CORONERS COURT OF THE AUSTRALIAN CAPITAL TERRITORY

Case Title:	**Inquest into the death of Mrs Judith Gaye Flynn**
Citation:	**[2022] ACTCD 5**
Hearing Dates:	**14 & 15 October 2021**
Last submission date:	**16 August 2022**
Decision Date:	**16 September 2022**
Before:	**Coroner Theakston**
Decision:	Numbered findings are made throughout these reasons
Catchwords:	**CORONIAL LAW** – cause and manner of death – matter of public safety – hospital fall – assessment of risk of falls – hi-low beds – supervision of patients – choice of ward
Legislation Cited:	*Coroners Act 1997* (ACT)
Representation:	**Counsel Assisting** Mr K Archer **Counsel for the Australian Capital Territory** Ms M Jones SC, instructed by the ACT Government Solicitor
File Number(s):	CD 22 of 2019

CORONER THEAKSTON:

Introduction

1. I begin by expressing my condolences to the family of Mrs Judith Gaye Flynn. I acknowledge the grief and anger experienced by them following Mrs Flynn's death.

2. Mrs Flynn died following a fall from a hospital bed while a patient at Canberra Hospital. Her family expressed to the Court their concerns about her care, and I consequently conducted an inquest. These are my reasons and findings.

Circumstances

3. Mrs Flynn was born in 1947 and was 72 years of age at the time of her death. The year before her death, she had lost her husband. They had been married for 48 years. Mrs Flynn left behind four daughters and eight grandchildren. One of her daughters, Dr Jo Lane, described Mrs Flynn as a dedicated wife, mother and grandmother, who pursued a range of interests, had a sense of humour and enjoyed the simple things in life.

4. Mrs Flynn lived independently until about a year before her death. In the latter part of her life, she suffered from a range of illnesses, including in late 2018 being hospitalised for delirium. That condition appears to have been triggered by an infection and a vitamin B12 deficiency.

5. Following the death of her husband and the above hospitalisation, Mrs Flynn moved from the coast to an aged care facility in Canberra, to be closer to her family.

6. On 14 January 2019 and following a fall, Mrs Flynn was admitted to Canberra Hospital. She presented with fluctuating cognitive functioning with a history of a suspected fall. She was initially admitted to the Emergency Department and the following day admitted to a general medicine ward for stabilisation and further investigation.

7. During the evening of 17 January 2019, Mrs Flynn fell again while reaching for a tray. The following day a physiotherapist assessed her as a high risk of further falls and recommended she be supervised by an assistant in nursing, and not be mobilised without supervision.

8. During the afternoon of 18 January 2019, the nurses observed Mrs Flynn climb out of bed and over the raised side bed rails. The Team Leader was told about the incident and a plan was formulated to move Mrs Flynn to a room closer to the nurses' station, which was to allow for better supervision. That room had a single assistant in nursing allocated, who could also assist with the supervision of Mrs Flynn. While a bed in that room was expected to become available within hours, that vacancy did not materialise before Mrs Flynn had a further fall.

9. Later that afternoon, Mrs Flynn was found to be wandering the corridors unsupervised. She was returned to her bed.

10. After eating dinner that evening, Mrs Flynn requested to use the toilet. The toilet was occupied. Mrs Flynn agreed to stay in bed while the nurse went to fetch a sanitary pad. While outside the room for only seconds, the nurse heard a bang and returned to find Mrs Flynn on the floor. Mrs Flynn was unresponsive and had obvious signs of a head injury. Scans later uncovered a large subdural haemorrhage with associated midline shift. It was determined that operative treatment was not appropriate, and Mrs Flynn was provided with palliative care. Mrs Flynn never regained consciousness. Two days

later on 20 January 2019 at 8:20 pm, Mrs Flynn was observed to have stopped breathing. At 9:40 pm a doctor certified her death.

11. The *Coroners Act 1997* (ACT) requires me to make a number of findings relating to the details of Mrs Flynn's death. Those findings, while tragic, are not controversial.

> **Finding No 1:** On 20 January 2019 at about 8:20 pm, Mrs Judith Gaye Flynn died at Canberra Hospital, due to a subdural haemorrhage sustained on 18 January 2019 when she fell from a bed located in a ward at Canberra Hospital.

Matter of public safety

12. The Coroners Act also requires me to state whether a matter of public safety is found to arise in connection with the inquest and I may comment on any such matter. I understand this to include matters of public safety that came to light during the proper conduct of the inquest, notwithstanding that they may not have directly contributed to Mrs Flynn's death.

13. Mrs Flynn's family initially had concerns about both the nature of the medical treatment and the patient care provided to Mrs Flynn. The latter was fittingly centred on the management of the risk of falling. For the reasons described below, I have found that matters of public safety have arisen in connection with this inquest.

Medical treatment

14. Once the clinical records were reviewed and the expert opinions considered, it became apparent that appropriate steps had been taken by staff at the hospital to diagnose and treat Mrs Flynn. She presented with functional decline, impaired mobility, cognitive impairment, and a history of falling and postural hypotension. The two experts commissioned by the Court, Dr Raftos, a specialist in emergency medicine, and Dr Clarnette, a consultant geriatrician, agreed that Mrs Flynn was appropriately assessed and treated by qualified practitioners. (Although I note that both experts also indicate it would have also been appropriate, at some point, for the general medicine team to receive input from a geriatric specialist.) Appropriate investigations were requested, and medications prescribed. Further, Mrs Flynn's mobility was assessed by a physiotherapist and her cognitive state assessed by an occupational therapist. I also note, in particular, that assessments excluded the presence of an infection and a vitamin B12 deficiency, two common and treatable causes of delirium.

> **Finding No 2:** Mrs Flynn was appropriately assessed and treated by qualified and caring practitioners.

Patient care

15. When Mrs Flynn was admitted to the hospital, she had a known history of falls. She was taken to the hospital by ambulance that day following a suspected fall, and had previous presentations to the hospital following falls. Additionally, Mrs Flynn was suffering impaired cognitive functioning and mobility, and had previously experienced leg weakness and postural hypotension. Unsurprisingly and upon initial admission to the hospital, Mrs Flynn was assessed as having a high risk of falling. That risk was significant, because falls in hospital are a well-recognised cause of preventable injury to patients that can have catastrophic consequences.

16. Three broad themes emerged from the evidence when considering what are appropriate controls to reduce the risk of falls. These themes were assessments, hospital beds and supervision.

Assessment of risk of falls

17. The evidence indicates that Mrs Flynn was assessed in relation to the risk of falling when she was initially admitted to the Emergency Department and again when admitted to a general medicine ward. The latter assessment rated Mrs Flynn as a high risk of falling. She was assessed a third time the morning after her first fall during this hospital admission period. The following day when reviewed by a physiotherapist, a note was made that Mrs Flynn 'cannot be unsupervised when mobile'.

18. The events of the afternoon of 18 January 2019 do not appear to have triggered any formal elevation in the assessment of Mrs Flynn's risk of falling. Having said that, the assessment was already very high, and those events appear to have initiated a plan to move Mrs Flynn to a high observation area.

19. It is very clear from the evidence that there was an understanding among the hospital staff that Mrs Flynn was a high risk of falling and control measures should be implemented.

> **Finding No 3:** Mrs Flynn was appropriately assessed as having a high risk of falling while at Canberra Hospital. That risk arose in part due to her history of falls and cognitive impairment.

Hospital beds

20. It became clear from the evidence that hospitals routinely use hi-low beds as a control for patients with a risk of falling. These beds were able to be lowered, to a height lower than that of a normal hospital bed, and thereby possibly reduce the height from which a fall may occur. These beds only possibly reduce that risk, because falls can occur in a range of circumstances and not just from a bed. For example, from any bed a patient may rise to their feet and then subsequently fall. In such circumstances the height of the bed may be of little consequence. Notwithstanding this, these beds are an important and valuable control in responding to a person's risk of falling. They may reduce the height of the fall and therefore reduce the harm caused by the fall. They may also be of particular assistance, such as in this case, where cognitive impairment is present. This is because notwithstanding any commitment by the staff to always assist a patient when they ambulate, such a patient may attempt to do so without warning and catch the staff off guard, including while staff are busy attending to a range of other essential duties on the ward.

21. In Mrs Flynn's case a hi-low bed was contemplated, but never provided. It never became clear why. Records of requests were not maintained. The requirement for such a bed was noted by the admitting nurse when Mrs Flynn was admitted to a general medicine ward. However, that requirement was not ticked off on Mrs Flynn's care plan. However, Mrs Flynn's normal hospital bed was kept at the lowest level. There was speculation that a hi-low bed may have been requested from Central Equipment, but stock may not have been available. However, that could not be confirmed by the evidence. It remains open on the evidence that, notwithstanding the best intentions of staff, the task of obtaining a hi-low bed for Mrs Flynn was left to someone, somewhere, to do something about it. If that were the case, unsurprisingly, one did not materialise.

> **Finding No 4:** Hi-low beds are a well-known control that could reduce the harm caused by particular falls.

> **Finding No 5:** Canberra Hospital did not provide Mrs Flynn with a hi-low bed.

22. Evidence was received that the hospital has since purchased more hi-low beds and there may not have been any subsequent incidents of staff not being able to obtain such a bed

for a patient. In 2020, a flow chart was also developed to assist staff with the process of requesting such beds, including when and how to escalate any request. It also includes, as a last resort, the step of placing a mattress on the floor until a hi-low bed becomes available.

23. I should also briefly address the use of bed rails. Hospital beds often have rails that can be raised or lowered to form an incomplete rail along each side of the bed. They are not particularly high and leave long gaps at the head and foot ends of the bed. They are probably quite effective at preventing a patient inadvertently rolling off the side of the bed, but they would not stop a determined patient from leaving the bed. Consistent with these limitations, the hospital has a policy that they should not be used for confused and disorientated patients who are also independently mobile. This is due to the risk that the patient may attempt to climb over or around the rails and may fall as a consequence.

24. Mrs Flynn obviously fitted into that category. The notes record that as late as 4:25 pm on the day of her ultimate fall, the bed rails were still raised. That is a concern. By that time, Mrs Flynn would have been observed to be confused and disorientated, non-compliant with requests to remain in bed unless assisted, wandering the ward and, on at least one occasion, attempting to climb over the rails.

25. However, the unchallenged evidence was that at the time of Mrs Flynn's ultimate fall, the bed rails were not raised.

> **Finding No 6:** For confused, disorientated, and mobile patients, raised bed rails can increase the risk and consequence of falls.
>
> **Finding No 7:** The bed rails to Mrs Flynn's hospital bed had been kept in the raised position, notwithstanding her circumstances and that the hospital policy requiring otherwise.
>
> **Finding No 8:** However, at the time of Mrs Flynn's ultimate fall, the bed rails were not in the raised position.

Supervision

26. The evidence comfortably established that supervision is an essential control for managing of the risk of falling, particularly for patients with cognitive impairment. In short, supervision provides an opportunity to keep a patient in a safe configuration, for example in bed as opposed to wandering the ward, as well as the opportunity to assist the patient when movement is necessary, for example using the toilet. It is of course a matter for the hospital to assemble and organise appropriate resources to provide that supervision.

> **Finding No 9:** Supervision is an important control for hospital patients with a high risk of falling.

Family support

27. Families, who are willing and able to attend hospital, are a resource in supplementing hospital supervision, and are particularly useful in advocating for, and communicating with, confused or disorientated patients. Families can repeat advice provided by nurses and can complement nurses' efforts to monitor and care for the patient. However, families often need to juggle competing priorities and they may not know how important it may be for them to attend at that time, unless they are kept informed about adverse events as they occur.

28. In this case the family was not informed about Mrs Flynn's earlier fall while on the ward, the decline in her cognition, or Mrs Flynn's confused and unsafe movements beyond her

bed on the afternoon of her fall. Consequently, they were not given an opportunity to attend in response to that information and assist Mrs Flynn.

> **Finding No 10:** Mrs Flynn's family was not informed about her penultimate fall or the decline in her cognition or her wandering behaviour on the afternoon of her ultimate fall.

Assistant in Nursing (AIN)

29. The hospital can supplement the nursing staff on a ward with an Assistant in Nursing. That person can, amongst other things, provide more continuous supervision of one or more patients. Dr Voon, Mrs Flynn's treating doctor, assumed that Mrs Flynn would be accommodated in a room with an AIN. There is no evidence that an additional AIN was requested by the staff, just as there is no evidence that the hospital had the capacity to provide an AIN at that time. There was a suggestion within the evidence that staff may not have been confident that any request for an AIN would be successful. There was direct evidence that a request was not made as there was the intention to move Mrs Flynn to another room.

> **Finding No 11:** An Assistant in Nursing is a known resource to assist with the care and supervision of a patient with a high risk of falling and cognitive impairment.

> **Finding No 12:** Canberra Hospital did not allocate an Assistant in Nursing to Mrs Flynn.

Relocation to a high observation area room

30. The other room being contemplated was a room described as the high observation area, located on the ward adjacent to the nurses' station, which was already resourced with an AIN. There was no suggestion that this room was either designed for the safe care of patients with a high risk of falling and cognitive impairment or that it contained any facilities that would assist with addressing that risk, other than offering better supervision by being closer to the nurses' station and having a dedicated AIN.

31. In any event, the expected bed within that room did not become available before Mrs Flynn's ultimate fall, as there was a delay in discharging an incumbent due to an unrelated issue with the pharmacy.

> **Finding No 13:** The General Medicine Ward included a room known as the high observation area that provided improved supervision of patients, including the allocation of a single Assistant in Nursing.

> **Finding No 14:** A bed did not become available in that room before Mrs Flynn's ultimate fall.

Geriatric Medicine Ward

32. Dr Clarnette provided the following summary with respect to the utility of geriatric medicine wards:

> Geriatric medicine wards have an amenity that's most suitable to assessing and managing elderly, frail people. Geriatricians are trained in assessment of elderly people and in rehabilitation principles. The nurses are also trained specifically in managing this group of people. So there is a culture on the ward that facilitates appropriate care for these people, but having said that, general physicians and nurses on general medical wards also have an affinity with how to manage these patients, but the environment on a geriatric medicine ward, in most hospitals, is optimised for managing patients who have longer length of stay than the general medical case would be.

33. Dr Voon, provided the following description about the choice of ward for Mrs Flynn:

> In the circumstances of her presentation why wasn't it that she was admitted to the geriatric ward?---There is an agreement between the geriatric and the general medicine department that in quite common presentations such as – such as her confusion and falls, you know, the patients who are over the 80 years of age comes in under geriatrics and those who are less than 80 years of age comes in under general medicine.
>
> Yes. So you understood that to be a policy of the hospital or some unofficial understanding as between the different areas of the hospital?---It's a policy of the general medical department in which I work in.
>
> And was that a written policy at that time? We're talking about 14 and 15 January 2019?---It is written, yes.
>
> All right. So your understanding was that there was a written document that said if you're under the age of 80 you can't be admitted – in these circumstances you can't be admitted to the hospital – to the geriatric ward of the hospital?---That's right.
>
> And without discretion?---There is discretion.
>
> All right, and what – what factors might influence the exercise of that discretion?---It depends on whether the patient is a private patient of one of the geriatricians in which case they may want to look after their own patients. The other factors would be if the patient was – had behavioural difficulties and was aggressive or – or needed constant supervision, and we can try and get them admitted to the – to the geriatric locked ward.
>
> All right. Okay, but in this case, following the discussions that you had with the doctor who initially assessed her, you felt that there was no discretion but to admit her into the general ward?---I felt that this lady definitely needed an admission to hospital - - -
>
> Yes?---for further investigation and management and – and it is quite a common presentation. We admit a lot, especially older patients with these presentations, so I was – I didn't see a need – I didn't think that she needed to come in under geriatrics.

34. Notwithstanding Dr Voon's understanding of the hospital policy, as described above, the actual policy provided for patients younger than 80 years to be admitted to the geriatric ward where dementia was a feature making the management of another acute illness difficult. In Mrs Flynn's case there was uncertainty about the cause of her fluctuating cognitive functioning, and a diagnosis of dementia was yet to be made. I also note that this policy was a hospital policy and was, axiomatically, therefore an arrangement determined and imposed by the hospital upon itself.

35. There is something uncomfortably incomplete about the way the evidence fell to suggest that a general medicine ward was adequate for the daily care of Mrs Flynn, while the very controls contemplated to address her high risk of falling could not be implemented there. While it is not known whether the Geriatric Medicine Ward would have had better access to those or other controls, a professional application of risk management principles would have involved asking that question, particularly when the controls contemplated in a general medicine ward were not immediately available. An admission to the Geriatric Medicine Ward may have also depended upon whether there was a vacancy and whether there were other patients competing for the same bed.

> **Finding No 15:** On the evidence it remained unclear whether the Geriatric Medicine Ward could have provided more appropriate care for Mrs Flynn.

Canberra Hospital Risk of Fall Strategies

36. At the time of Mrs Flynn's falls, the hospital had the following strategies in place, designed to address risks of falling:

    (a) a falls assessment as part of the Patient Care and Accountability Plan,

    (b) a bed rail matrix guide that was incorporated into the Emergency Department/Medical short Stay Risk Assessment Form,

    (c) documentation of falls through Riskman, and follow up investigation and proposed interventions,

    (d) escalation process for incidents and ongoing review of incidents by the Quality and Safety Division,

    (e) a Falls Assessment Management and Preventative Procedure,

    (f) a voluntary online education package for staff, covering falls assessment, management and prevention,

    (g) all new staff at the hospital were required to undertake training in falls management as part of their orientation, and

    (h) falls champions and falls champions' workshops.

37. Following Mrs Flynn's death, the hospital made the following changes:

    (a) acquisition of additional hi-low beds,

    (b) changes to the process for requesting hi-low beds, a flow chart reflecting that new process and the inclusion of a step in that process of placing mattresses on the floor as a last resort while waiting for a hi-low bed,

    (c) safety huddles at the commencement of each shift as part of the handover, to include discussions of patients who are at a risk of falling, including specific interventions in place and what equipment has been requested,

    (d) the introduction of the Banner Mobility Assessment Tool, and

    (e) the above online education package for falls was made mandatory for all nursing staff in the General Medicine Ward and in the Division of Medicine.

38. Canberra Hospital also conducted a root cause analysis, which identified most of the above shortcomings. Following that analysis, the Hospital made the further following changes:

    (a) improvements to Patient Care and Accountability Plan by redesigning the Falls Risk Assessment form, to make it easier to complete and adding a component addressing cognitive state risks, and

    (b) staff are required to complete a *Falls Education, Falls and Risk Management Tool* and audits are conducted to ensure completion.

39. In light of those changes, I do not propose to make any recommendations.

Conclusion

40. It cannot be said that the failure of Canberra Hospital to instigate various controls caused Mrs Flynn's ultimate fall, which later resulted in her death. However, those failures individually and collectively increased the risk of Mrs Flynn falling and the seriousness of any injury resulting from such falls. I am left with the strong impression that, notwithstanding the best intentions of staff, the hospital as a whole did not operate in a coordinated way to ensure that appropriate controls were put in place. I make this observation cognisant of the workload and organisational challenges experienced by staff, and the difficulties in managing a large and dynamic organisation.

41. I again offer my condolences to the family and friends of Mrs Flynn.

I certify that the preceding forty-one [41] numbered paragraphs are a true copy of the Reasons for Decision of his Honour Coroner Theakston

Associate: Jack Watson

Date: 16 September 2022