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 Carmen Cano

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

a) The identity of the deceased is Carmen Cano.

b) Mrs Cano was born on 14 May 1936 and was 84 years of age when she died. She was divorced, has three children and was a retired chef. Before her death, she suffered dementia and osteoporosis. She was a resident of the Huon Regional Care aged care facility in Franklin. She was assessed as being at a high risk of falling, although had not suffered numerous or regular falls at the facility. She was cognitively impaired due to her dementia and often wandered from her room.

At 12.30am on 27 February 2021 Mrs Cano was found on the floor in a corridor of the facility. When she was found, she had pain in her left hip and could not weight bear the left side. She was provided with care and analgesia until ambulance paramedics arrived and took her to the Royal Hobart Hospital. In hospital, she was assessed as having a fracture of her left hip and underwent surgery for the fracture on 1 March 2021. Although the surgery was deemed to be high risk, it was necessary to control her pain. After the surgery, Mrs Cano's family requested that she be provided with comfort care and she was transferred back to the facility on 3 March 2021. She passed away four days later.

c) Mrs Cano died as a result of complications of a fractured left hip suffered in an unwitnessed fall in her aged care facility.

d) Mrs Cano died on 7 March 2021 at Franklin, Tasmania.

In making the above findings I have had regard to the evidence gained in the investigation into Mrs Cano's death. The evidence includes;

- The police report of death;
- An opinion of the forensic pathologist;
- Identification and life extinct affidavits;
- Medical Certificate of Death initially issued by a medical practitioner;
- Huon Regional Care records;
- Review by the coronial forensic nurse of the supervision and care by Huon Regional Care surrounding the fall.

Comments and Recommendations

I am satisfied that Mrs Cano's fall could not have been reasonably prevented and that appropriate falls assessments and prevention measures had been put in place by Huon Regional Care.

In this case, a Medical Certificate of Cause of Death was initially issued by a general practitioner, despite the death arising from unnatural causes. It should be borne in mind by medical practitioners and staff of aged care facilities that where the consequences of a fall are a significant cause of death, the death should be reported to the coroner.

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

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

Dated: 14 July 2021 at Hobart Coroners Court in the State of Tasmania.

Olivia McTaggart
Coroner