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 Jacqueline McNeair

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

a) The identity of the deceased is Jacqueline McNeair;

b) Mrs McNeair died in the circumstances set out further in this finding;

c) Mrs McNeair's cause of death was a subdural haematoma following a mechanical fall with head strike; and

d) Mrs McNeair died in the Launceston General Hospital in Tasmania on 4 December 2018.

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Mrs McNeair's death. The evidence comprises the Police Report of Death for the Coroner, an opinion of the pathologist who conducted the autopsy, relevant police and witness affidavits, medical records and reports, opinion of the coronial medical consultant and forensic evidence.

Jacqueline McNeair was born on 12 March 1939 and was aged 79 years of age at the time of her death. She is survived by her husband, Alwyn McNeair, and two adult children, Ryan McNeair ('Mr McNeair') and Lisa McNeair ('Ms McNeair').

Mrs McNeair was diagnosed with type 2 diabetes approximately 25 years before her death. She suffered a variety of other medical conditions as a result of the diabetes, including peripheral heart disease, retinopathy and limited nerve sensation in her extremities. She had a partial foot amputation in 2013 as a result of non-healing diabetic ulcers. It was recommended by medical practitioners that the whole foot be amputated, however Mrs McNeair resisted due to fear of mobility restrictions. She continued to have non-healing diabetic foot ulcers up to the time of her death. In the six to eight weeks before August 2018, Mrs McNeair's health began to deteriorate and she had reduced mobility.

On 8 August 2018 Mr McNeair transported his mother to a routine podiatry appointment at the Northern Integrated Care Services (NICS) at the Launceston General Hospital (LGH). At

the conclusion of the appointment Mrs McNeair went to the public toilet. She fell whilst opening the door. She suffered a nose bleed, two skin tears, and complained of a sore elbow at the time of the fall. She was treated for the skin tears and nose bleed.

Mr McNeair attended the LGH to collect Mrs McNeair. In the Emergency Department an x-ray of Mrs McNeair's arm was conducted and revealed that the right humerus had been fractured. Mrs McNeair was admitted. It was decided that surgery was not viable due to her heart condition. She remained at the LGH for approximately six weeks, before being transferred to the George Town Hospital (GTH) for ongoing care.

Mrs McNeair's health fluctuated while at GTH. She had a number of hypoglycaemic episodes, which were treated. Her heart medication was changed during this time and her heart health improved.

On 3 September, Mrs McNeair's Goals of Care plan (GOC) was amended to indicate that she was not for CPR or intubation. This decision was made based on medical grounds and Mrs McNeair's wishes.

At approximately 12.00pm on Friday 23 November 2018, Mrs McNeair went for her regular walk in the hospital ward with Registered Nurse, Sally Koetse. The pair walked about 10 metres down the corridor and then made the return trip. When they arrived at her room, Mrs McNeair indicated that she needed to use the toilet. Ms Koetse left her a short distance from the door and moved to open the toilet door to allow Mrs McNeair entry. Ms Koetse turned and saw Mrs McNeair falling backwards. She moved to stop the fall but could not reach her in time. Mrs McNeair fell backwards, striking her head on the porcelain sink and falling to the floor striking her head a second time on the ground.

Mrs McNeair began gasping and turning pale. Ms Koetse activated the emergency button and placed Mrs McNeair into the recovery position. A number of staff attended to assist. It was immediately obvious that the head strike was severe in nature. Mrs McNeair was provided with oxygen and her GOC plan was discussed. She was transported by ambulance to the LGH. Mrs McNeair was admitted to the LGH, where a CT scan revealed a catastrophic left-sided subdural haematoma. She was placed in palliative care with a very poor prognosis. Mrs McNeair died at 6.00am on 4 December 2018.

On 5 December 2018, an autopsy was performed by pathologist, Dr Rosanne Devadas. Dr Devadas formed the opinion that the cause of death was a subdural haematoma caused by a

mechanical fall with head strike. She stated that frailty, poor mobility, vision and balance were contributing factors in her death. I accept Dr Devadas' opinion.

In their affidavits for the coronial investigation, Ryan and Lisa McNeair expressed a number of concerns regarding the care and treatment of their mother at both the LGH and GTH. Although some of these concerns do not relate to the circumstances of death, I deal with the main issues below.

Firstly, Mr McNeair indicated that the podiatrist put Mrs McNeair's shoes on the wrong feet on 8 August 2018, before her initial fall, and that this contributed to the fall. Ms McNeair stated that the shoes were specifically made for Mrs McNeair's partial foot amputation, and being on the wrong feet would have caused her to be unsteady. In this regard, NICS Nurse Unit Manager, Samantha Beatie, stated that she was informed by the treating podiatrist that Mrs McNeair insisted on independence, often refusing assistance, and that she put her shoes on herself. Ms Beatie stated that, because of the design of the shoes, it would make no difference which foot they were on.

Mr McNeair alleged that the staff of the GTH was lax in their attitude and treatment of Mrs McNeair's diabetes, and that they had to be instructed by him to make particular treatments. The medical records indicate that all routine blood sugar checks were conducted in accordance with hospital procedure and that Mrs McNeair was treated accordingly. All reports indicate that Mrs McNeair was in good health and spirits on 23 November 2018 prior to her fall. Any hypoglycaemic episodes prior to this are not directly related to the fall and subsequent death of Mrs McNeair.

Concerns were further raised by Mr McNeair and Ms McNeair that their mother, at the time of her fall, was left alone for too long, with the nurse too far away from her.

As indicated further on, I make no criticism of her supervision. GTH Nurse Unit Manager, Treica Ware, indicated that integrated care plans were conducted daily which included a fall risk assessment. Mrs McNeair was rated at a level two on 23 November 2018 and for the 20 days preceding. Level two requires the assistance of one staff member getting in and out of bed, sitting and standing, and the use of a standing aid.

Mr McNeair also believed that the care provided immediately following the fall on 23 November 2018 was inadequate. He believed that the ambulance had taken too long to transport Mrs McNeair to the LGH. The evidence indicates that multiple staff members responded to the emergency call, including Dr Mooney, who was Mrs McNeair's regular doctor

during her stay at GTH; treatment was provided accordingly. It was immediately obvious to the medical staff that the result of the fall was catastrophic and Mrs McNeair was comforted until transport was arranged.

Ms McNeair indicated that she believed Mrs McNeair should have been using the full arm support frame instead of the four wheel walking frame and had raised these concerns with Ms Ware. The medical records indicate that Mrs McNeair was evaluated by a physiotherapist on 20 November 2018 and was able to use either frame, and she was able to choose which frame to use according to how she was feeling. Ms Koetse stated that she gave Mrs McNeair the option of frames on 23 November 2018 and that she chose the four wheel frame.

As part of the investigation a report was completed by Dr Anthony Bell, medical consultant to the Coronial Division. In his report Dr Bell stated:

> *"The fall on 16(sic) August 2018 may or may not have related to the shoes on the wrong feet. The Darko medical shoe is not shaped in the same manner as usual shoes. The patient had many reasons to fall especially the peripheral neuropathy and forefoot amputation on the left foot.*
>
> *"The management by referral to the emergency department for care is standard procedure in hospitals. Wards and doctors on wards are not appropriate places to manage acute patients.*
>
> *"The management at the GTH appears satisfactory. The glucose monitoring was performed as ordered. The episode of hypoglycaemia was unexpected given the pattern of glucose levels.*
>
> *"The fall on 23 November 2018 is the major concern. The change of walking assistance device is probably not implicated in the aetiology of the fall. The records do suggest a slow deterioration in stability and easy fatigability over the day. The evidence also includes the observations by the patient's daughter of the patient teetering backwards at times. The change probably relates to slow deterioration of the peripheral neuropathy leading to increased instability. Recognition of such changes is difficult on a day to day basis and requires considerable insight. The description by Ms Koetse appears to be an accurate description. The patient reached the stage where two assistants were probably needed.*
>
> *"The incidence of falls increases with age and varies according to living status. Between 30% and 40% of community-dwelling people over the age of 65 years fall each year, increasing to about 50% for those 80 years and older. Multiple factors are involved including sensory systems,*

> *muscle activation, visual impairment and medication use. It is likely that the majority of falls that occur in the hospital setting may not actually be preventable.*
>
> *"The overall care provided at GTH appears to be satisfactory.*
>
> *"The index fall is well described and indicates the difficulties in management."*

I accept the opinion of Dr Bell.

In summary, Mrs McNeair had a range of complex health issues. She received adequate and appropriate care during her stays at LGH and GTH. The care she received was consistent with hospital policy and the assessments made of her care needs. Although Mrs McNeair may have required two assistants to mobilise at the time of her death, I agree with Dr Bell that this would have been difficult to assess prior to her fall. I make no criticism of the actions of staff surrounding Mrs McNeair's fall. Unfortunately, it was not reasonably preventable.

Comments and Recommendations

I note that Ms Beatie identified, soon after the initial fall on 8 August, that the weight of the door may have been a contributing factor leading to the events that followed. I cannot assess upon the evidence whether this is correct. Nevertheless, the LGH has subsequently replaced the hinged door with an electronic sliding door operated by pushing a button panel.

I extend my appreciation to investigating officer Constable Kelly Donaldson for her investigation and report.

The circumstances of Mrs McNeair'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 McNeair.

Dated: 27 July 2020 at Hobart Coroners Court in the State of Tasmania.

Olivia McTaggart
Coroner