is apparent that Mr Delaney has moved his chair himself, possibly so as to be in the sun. No-one witnessed the fall; however staff were notified by other residents who noted that Mr Delaney had fallen back against the building wall. When he was located by staff, he was still sitting in the chair, his shoulders were against the brick wall and his neck was bent with his head leaning forward. A hoist was used to get him out of the chair and he was taken into his room where he was placed on his bed. He underwent a health assessment with general observations taken and although these appeared normal, Mr Delaney was complaining that he had a sore shoulder and that he could not feel one of his legs properly.

Accordingly an ambulance was called and his sister was informed as to the incident. Mr Delaney was transported to the North West Regional Hospital. Investigations determined that Mr Delaney had suffered a traumatic fracture to the C7 vertebrae and subluxation of the C6/7 joint in his neck. Given his age, frailty and other medical conditions, surgery was not considered an appropriate option. Conservative measures were taken with the primary purpose of maintaining the comfort of Mr Delaney. Over time his condition deteriorated with the development of pneumonia and he died in hospital on 28 January 2015.

Comments and Recommendations:

It became apparent during this investigation that the use of light weight plastic chairs was not optimal, especially where used in outdoor areas that may not have been level. Since the incident in which Mr Delaney was injured, all of the outside plastic chairs at the Eliza Purton Care Home have been replaced with metal chairs. This was an appropriate step to mitigate the risk of a future similar incident.

I would also recommend, however, that appropriate steps be taken to ensure that residents using these chairs outdoors are confined to areas where the base upon which the chairs are placed is level and stable.

I would also recommend that some formal procedure be in place to provide ongoing monitoring of residents in outdoor areas of aged care facilities. In this facility, as I assume others, there are call buttons or alarm buttons for residents to use in their rooms. However, there does not appear to have been any such system covering the outdoor areas, nor does there appear to have been a process whereby the monitoring of the activities and condition of residents in an outdoor area was checked on a regular basis.

I would also recommend that the management of Eliza Purton Care Homes carry out an assessment as to whether the most appropriate action was taken upon the initial movement of Mr Delaney; given the circumstances indicated the possibility that he had suffered a neck injury. Although there is no indication in this case that moving him from the chair to his bed caused any additional injury or increased the effects of the injury, the possibility must be considered in dealing with such circumstances.

In concluding, I convey my sincere condolences to the family of Mr Delaney.

Dated: 28 January 2016 at Hobart Coroners Court in the State of Tasmania.

Stephen Raymond Carey
Coroner