MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Olivia McTaggart, Coroner, having investigated the death of Wilma McTye

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

a) The identity of the deceased is Wilma McTye;
b) Mrs McTye died as a result of head injuries due to multiple falls;
c) The cause of death was acute on chronic subdural haematoma; and
d) Mrs McTye died on 25 June 2018 at Hobart in Tasmania.

In making the above findings I have had regard to the evidence gained in the investigation into Mrs McTye's death. The evidence comprises a police report of death; an opinion of the State Forensic Pathologist who conducted the autopsy; identification and life extinct affidavits; and medical and nursing home records and reports.

Wilma McTye was born on 20 April 1937, was widowed and was aged 81 years at her death.

On 1 November 2017 Mrs McTye became a resident of the Strathaven aged care facility in Rosetta due to a significant decline in her health and ability to care for herself. She suffered from Lewy Body Dementia which caused her difficulty with concentration and attention, extreme confusion, difficulties judging distances (rendering her prone to falls), hallucinations and fluctuations in mental state.

At Strathaven Mrs McTye was assessed as a high falls risk from the date of her admission. Strategies were put in place by staff to manage her risk, including a bed sensor alarm, positioning her bed as low, ensuring she had appropriate footwear and encouraging exercises for mobility. She required physical assistance by a staff member for mobility and walked with a four pronged walking aid. There were also strategies in place for staff to interact with her in such a way as to reduce her falls risk.

At the nursing home, she suffered four recorded falls. The first of these falls occurred on 1 December 2017 in which Mrs McTye appears to have fallen in the bathroom and hit her head. However, after investigation by staff, there appeared to be no ongoing injuries as a result of this fall. However, Mrs McTye declined considerably after April 2018 due to progression of her dementia. In particular she showed a lack of insight into risk and her own safety.

No further falls were reported until three falls occurred on 12, 16 and 18 June 2018 respectively. The first two falls did not result in apparent injuries and the nursing home subsequently reviewed her falls risk assessment. The third fall, occurring at 12.30am 18 June 2018 was unwitnessed. Mrs McTye was found on the floor of her room behind her door and unable to provide a detailed explanation to staff as to how she had fallen.

Although Mrs McTye initially appeared to exhibit no serious symptoms in respect of the fall, she became unresponsive and, approximately 12 hours later, was conveyed to the Royal Hobart Hospital. In hospital, she was found to have a large acute on chronic subdural haematoma. Her course was also complicated by a urinary tract infection.

On 19 June 2018 Mrs McTye was transferred to the Whittle Ward for end-of-life care after discussions with her family who did not seek operative management in accordance with her goals of care plan. She passed away on 25 June 2018.

At autopsy, the State Forensic Pathologist formed the opinion that Mrs McTye's cause of death was due to an older injury (or injuries) as well as the fall occurring on 18 June 2018. It is therefore possible that an injury suffered in the fall of 12 June may have contributed to her death or even an earlier unwitnessed fall not detected by nursing home staff.

I am grateful to Strathaven for its assistance and helpful information provided for the investigation.

I am satisfied that the staff of the nursing home correctly and thoroughly assessed Mrs McTye as a high falls risk and took all reasonable steps to mitigate that risk. Unfortunately, her dementia worsened considerably in the months before her death and there was no further action that could reasonably have been taken to prevent her death.

Comments and Recommendations

The circumstances of Mrs McTye's death are not such as to require me to make any comments or recommendations pursuant to Section 28 of the *Coroners Act* 1995.

I convey my sincere condolences to the family and loved ones of Mrs McTye.

Dated: 15 October 2018 at Hobart Coroners Court in the State of Tasmania.

Olivia McTaggart
Coroner