FINDINGS and RECOMMENDATION of Coroner Simon Cooper following the holding of an inquest under the *Coroners Act* 1995 into the death of:

Doreen Mansfield

Record of Investigation into Death (With Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Simon Cooper, Coroner, having investigated the death of Doreen Mansfield with an inquest held at Hobart in Tasmania make the following findings.

Hearing Date

20, 21 and 24 September 2018 at Hobart in Tasmania

Representation

E Avery Counsel Assisting the Coroner

G Chen for the Tasmanian Health Service

G Dolliver for Nurses Howells and Jendrich

R Phillips for Ms A Boon (24 September 2018 only)

B Hilliard for Nurse J Thompson

Introduction

1. Doreen Mansfield was born in Beaconsfield on the Tamar River in northern Tasmania on 1 October 1936. She was 78 years of age when she died. At the time of her death she was a single woman who was both widowed and divorced. She had worked as a Leading Hand at Universal Textiles in the northern suburbs of Hobart as well as a teacher's aide at Claremont High School.

2. For much of her life Mrs Mansfield had suffered from Bipolar Affective Disorder. This was managed in the main by the use of lithium. A consequence of lithium use for a prolonged period of time however was that she suffered from both chronic kidney disease and renal toxicity.

3. In addition to lithium treatment, Mrs Mansfield was regularly treated with Electro Compulsive Therapy (ECT).

4. As well as Bipolar Disorder, Mrs Mansfield suffered depression and a variety of physical ailments including type 2 diabetes, hypertension, coronary artery disease and hypercalcaemia (abnormally high levels of calcium in the blood).[1]

5. Mrs Mansfield was a mother to 3 children: Cheryl born in 1956, Shane born in 1960 (who died in 2002) and Robyn born in 1962. Both Cheryl and Robyn were close to their mother and Robyn was her carer for about 10 years prior to her death.

6. Mrs Mansfield was admitted to St Helen's Private Hospital approximately 3 weeks prior to her death following what her daughter Robyn described as 'another episode'.[2] Mrs Mansfield refused to undergo ECT which her treatment team considered essential. Accordingly, an application was made to the Mental Health Tribunal for an order under the *Mental Health Act* 2013. The Tribunal made a treatment order on 22 July 2015 pursuant to section 37 of that *Act*.[3] The order was expressed to remain in force until 22 October 2015. Mrs Mansfield was subject to that order at the time of her death on 2 August 2015. The order provided, amongst other things, that Mrs Mansfield was to be detained for treatment at the Royal Hobart Hospital (RHH) as an inpatient. She was therefore transferred to the RHH's Department of Psychiatric Medicine where she was detained to undergo a course of acute and maintenance ECT.

7. As a consequence of the order under the *Mental Health Act* 2013 being current at the time of her death, Mrs Mansfield was a person "held in care" in terms of section 3 of the *Coroners Act* 1995 ("the *Act*"). As such, an inquest into her death was mandatory and I am obliged to report on

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[1] Exhibits M8 and M9; see also report of Dr AJ Bell exhibit M11.

[2] Exhibit M17, Affidavit of Robyn Scott sworn 9 November 2015.

[3] Exhibit M7.

the care, supervision and treatment of Mrs Mansfield while she was held in care.[4]

The Role of the Coroner

8. Before an analysis of the circumstances surrounding Mrs Mansfield's death is undertaken it is important to say something about the role of a coroner. A coroner in Tasmania has jurisdiction to investigate any death which appears to have been unexpected or unnatural. In this case, as has already been mentioned, because Mrs Mansfield died in care the *Act* makes an inquest mandatory.[5] An inquest is a public hearing.[6]

9. When investigating any death at an inquest, a coroner performs a role very different to other judicial officers. The coroner's role is inquisitorial. She or he is required to thoroughly investigate a death and answer the questions (if possible) that section 28 of the *Act* asks. These questions include who the deceased was, the circumstances in which he or she died, the cause of the person's death and where and when the person died. This process requires the making of various findings, but without apportioning legal or moral blame for the death. A coroner is required to make findings of fact from which others may draw conclusions. A coroner is also able, if she or he thinks fit, to make comments about the death or, in appropriate circumstances, recommendations to prevent similar deaths in the future.

10. A coroner neither punishes nor awards compensation – that is for other proceedings in other courts, if appropriate. Nor does a coroner charge people with crimes or offences arising out of the death the subject of investigation. In fact, a coroner in Tasmania may not even say that he or

[4] see section 28(5).
[5] Section 24(1).
[6] See section 3.

she thinks someone is guilty of an offence.[7]

11. As was noted above, one matter that the *Act* requires is finding how the death occurred.[8] It is well-settled that this phrase involves the application of the ordinary concepts of legal causation.[9] Any coronial inquest necessarily involves a consideration of the particular circumstances surrounding the particular death so as to discharge the obligation imposed by section 28(1)(b) upon the coroner.

12. The standard of proof at an inquest is the civil standard. This means that where findings of fact are made a coroner needs to be satisfied on the balance of probabilities as to the existence of those facts. However, if an inquest reaches a stage where findings being made may reflect adversely upon an individual, it is well-settled that the standard applicable is that articulated in *Briginshaw v Briginshaw*[10], that is, that the task of deciding whether a serious allegation is proved should be approached with great caution.

13. As has already been noted, section 28(5) of the *Act* imposes an obligation on a coroner to report on the care, supervision or treatment of any person held in care at the time of their death. The rationale for such a requirement is the public policy reason of ensuring that the death of every person who is detained against his or her will in any state-run institution, by reason of an order of a court, tribunal, or the executive, is carefully, independently and transparently examined.

Circumstances of Death

14. The evidence was that while an inpatient at the RHH and subject to the order made under the *Mental Health Act*, Mrs Mansfield suffered an

[7] Section 28(4).
[8] See section 28(1)(b).
[9] See *March v E. & M.H. Stramare Pty. Limited and Another* [1990 – 1991] 171 CLR 506.
[10] (1938) 60 CLR 336 (see in particular Dixon J at page 362).

unwitnessed fall in her room on 1 August 2015, the day before her death. That Mrs Mansfield fell and suffered the injuries she did was not in any way in dispute. However, why she fell; the standard of care afforded to her while detained at the RHH in the lead up to her fall; and the appropriateness of the care she received after surgery to repair her fractured left femur were all issues examined carefully and in detail at the inquest.

Investigation

15. The fact of Mrs Mansfield's death was reported as required by the *Act.*[11] An investigation was commenced. Mrs Mansfield's body was formally identified.[12]

16. Ms Robyn Scott, Mrs Mansfield's senior next of kin objected, as was her right[13], to an autopsy being conducted upon her mother. At the same time, she expressed concerns as to the treatment her mother received. I observe that the role of the coroner is to investigate, fully, any reportable death. Part of that investigation ordinarily involves directing a forensic pathologist to carry out an autopsy so as to attempt to determine, with precision, the cause of death and any contributing factors. An autopsy is particularly important where allegations are made as to inadequate treatment and the deceased person is in care. I observe Ms Scott made a number of allegations during her evidence at the inquest about what she claimed was inadequate or inappropriate care of her mother. The failure to carry out a full autopsy can mean that an investigation is not as complete as it should be, and concerns held by the senior next of kin or family may not be able to be properly addressed.

17. In any event, Dr Donald McGillivray Ritchey, a very experienced forensic pathologist, examined Mrs Mansfield's body and reviewed her medical

[11] See section 19(1).
[12] Exhibit M3 affidavit of Constable Teal Woolford sworn 16 November 2015.
[13] See section 38 of the *Act.*

records. Dr Ritchey expressed the opinion that the cause of Mrs Mansfield's death was complications arising from the fracture of her left femur, sustained in a fall from standing height. I accept Dr Ritchey's opinion. I note that Dr Anthony J Bell, medical adviser to the Coroner's office, reviewed the circumstances of Mrs Mansfield's death and expressed himself to be in agreement with Dr Ritchey.[14]

Admission to the RHH

18. Mrs Mansfield was admitted to the RHH on 20 July 2015 as a consequence of the order made under section 39 of the *Mental Health Act* 2013 mentioned above. There is no basis to criticise the decision to admit her to the RHH.

19. Mrs Mansfield was accommodated in the RHH's Department of Psychiatric Medicine. She was allocated room 1 (as it then was) in the Department. The evidence was that room 1 was the room most distant from the nurses' station, being somewhere in the order of 60 or 70 metres away from it.[15]

20. I am satisfied that while the Department had had elderly patients in the past (although elderly psychiatric patients were normally accommodated at the Roy Fagan Centre),[16] difficulties attended the treatment of immobile geriatric patients, given that, as a rule, the profile of patients was generally much younger than Mrs Mansfield. That having been said, there is no evidence which supports, at all, a conclusion that the decision to accommodate Mrs Mansfield in the Department was wrong or in some way not justified. She was, on the evidence, plainly very ill indeed and the Department was an appropriate place for her to receive the treatment she needed. I will return to the issue of the suitability of the

[14] See Exhibit M 11
[15] Evidence of A Howells, Transcript page 43, line 20
[16] Evidence of J Thompson, Transcript page 139, line 5

room in which she was accommodated a little later in these findings.

21. In any event, after her admission to the RHH, ECT was commenced and her usual medications were continued. Medical records suggest there was no obvious improvement in her condition. Equally the evidence is that her condition did not deteriorate. The records and evidence at the inquest suggest she was immobile at times, exhibiting clear signs of depression and refusing to eat or drink. On other occasions she seems to have had elevated "highs".

22. In the first of a number of complaints raised about her mother's treatment, Ms Scott said in an affidavit tendered at the inquest that she:

> "*Pleaded with staff at the RHH to take [Mrs Mansfield] off anti-psychotic medication as [she] was of the opinion she didn't need it with the shock treatment and her antidepressant medication."*[17]

23. There was no evidence from a single member of Mrs Mansfield's treating team that any such plea had been made. No medical evidence supported the assertion made by Ms Scott that Mrs Mansfield did not require anti-psychotic medication. I observe, with all due respect to Ms Scott, that she described herself in her evidence at the inquest as a "stay at home person… [with] a bad back". There was no evidence Ms Scott had any form of medical qualifications. All other evidence from all other sources which dealt with this issue, including from medical staff involved in Mrs Mansfield's treatment, the medical adviser to the Coroner's office, and the plethora of medical records tendered, make very clear that Mrs Mansfield in fact did require anti-psychotic medication.

[17] Exhibit M17, affidavit sworn 9 November 2015.

24. I reject Ms Scott's assertion that her mother did not require anti-psychotic medication, or, put another way, that Mrs Mansfield was prescribed medication she did not need or perhaps even harmed her. I do not accept that Ms Scott made any such plea or request of any member of her mother's treating team at the RHH.

Falls Risk Assessment

25. As has already been noted, Mrs Mansfield died as a consequence of injuries she received when she fell in her room at the RHH around 8.30am on 1 August 2015. Although Mrs Mansfield seems to have had virtually no history of falls, the issue of whether adequate steps were taken to guard against the risk of her falling and injuring herself was a matter of central concern at the inquest. I turn to consider that issue.

26. The evidence was that Mrs Mansfield was admitted to the RHH on 21 July 2015. On the same day a falls risk assessment using the Tasmanian Health Service Falls Risk Assessment Tool (FRAT) was completed with input from both Ms Scott and Ms Muskett (Mrs Mansfield's daughters), by Registered Nurse, Karen Plunkett. That document was included in Mrs Mansfield's medical records which were tendered at the inquest.[18]

27. Both Ms Scott and Ms Muskett confirmed that their mother had no history of falls in the lead up to her death and Ms Muskett specifically recalled advising Nurse Plunkett that her mother had not had any falls in the last 12 months.[19]

28. I note that St Helens Hospital did not provide anything in the nature of a falls risk assessment to the RHH when Mrs Mansfield was transferred from St Helens.

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[18] Exhibit M9, medical records progress notes at page 93.
[19] Evidence of Cheryl Muskett, transcript page 38.

29. As a consequence of the falls risk assessment, in part based upon information provided by her daughters, Mrs Mansfield's fall risk was assessed to be at the lowest end of the medium risk category. I am satisfied on the evidence that this assessment was carried out in accordance with Tasmanian Health Service guidelines, using accurate information provided, in part, as I have said, from Mrs Mansfield's daughters and provided as accurate an assessment of her likelihood of falling as could be reasonably determined. In particular, supervision and the use of a high or low bed or bed rails were not issues considered by medical staff as necessary to safeguard Mrs Mansfield against the risk of falling, given the result of the assessment. There is absolutely no evidence to suggest that the assessment was carried out in a way that was inappropriate, incorrect or inaccurate.

30. This evidence was given by the Nurse Unit Manager of the Department, Ms Debra Solomon, that she had reviewed Mrs Mansfield's records after her death and considered that the assessment noted in the records was appropriate. There was no evidence to the contrary and Ms Solomon's evidence was not challenged. I accept her evidence on this point.

31. A number of entries in Mrs Mansfield's medical records at the RHH touch upon Mrs Mansfield's reluctance to get out of her bed or walk. Those records appear in the period up to and including 30 July 2015.[20] The picture that emerges from those entries is Mrs Mansfield being very reluctant to leave her bed and unlikely to walk anywhere on her own.

32. In all the circumstances it is difficult to see that Mrs Mansfield's risk of falling was at all greater than it had been assessed i.e. in the lowest end of the medium risk category.

[20] see Exhibit M9, medical progress notes in RHH records.

33. However, Registered Nurse, Stephen Jendrich, gave evidence that whilst working part-time on the ward (he being the ECT coordinator which involved him working part-time on the ward and part-time doing ECT [21]), carried out his own falls risk assessment (he said on 23 July) and assessed Mrs Mansfield's risk as 'extremely high'.

34. Nurse Jendrich claimed that he carried out the falls risk assessment as the result of an attendance on Mrs Mansfield at about 11.00am on 23 July, during which attendance he said Mrs Mansfield attempted to pull herself to the floor. He gave evidence that a graduate diploma Nurse, Jalasia Martin, was present at that attendance.

35. He said in evidence that he then discussed the result of his assessment with either of Mrs Mansfield's daughters (he could not say which) and raised his assessment with his supervisor, Nurse Joanne Thompson. In the course of raising the falls risk assessment Nurse Jendrich said he sought Nurse Thompson's permission to change Mrs Mansfield's room, but that Nurse Thompson refused. Nurse Jendrich said that Nurse Thompson responded to his request by saying:

> *"No fucking way she is a private patient she has a fucking single room… [and] no fucking way end of story".*[22]

36. Nurse Jendrich also claimed that he had placed his falls risk assessment on Mrs Mansfield's medical records. He said he was unable to locate the original falls risk assessment completed by Nurse Plunkett. No falls risk assessment completed by Nurse Jendrich on 23 July 2015 (or indeed at any time) was on the records tendered at the inquest. However, the falls risk assessment completed by Nurse Plunkett was on the records. Nurse Jendrich suggested that someone had removed "his" falls risk

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[21] Transcript page 75 line 15.
[22] Exhibit M21, Statement of Steven Claus Jendrich, unsworn, dated 28 October 2016.

assessment from the records.[23] If true, this would amount to serious misconduct or indeed potentially criminal behaviour. Equally, if Nurse Jendrich's allegation is not true, and deliberately so, then it too would likely amount to serious misconduct or criminal behaviour on his part.

37. His allegation about Nurse Thompson's response to his request is equally grave.

38. There is no documentary evidence or from a single witness that corroborates any aspect of Nurse Jendrich's evidence. I also note that his statement, made 15 months after Mrs Mansfield's death, was far from what might be described as contemporaneous. I also observe that he refused to give a statement when initially approached by investigating police. He was contacted on numerous occasions by the investigating officer, Constable Duncan, who attempted to obtain an affidavit from him but after consultation with his union ceased contact with Constable Duncan. I also note that Constable Duncan's account of his less than satisfactory dealings with Nurse Jendrich was not challenged by Nurse Jendrich's counsel.

39. I have serious reservations about the substance of Nurse Jendrich's evidence. There are a number of reasons for reaching this conclusion.

40. Nurse Jendrich was a far from impressive witness. Although fact finders must be careful not to ascribe too much weight to the physical demeanour of a witness giving evidence (and I do not) my observations of Nurse Jendrich go much deeper than mere appearance. On several occasions he re-canted completely from early evidence. An example is that he claimed in evidence at the inquest that a source of information for the completion of the falls risk assessment was Mrs Mansfield's

[23] Exhibit M21, paragraph 15.

medical records but later in his evidence said that was not the case.[24]

41. In addition Nurse Jendrich appeared to be frequently reconstructing his evidence, using expressions such as ‘I would have’ and similar.[25]

42. He claimed that Nurse Martin had been with him when he conducted the assessment of Mrs Mansfield. However, nurse rostering records tendered at the inquest showed that Ms Martin did not work on the 23 July.[26] I note that when confronted with the rostering records demonstrating Ms Martin was not present at work Nurse Jendrich claimed the document was “wrong”. There is no evidence, at all, to suggest that the material was wrong other than Nurse Jendrich’s memory – and that was demonstrably unreliable. His assertion that his memory was to be preferred over rostering records is but one instance of why I formed the view he was an inherently unreliable witness.

43. Nurse Jendrich’s evidence about the nature of the document he said he completed as part of the falls risk assessment was conflicting even on the simple point as to whether it consisted of one page or more.[27]

44. Turning to his evidence of the circumstances surrounding making the assessment, Nurse Jendrich said that Ms Scott and Ms Muskett arrived to visit their mother at approximately 11.15am. If his version of events is true this left a mere 15 minutes for Mrs Mansfield to have attempted to pull herself to the floor, be assisted back to bed, and for a full falls risk assessment to be completed. Having regard to the content of the falls risk assessment completed by Nurse Plunkett, such a short period of time seems to be inherently unlikely.

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[24] Transcript page 100 line 30 and following.

[25] Transcript pages 104 -106.

[26] see Annexure to Exhibit M23 and Exhibit M22.

[27] Transcript pages 87-90.

45. Nurse Jendrich conceded that he was mistaken about one entry made in the notes at about 10.00am, which recorded histrionics on the part of Mrs Mansfield, her showering, having lunch and a visit by her daughters. All this is inconsistent with the evidence of Mrs Mansfield's daughters arriving at 11.15am and lunch being served at midday.

46. Nurse Jendrich's evidence that he required Nurse Thompson's permission to move Mrs Mansfield to another room is, I find, simply not correct. All the evidence from Nurse Thompson and Ms Solomon, (with which Mr Jendrich seemed to agree in cross examination) was that Mr Jendrich was senior, and not junior, to Nurse Thompson on 23 July 2015. He therefore did not require Nurse Thompson's permission to move Mrs Mansfield.

47. I do not accept Nurse Jendrich's evidence that he had completed the falls risk assessment and that it had been removed from Mrs Mansfield's medical records by a person or persons unknown. It was rebutted, completely in my view, by the evidence from Mr Mark Upton, the manager of patient information services, who expressed the view that the record was complete and in chronological order.

48. In summary, I do not accept Nurse Jendrich's evidence that he completed a second falls risk assessment, that he upgraded Mrs Mansfield's falls risk to 'extreme', that he placed the falls risk assessment on Mrs Mansfield's medical records, and that the document was removed by a person or persons unknown.

49. I find Nurse Jendrich's evidence to have been both utterly implausible and completely unreliable. Fundamentally, there was simply no reason for anyone to have removed 'his' falls risk assessment and then replaced it with the original falls risk assessment. Stated that way (and Nurse Jendrich agreed that for his account to be correct that is what

must have happened[28]) the proposition is risible.

50. Mindful as I am of the standard applicable as postulated in *Briginshaw v Briginshaw*[29] I am unable to determine, affirmatively, that the evidence that Nurse Jendrich gave as to completing another falls risk assessment was deliberately untruthful. It is, I suppose, possible that he was mistaken or that his memory was poor.

51. Equally, I completely reject his claim that Nurse Thompson abused him when he sought her permission to move Mrs Mansfield. I reject this evidence because I am satisfied for the reasons set out above that Nurse Jendrich was, to say the least, an extremely unreliable witness. In contrast, Nurse Thompson impressed as careful and honest in her refuting the allegation made by Nurse Jendrich against her.

52. By way of example of his unreliability in this regard, Nurse Jendrich claimed, for the very first time whilst giving evidence at the inquest, that he had asked Nurse Thompson for a high/low bed. Whilst giving oral evidence he said that he very clearly remembered it, but could not recall whether he had included it in his written statement or not.[30] It is not in his statement.

53. As was the case with the alleged falls risk assessment, no other witness nor even a single piece of evidence corroborates in any way Nurse Jendrich's claims in this regard. Again, I note that there was no reason for Nurse Jendrich to seek Nurse Thompson's permission and hence no reason for Nurse Thompson to reply to that request in the manner alleged, or at all. At the risk of repetition he did not need anyone's permission to move Mrs Mansfield. Finally, as noted above, even if he did need someone's permission he certainly did not need it from Nurse

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[28] See transcript page 112, lines 19 to 22.
[29] Supra.
[30] Transcript page 109, at line 25 and following.

Thompson whom he "out ranked" as at 23 July 2015.[31] Where Nurse Jendrich's evidence conflicts with the evidence of any other witness I reject his evidence.

Suitability of Accommodation

54. The evidence was that the room in which Mrs Mansfield was accommodated and fell, and thereby sustained her ultimately fatal injuries, was a distance removed from the nurses' station. In addition, in keeping with all other rooms within the psychiatric ward, it did not have a call bell. The rationale for not having a call bell, at least at the time of Mrs Mansfield's fall, was that the cord attached to such call bell could be used by patients for the purposes of self-harm or suicide. Obviously alternatives to call bells with cords exist and ought to be available for use in appropriate cases. That having been said it is not clear to me that the absence or otherwise of a call bell had any causal nexus between the fact of Mrs Mansfield's fall and her subsequent death.

55. Ms Scott gave evidence that there was a sign on the wall of the room which read words to the effect "if you need any help just yell". She said that the sign was on the wall adjacent the bed.[32] Ms Scott did not provide the evidence as to the sign, content and position thereof to police nor did she raise it in subsequent meetings that she attended with senior hospital management.

56. Her sister gave similiar evidence with respect to the signage although could not recall the wording.[33]

57. Several other witnesses, including Registered Nurse Ashley Howells, and Nurse Thompson, gave evidence at the inquest on this point. Their

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[31] see Exhibit M22.
[32] Transcript pages 14 – 15 and Exhibit M17.
[33] Transcript page 34.

evidence about a sign was completely contrary to the evidence from Ms Scott and Ms Muskett, although it was clear enough that in the absence of a call bell the only mechanism by which Mrs Mansfield could alert staff she required assistance was verbally.

58. In the circumstances I am not satisfied that any such sign was on the wall of Mrs Mansfield's room, although I do accept, and it is not contentious, that in the absence of a call bell it was necessary for Mrs Mansfield to summon help verbally.

59. It was common ground at the inquest that no operative motion detectors were available in room 1 (or, it seemed, anywhere else in the ward). The usefulness of motion sensors generally in a psychiatric ward is doubtful. However, where an immobile geriatric patient such as Mrs Mansfield is to be accommodated in a psychiatric ward then the situation is, in my view, materially different. This is especially so when the particular circumstances of Mrs Mansfield's immobility are also considered. The falls risk assessment that had been carried out by Nurse Plunkett and many observations recorded in her medical risk records indicated an unwillingness on her part to move at all. Therefore, motion sensors in her room would have been of assistance to her treatment team in ensuring her safety whilst she was an involuntary patient.

60. It is obvious that motion sensors would not have prevented Mrs Mansfield from falling. However, they should have been available for use.

Treatment Generally

61. Dr AJ Bell MD FRACP FCICM, Medical Adviser to the Coroner's office, reviewed the circumstances of Mrs Mansfield's care and treatment. He expressed the opinion that her psychiatric acute care was of a good standard and that her medical care post-fracture was also of a good

standard.

62. Mrs Mansfield's daughters, particularly Ms Scott, made a number of serious but I find completely unsubstantiated claims in relation to their mother's treatment both pre and post-operation. Both daughters said that their mother had been told by unidentified nurses at the RHH to simply urinate in her bed when efforts to place a bed pan under her were unsuccessful.[34] All other witnesses questioned about this issue strongly rejected any suggestion it was true. I am satisfied it was not true.

63. Ms Scott claimed that Registered Nurse, Angela Frank, blamed her for her mother's fall. Again I completely reject Ms Scott's allegation against Nurse Frank. Nurse Frank was impressive in her rebuttal of this very serious allegation and presented as a candid and credible witness. In contrast Ms Scott did not.

64. Ms Scott also alleged that her mother had been handled roughly following the operation and had vomited on herself. Nurse Frank, a nurse of 35 years' experience who was directly involved in Mrs Mansfield's care after the fall, could recall no aspect of Mrs Mansfield's care that fell below an acceptable standard and had no recollection of Mrs Mansfield vomiting on herself.[35] Nothing supporting such an allegation is recorded anywhere in Mrs Mansfield's medical records. Not a single witness supported Ms Scott's allegation. None of the allegations raised of the being told to urinate in bed, being blamed for a fall, and being roughly handled after surgery, was said or raised in any circumstances by either Ms Scott or Ms Muskett at any time prior to the inquest – and both had ample opportunity to do so.

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[34] see transcript pages 20 and 36
[35] see transcript page 159

65. It is enough to say that I do not accept any of the allegations detailed by Ms Scott and/or Ms Muskett. Both witnesses were singularly unimpressive. Their allegations are entirely unsubstantiated, suggestive of recent invention, lack any support at all from any objective evidence, and are inherently improbable.

Changes Following Mrs Mansfield's Death

66. Extensive evidence was received at the inquest from Ms Solomon in relation to the significant changes within the Department of Psychiatry following Mrs Mansfield's death. The most significant of those changes was the transfer of the Department to a new purpose-built unit. It is clear to me that at the time of Mrs Mansfield's admission and death the building in which the Department was housed was less than suitable for purpose. However, the evidence from Ms Solomon indicates that a significant overhaul of the physical environment within which the Department of Psychiatry is housed has been made.

67. The evidence was that the new unit is divided into three smaller units based on the level of patient acuity.

68. Evidence was also given in relation to changes with respect to admission procedure. Those changes focus on assessing the level of risk and clinical need and then determining the safest option for the patient in terms of unit placement, room type and room location. The changes are likely to lead to an improvement in patient care.

Formal Findings

69. On the basis of the evidence at the inquest I make the following formal findings pursuant to section 28(1) of the *Act* that:

    a. The identity of the deceased is Doreen Mansfield;

b. Mrs Mansfield died in the circumstances set out in this finding;

c. The cause of Mrs Mansfield's death was complications arising from a left femur fracture following an unwitnessed fall in her room at the RHH; and

d. Mrs Mansfield died on 2 August 2015 at the RHH, Hobart in Tasmania.

Report on Care, Supervision and Treatment

70. As indicated earlier in these findings, it is necessary for me to comment upon the care, supervision and treatment of Mrs Mansfield whilst she was a person held in care at the RHH.

71. Broadly speaking, I am quite satisfied that the care and treatment of Mrs Mansfield was of an appropriate standard. The unchallenged evidence from Dr Bell is particularly persuasive in this regard.

72. The supervision of Mrs Mansfield could, in my view, have been improved. There was a good deal of evidence in relation to the lack of staff and poor staff-to-patient ratios, which no doubt placed significant demands upon the dedicated treatment team.

73. In addition, while there is no doubt that there may have been good reason for Mrs Mansfield to be accommodated a distance from the nurses' station, had she been able to be accommodated closer to the station then her supervision may well have been improved. In addition, I have already touched upon the importance of motion sensors being utilised in her room. Finally, the absence of a call button for Mrs Mansfield was unfortunate.

74. However, I do note the evidence in relation to the physical changes to the Department following Mrs Mansfield's death.

75. I also have regard to the evidence with respect to the admission procedure changes. Had a process of the type now in use been in use at the time of Mrs Mansfield's admission then it is likely that she may not have been accommodated where she was.

Recommendation

76. Surprisingly, it became apparent during the inquest that the original physical paper medical record relating to Mrs Mansfield had been destroyed, notwithstanding the fact that her death was the subject of a Coronial investigation and a mandatory inquest. This is unacceptable. It certainly caused difficulty in a practical sense in endeavouring to determine the truth or otherwise of Nurse Jendrich's allegation that a person or persons had removed material from those records. Accordingly, I **recommend** that in every case where the death of a patient at the Royal Hobart Hospital is the subject of an investigation pursuant to the *Coroners Act* 1995 all records be preserved and maintained until the conclusion of that investigation.

Conclusion

77. In conclusion, I offer my sincere and respectful condolences to Mrs Mansfield's family on their loss.

Dated 22 February 2019

Simon Cooper
Coroner