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

ALICE MARY FOWLER

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Record of Investigation into Death (With Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

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

Hearing Dates

14, 15, 16 December 2020 at Hobart in Tasmania and then adjourned for written submissions.

Representation

C Lee – Counsel Assisting the Coroner
G Chen – State of Tasmania and Tasmanian Health Service
R Phillips – Registered Nurse Uma Kennedy
T Cox – Registered Nurse Emma Ackerley

Introduction

1. On 8 December 2015, Mrs Fowler died in the Royal Hobart Hospital (RHH). She was born in Hobart on 9 November 1924 and thus 91 years of age at the time of her death. Fiercely independent, she lived alone in her home in West Hobart, until a few days before her death. Her son, Richard, said that his mother enjoyed reading and watching television.[1]

2. Mrs Fowler's health was, not surprisingly perhaps for someone of her age, poor. Her balance and mobility were significantly compromised, she was unable to walk more than five metres without stopping, was sufferering from demenatia and her hearing was poor. Nonetheless, Mrs Fowler cooked her own meals and refused to countenance moving to a residential aged care facility. The evidence does suggest strongly that her continued independent accommodation was obviously problematic by the latter part of 2015.

[1] Affidavit of Richard Philip Fowler, sworn 27 May 2016, Exhibit C6, page 1 of 4.

3. Mrs Fowler was under the care of her general practitioner, Dr Danny Rimmer. Dr Rimmer referred her to the Aged Service Southern Area Team at the RHH on 13 September 2015. In that referral, Dr Rimmer made specific mention of Mrs Fowler having mild-to-moderate dementia and significant hearing impairment.

4. Mrs Fowler was seen by a nurse practitioner in aged care, Ms Jane Davis, on 14 October 2015 as a consequence of that referral. Ms Davis assessed Mrs Fowler and concluded she was a "high fall risk". In her report following the assessment, Ms Davis noted Mrs Fowler had sustained two falls in the preceding six months.[2]

5. Following the assessment on 14 October 2015, Ms Davis referred Mrs Fowler for physiotherapy. In the referral Ms Davis noted Mrs Fowler was "very deaf", had a poor memory, poor balance and was a fall risk.

6. On 26 November 2015 a report by a geriatrician who had reviewed Mrs Fowler, noted that she had hearing that was so impaired it was necessary for him to write down many of the questions to her. The same report noted Mrs Fowler was able to read, and understand, those questions. The geriatrician reported that Mrs Fowler was suffering from dementia, probably of the "Alzheimer's type". The same report noted that Mrs Fowler's current arrangements were not sustainable and recommended the appointment of a guardian.[3] All this information was recorded in her digital medical record kept by the Tasmanian Health Service (THS). The THS operates the Royal Hobart Hospital (RHH).

7. On 2 December 2015, Mrs Fowler fell from her bed in her home. Mr Richard Fowler's evidence was that the bed from which his mother fell was old and relatively speaking, low to the ground.[4] He said that he was interstate with his wife the time of his mother's fall. Mr Fowler said that his mother contacted his son, Adam, and her niece, Emma, the day after her fall (i.e. 3 December 2015). Those family members took Mrs Fowler to her GP, Dr Rimmer.[5]

8. Dr Rimmer was sufficiently concerned about the injury to her wrist that he referred Mrs Fowler to the RHH for an x-ray. Dr Rimmer sent his notes to the hospital by facsimile at 10.50am the same day. Mrs Fowler's medical records at the RHH record her arriving at 10.56am. I will return to the course of her treatment at the RHH shortly.

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[2] Exhibit C11, pp 145 – 147.
[3] Exhibit C11 - report Dr Blair Adamczeski - pp 137 – 139.
[4] *Op cit*, Exhibit C6.
[5] *Supra*, page 2 of 4.

What a Coroner Does

9. But before proceeding any further to consider Mrs Fowler's death, it is, I think, important to say something about what a coroner does. A coroner in Tasmania has jurisdiction to investigate any death which appears to have been, accidental, unexpected or unnatural.[6] Mrs Fowler's death meets this statutory definition as it resulted from an accidental fall.

10. When investigating any death (whether at an inquest or not), 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(1) of the *Coroners Act* 1995 (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.[7] 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.

11. A coroner does not punish anyone or award compensation – that is for other proceedings in other courts, if appropriate. Nor does a coroner charge people with crimes or offences arising out of a death that is the subject of investigation. In fact, a coroner in Tasmania may not even say that he or she thinks someone is guilty of an offence.[8] I should make it very clear indeed that I do not consider anyone has committed any crime or offence in relation to Mrs Fowler's death.

12. As was noted above, one matter that the Act requires is finding how the death occurred.[9] It is well-settled that this phrase involves the application of the ordinary concepts of legal causation.[10] Any coronial investigation, including an 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.

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[6] Section 3.
[7] *R v Tennent; ex parte Jager* [200] TASSC 64, at par 7.
[8] Section 28(4).
[9] See section 28(1)(b).
[10] *March v Stramare* (E&MH) Pty Ltd [1990-1991] CLR 506.

13. 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*[11], that is, paraphrasing Dixon J (as he then was) that the task of deciding whether a serious allegation is proved should be approached with great caution.

14. A coroner is not bound by the rules of evidence.[12] This does not mean that an inquest operates in some type of evidentary or procedural state of anarchy; the rules evidence are not abolished by the Act, but rather, they are relaxed.[13]

15. The doctrine of procedural fairness requires that where a person or other legal entity may be the subject of adverse findings "*a coroner is obliged to permit the person to be legally represented, call and examine or cross-examine witnesses, and make submissions pursuant to section 52(2) and (4) of the Act*".[14]

The Original Investigation

16. Mrs Fowler's death, on 8 December 2015, was reported under the *Coroners Act* 1995. The matter proceeded to as what might be described as a "standard" coronial investigation. Evidence was obtained and records secured and examined. On 8 February 2018, Coroner Chandler delivered a finding about Mrs Fowler's death. He did not hold an inquest. Not holding an inquest is far from unusual in Coronial matters. Indeed, the vast majority of matters reported in this jurisdiction, and any other within the Commonwealth of Australia, do not proceed to an inquest. The fact that Coroner Chandler did not hold an inquest is, to my mind, completely irrelevant.

17. In his finding Coroner Chandler said, relevantly:

> *"A falls risk assessment at the RHH necessitates completion of a document entitled Falls Risk Assessment Tool (FRAT). In Mrs Fowler's case this document was completed by registered nurse, Ms Uma Kennedy. A portion of the FRAT is entitled 'Falls Risk Assessment' and requires the level of risk to be scored against four named criteria. Nurse Kennedy has left that part of the form blank. However, she has rated Mrs Fowler to be in the High Risk category. Another portion of the FRAT is entitled 'Individualised*

[11] (1938) 60 CLR 336 in particular Dixon J (as he then was) at 362.
[12] See section 51 of the *Coroners Act* 1995.
[13] See *Connelly v P & O Resorts Pty Ltd T/A Cradle Mountain Lodge* [1996] TASSC 132
[14] *Attorney-General for the State of Tasmania v Copper Mines of Tasmania Pty Ltd* [2019] TASFC 4, per Blow CJ at paragraph 30.

Strategies.' It identifies a number of risk minimisation devices. Some of the options relevant to Mrs Fowler's circumstances include 'Bed at Correct Height for Exit', 'HI-LO bed/low bed'; 'Floor mat next to Bed'; 'Bed Rails Down'; 'Bed/Chair Sensor' and 'Supervise at all times in Bathroom/Toilet.' Again that portion of the form has also been left blank. I am informed that when interviewed by her employer, Nurse Kennedy advised that she was unable to recollect the reasons these parts of the FRAT were not completed. Further, she says that she does not recall whether any of the strategies listed in the FRAT were put in place for Mrs Fowler.

In my view, Mrs Fowler's fall and its fatal consequences would, in all likelihood, have been avoided if the RHH had ensured that her falls risk was comprehensively assessed and strategies put in place to respond to that risk. It follows that her death was preventable."

18. The part of the finding set out above is capable of being read as a criticism of Registered Nurse (RN) Kennedy. It is also apparent that the finding (and in particular that part set out above) was made without RN Kennedy being afforded procedural fairness. In other words, she was not given an opportunity to put her side of the story.

The Application to Re-open the Investigation

19. On 12 October 2018, Phillips Taglieri, Solicitors, on behalf of RN Kennedy, made an application pursuant to section 58 of the *Coroners Act* 1995 that the investigation into Mrs Fowler's death be re-opened. That application was made, essentially, on the basis that RN Kennedy had been the subject of adverse findings but had not been afforded procedural fairness. On 7 December 2018, after considering the application and material in support, Chief Magistrate Geason directed that the investigation be re-opened and the findings be re-examined.

20. The inquest which informed these findings proceeded as a consequence of that direction.

Issues at the Inquest

21. Once re-openned, the investigation was what lawyers called '*de-novo*' or, in plain English, completely afresh. The investigation did not involve a review of Coroner Chandler's finding to decide whether in some way it was "right" or "wrong"; rather it was my obligation to consider all the circumstances of Mrs Fowler's death. Accordingly, I gave consideration to what issues, additional to the matters which the

Coroners Act 1995[15] makes mandatory, a number of other issues should be looked at. Perhaps obviously given that Mrs Fowler's death was the result of a fall by an elderly person in a hospital, a focus of my investigation was the adequacy of steps taken to protect Mrs Fowler from a fall.

22. Several issues were identified in advance of the inquest and circulated to all interested parties well before evidence was taken. Those issues – or the 'scope' of the inquest - were:

    a) What medical history was available to RHH medical staff in relation to Mrs Fowler's risk of fall;
    b) Any actions undertaken by RHH staff to reduce the likelihood of Mrs Fowler having a fall and/or sustaining any injury;
    c) The circumstances leading up to Mrs Fowler's fall;
    d) The actions of RHH staff in response to Mrs Fowler's fall;
    e) Any actions that should reasonably have been taken to mitigate against the risk of Mrs Fowler having a fall; and
    f) Ways of preventing further deaths from falls.

23. Issue (a) has already been addressed earlier in this finding. Staff at the RHH had available to them Mrs Fowler's digital medical record which contained the information set out above. That information included that she had been assessed as a "high fall risk", that she had sustained two falls in the six months preceding October 2015, that she was very deaf, had a poor memory and poor balance.

24. A significant focus of the inquest was a document known as a FRAT.[16] Evidence was received in relation to what it was, what the requirements were in relation to it, when it had to be completed, by whom and within what time frame, who in fact completed it in relation to Mrs Fowler, whether any deficiencies existed with the information contained in it, and would those deficiencies have changed the outcome. I will return to that issue later in these findings, but I think it is important to make the point that whatever the deficiencies in relation to the completion of paperwork relating to Mrs Fowler, any such deficiencies did not cause her death.

[15] Section 28 (1)
[16] Falls Risk Assessment Tool.

Circumstances of Death

25. I return now to the course of Mrs Fowler's treatment at the RHH. The findings which follow are based on the evidence at the inquest. That evidence included hearing from a number of witnesses (each of whom was cross-examined about aspects of their evidence by experienced counsel). I note that I consider each of the witnesses did their very best to give their evidence truthfully. Each laboured under the significant disadvantage of being asked to recall incidents which had occurred five years before they gave their evidence. Witnesses accounts will always vary to a degree; the degree of variation is of course influenced by, amongst other things, the passage of time. As Mr Lee, Counsel Assisting, correctly observed, the passage of time also exacerbated difficulties associated with witnesses attempting to accurately explain which particular policy was in place at any given time.

26. In addition, a significant amount of documentary evidence was received at the inquest. In real terms, little, if anything, was in dispute. I find that after review by a multi-disciplinary team on 3 December, and in consultation with Mrs Fowler's family, it was decided that she lacked the capacity to care for herself and she was therefore admitted to the RHH Medical Unit. That admission occured later in the afternoon / early evening.

27. At the time Mrs Fowler was in the RHH, a Patient Assessment Referral Information System (PARIS) was in operation. The protocol which governed that system (the so-called "PARIS protocol"[17]) had been in operation for about six months prior to Mrs Fowler's admission to the RHH. The evidence at the inquest was that the system was a standardised process to assist in the screening and assessment of all patients at their admission. The evidence at the inquest was that the PARIS form needed to be completed within 36 hours of a patient's admission to hospital.

28. Another important document, both in the context of Mrs Fowler's stay at the RHH, and the issues addressed at the inquest, was the Falls Risk Assessment Tool (FRAT) document. The evidence was that the purpose of that document was to guide the assessment of the risk of any given patient suffering a fall. Part of the process that was in place was the development of an individual action plan, once a patient had been identified, using the FRAT, as a risk of fall.

[17] Exhibit C29.

29. The evidence was that a protocol entitled "Preventing Falls and Harm from Falls"[18], which governed the completion and utilisation of the FRAT form, had been in place since about May 2015. That protocol required that the FRAT must be completed within 24 hours of admission.

30. Mrs Fowler was admitted to the Assessment and Planning Unit (APU) at 9.45pm. At that time RN Kennedy was working in the Unit and was assigned to nurse Mrs Fowler. In addition to making a statutory declaration and swearing an affidavit, RN Kennedy was called to give evidence at the inquest. She was cross-examined about aspects of her evidence. I consider her evidence to have been given honestly and accurately, to the best of her ability. I had no hestiation in accepting her evidence.

31. It was apparent that RN Kennedy was appropriately qualified (having been a registered nurse since 2011, and had worked at the RHH since the same year). Her evidence at the inquest was that she would quite often fill out a PARIS form but could not remember whether she was familiar with the applicable protocol.

32. On 3 December 2015, the only occasion where RN Kennedy had professional (or indeed any) contact with Mrs Fowler, she said that she was working a "late" shift. That shift commenced at 2.00pm and concluded at 10.30pm. The evidence was a shift handover would occur between 10.00pm and 10.30pm.

33. I find, on the basis of RN Kennedy's evidence, which was supported by a Medical Services Nursing Admission Note in Mrs Fowler's medical records[19], that RN Kennedy nursed Mrs Fowler for no more than 75 minutes (8.45pm to 10.00pm). RN Kennedy's evidence was that she commenced the process of completing a falls risk assessment using a form called a Falls Risk Assessment Tool (FRAT), but because she finished work at 10.30pm, she had insufficient time to complete the FRAT. She also completed the PARIS form in respect of Mrs Fowler.

34. As I have previously noted, the applicable protocol did not require the FRAT to be completed for 24 hours. Not unreasonably in my view, RN Kennedy considered that another nurse on another shift following her's would finish the FRAT. However, that did not happen, despite the fact that a number of opportunties existed for the form to have been completed.

[18] Exhibit C19.
[19] Exhibit C11, page 211.

35. Some criticism was made of the fact that the parts of the FRAT form which RN Kennedy in fact completed may have been a little inaccurate. I do not consider anything much turns on this. In the final analysis, a FRAT form is a tool designed to focus attention upon the fact that a patient is a falls risk, and assist medical staff (in particular nurses) to formulate an appropriate response to manage that risk. Whilst evidently the correct information is to be preferred, any information is better than no information. Moreover, as I will shortly touch upon, even if there were aspects of the information included by RN Kennedy in the form which were perhaps lacking, there was nothing to stop any of the nurses who were subsequently responsible for Mrs Fowler's care, from completing the form and, if they considered it appropriate, correcting aspects of the information.

36. In any event, RN Kennedy handed over Mrs Fowler's care to a night shift nurse in APU. She said in her evidence at the inquest that she "would" have told the nurse to whom she was handing over Mrs Fowler's care, that she had not completed the FRAT form. Other than RN Kennedy's evidence about what may or may not have happened five years earlier, there is no other evidence about what occurred at the handover. There was evidence that handover sheets were (and perhaps still are) completed and exchanged at handover following the conclusion of the shift disposed of. In any event, I have no reason not to accept RN Kennedy's evidence that more likely than not, consistent with her normal practice, she would have pointed out to the night shift nurse to whom she handed over Mrs Fowler's care that she had not completed the FRAT. Whatever occurred at handover, it is quite apparent that the night shift nurse did not complete the FRAT. The night shift nurse then handed Mrs Fowler's care to a day shift nurse in APU at around 8.00am on 4 December. That nurse did not complete the FRAT either.

37. Later that morning, Mrs Fowler was reviewed by a Nurse Practitioner in aged-care. The practitioner seems to have concluded that Mrs Fowler would require residential aged care placement. This course was discussed with Mrs Fowler and family members later in the day. Mrs Fowler's medical records indicate that around the same time she was referred for physiotherapy. However, it was recorded in the notes that: "[d]ue to limited resources, there will be a delay in physiotherapy services to see this patient. All referrals are being reviewed and prioritised daily. A physiotherapy assessment will occur as soon as a therapist is available…".[20] In fact, Mrs Fowler did not receive any physiotherapy before her death.

[20] Medical records, Exhibit C11, Page 220.

38. Later still that morning, Mrs Fowler was transfered from APU to Ward 1B. She was now under the care of a fourth nurse. That nurse did not complete the FRAT either. Mrs Fowler's care was then transferred to a fifth nurse, working afternoon shift, in Ward 1B North. That nurse did not complete the FRAT either.

39. I have set out the history of Mrs Fowler's nursing care, and highlighted the fact that not one of the nurses who looked after her completed the FRAT, to illustrate the point that, in my view, not one nurse (and certainly not RN Kennedy) was to blame for the FRAT not being completed. The evidence at the inquest made it quite clear that the failure was a systemic one. But as I have already said, I do not consider that the failure to complete the FRAT was causative of Mrs Fowler's death.

40. In any event, returning to the timeline of the last hours of Mrs Fowler's life, at 10.00pm on 4 December, Mrs Fowler's care was transferred to a sixth nurse, RN Ackerely. RN Ackerely gave evidence at the inquest. Like RN Kennedy, RN Ackerly impressed as an honest witness and a cabale and caring nurse. She had been a registered nurse since earlier in 2015, but had a lengthy history in the aged care industry. I had no hestiation in accepting her evidence. I also specifically accept Mr Lee's submission that by the time RN Ackerly took over responsibility for Mrs Fowler's care it was far too late for her to have done anything about the failure to complete the paperwork associated with assessing Mrs Fowler's risk of falling.

41. Her evidence about the relevant shift was that it was especially busy. She said that within minutes of the shift starting at 10.00pm on 4 December 2015, a medical emergency team call was made. That medical emergency team call was followed by another one. RN Ackerly said that handover was not completed until 11.00pm (I infer that the nurse responsible for handing over to RN Ackerly stayed behind). RN Ackerly said she was provided with a handover document (this is consistent with RN Kennedy's evidence, and that handover document was supplemented by verbal information which she would write on the form. Like RN Kennedy, she gave evidence that at the end of a shift the handover document was destroyed.

42. RN Ackerly said that when she commenced nursing Mrs Fowler she, Mrs Fowler, was in a standard hospital bed at the standard height with the bed rails raised.[21]

[21] See affidavit of Emma Ackerley, sworn 10 December 2020, exhibit C 32.

43. In the early morning of 5 December, according to the evidence, at about 3.00am, Mrs Fowler fell from her bed in Ward 1B. RN Ackerly described in her affidavit what happened as follows:

> "*I remember around 2 AM in the morning [sic] she started to become confused and impulsive. I saw that she had skidded herself down the bed (by this I mean she had shuffled herself down the length of the bed to the end of the bed) and was in a seated position about to get off the end of the bed. She had previously had a subcutaneous fluid line inserted into her back. The line had come out of her back. I remember asking her "What are you doing?" And she replied cheekily "Just seeing what I can get away with". I recall that she was funny. I took her to the toilet again returned her to bed with the bed rails up.*
>
> *I also recall that I said to her to use the nurse bell if she needed anything and I reconnected the sub-cut line to her back.*
>
> *At this time, I didn't think there was any heightened risk of her getting out of bed. I thought it was just a one off.*
>
> *I remember being in this room for much of the shift because…another woman had become unresponsive and a MET call had been made.*
>
> *The next recollection I have is that shortly before the fall, I saw that one of her legs was over the bed rails. Her right leg was over the rail indicating to me that she had tried to get out of bed on the left hand side. I remember on this occasion that I asked her what she was doing and whether she needed anything such as to go to the toilet, have a drink or something to eat and she replied no.*
>
> *After this incident, I pulled down the bed rails and lowered the bed to the lowest possible position. From my experience and training, if a patient is attempting to get out of bed, it is preferable to pull down the rail so that any fall is from a lower height. At that point in time, it was not an option to get a sitter. We simply didn't have the resources to have somebody sit there watching one patient when there were many others to attend to.*
>
> *It was also not an option to get a mat. In my view, this would have posed a greater risk to Mrs Fowler because it was not so much the case that she was going to roll out of bed, instead you try to get out of bed and then the risk of her falling became heightened.*

After I lowered the bed rails I went to get a bed alarm from the cupboard in the storeroom which was about 15 metres away from the room in which Mrs Fowler was hospitalised. The purpose of getting the bed alarm was so that if Mrs Fowler tried to get out of bed again, I would be alerted. The hospital records note that staff heard a yell and then attended on Mrs Fowler. I remember when I got to the room, Mrs Fowler was lying a couple of meters away from the bed on the ground. After an initial assessment of nil obvious injuries, I utilised the attendants to help her back to bed. It was then I knew she had fractured her hip. She was in a lot of pain. I made an emergency call (MET call) and recall Dr Tom appeared again. Then Dr Chan, the registrar, arrived and he took over management of Mrs Fowler's care."

44. Intially, Mrs Fowler appeared stable, but her condition deteriorated and so at about 5.00am a Medical Emergency Team (MET) call was made. An x-ray showed she had sustained a fracture of her left hip. It was decided, with family involvement, that surgery was not an option and to initiate palliative care. There were initial difficulties in managing Mrs Fowler's pain and this was not satisfactorily achieved until the evening of 7 December. Mrs Fowler died at 2.00pm the following day.

45. RN Katrina Monash, who was RN Ackerly's supervisor on the night of 4-5 December 2015, (although she had no specific memory of Mrs Fowler) also made an affidavit[22] and gave evidence at the inquest. RN Monash's evidence supported that of RN Ackerly's about the specific circumstances of the shift when Mrs Fowler suffered her fatal fall. In addition, RN Ackerly gave helpful evidence with respect to the physical structure of Ward 1B, rostering practices and staff numbers. She said that as at December 2015 the Ward was a 28 bed ward with patients allocated between 3 to 4 night shift duty staff. This meant that each nurse had responsibility for somewhere between eight and 10 patients.

46. RN Monash said she had no specific memory of Mrs Fowler, nor her fall. No criticism should be directed at RN Monash of failing to recall the specific fall. Self-evidently, a nurse of 30 years' experience will have had occasion to deal with thousands of patients and many falls.

47. RN Monash addressed in her evidence the issue of sitters, bed rails, bed check alarms and call bells. I found her evidence helpful and persuasive.

[22] Exhibit C25, affidavit sworn 14 September 2020.

48. RN Rachel Broughton, the nurse unit manager of Ward 1B North at the time of Mrs Fowler's death, also made an affidavit[23] and gave evidence at the inquest. RN Broughton was not working at the time of Mrs Fowler's fall but given her experience and the role she played her evidence was relevant and of assistance. Nothing she said was particularly contentious and like RN Monash, she addressed issues with respect to the steps that could be taken to help mitigate against the falls of elderly patients. Like RN Monash, I found RN Broughton's evidence to be of assistance.

49. The final witness at the inquest was recently retired executive director of nursing, Associate Professor Coral Payton. Ms Payton's evidence was concerned with*, inter alia*, the policy history at the RHH. Mr Lee submitted, and I agree, that Ms Paton presented as an impressive witness and her evidence should be accepted.

50. Summarising that evidence, Ms Paton explained how the RHH is performing against international benchmarks and the like.

Investigation

51. As I have already said, following Mrs Fowler's death, the fact that it had occurred, was reported in accordance with the requirements of the *Coroners Act* 1995. Both the RHH and Tasmania Police made reports. Those reports were made in writing and tendered at the inquest.[24]

52. Mrs Fowler's body was formally identified[25] and transferred to the hospital mortuary. At the mortuary, experienced Forensic Pathologist, Dr Donald Ritchey MD, MSc, FRCPA, carried out a *post-mortem* examination on 9 December 2015. Dr Ritchey provided a report, which was tendered at the inquest.[26] In that report he expressed the opinion that the cause of Mrs Fowler's death was a pelvic haematoma complicating a fracture of the neck of her left femur. Dr Ritchey said that he considered that the femur had been fractured in a fall from standing height. He noted significant contributing factors to her death were advanced atherosclerotic and hypertensive coronary vascular disease, emphysema and dementia.[27]

[23] Exhibit C 26, affidavit sworn 21 August 2020.
[24] Exhibits C1 and C4, respectively.
[25] Exhibit C3, Affidavit of Constable Fabienne Jamieson, sworn 8 December 2015.
[26] Exhibit C5, Affidavit of Dr Donald Ritchey, sworn 4 January
[27] Supra, exhibit C5 page 10 of 12.

53. Dr Ritchey noted that Mrs Fowler had suffered multiple falls on the day prior to her death, including the fall in hospital in which she sustained the ultimately fatal fracture of the neck of her left femur. He said that the haematoma of the floor of her pelvis he found at autopsy would likely be survivable "*in a younger healthy person… [but] in the setting of advanced natural disease it proved fatal*".

54. I accept Dr Ritchey's opinion. I am satisfied Mrs Fowler died because of injuries sustained by her in a fall which injuries would have been survivable in a younger, fitter and less frail person.

Formal Findings

55. On the basis of the evidence presented at the inquest, I make the following findings pursuant to section 28(1) of the *Coroners Act* 1995:

    a) The identity of the deceased is Alice Mary Fowler;
    b) Mrs Fowler died as a result of injuries sustained in a fall while a patient in hospital;
    c) The cause of Mrs Fowler's death was a pelvic haematoma complicating a fracture of the neck of her left femur; and
    d) Mrs Fowler died on 8 December 2015 at the Royal Hobart Hospital, Hobart in Tasmania.

Conclusions and Comments

56. Having regard to all of the evidence, I have carefully reached the conclusion that Mrs Fowler's death was, as Mr Lee submitted, not preventable. A number of measures were canvassed at the inquest including the use of sitters, high-low beds, and the like, but it is apparent to me that all or any of those measures could not have prevented Mrs Fowler from falling and fracturing her hip. The presence of the sitter might have assisted in preventing a fall but it would not have prevented it from occurring. Mats on the floor near the bed would not have stopped Mrs Fowler falling – although they ***may*** have served to have lessened the impact of any such fall. A lower bed (such as the one in which Mrs Fowler slept in at her home, and from which she fell) would not have prevented her from falling. Neither would a bed alarm.

57. The evidence at the inquest satisfies me that RN Ackerley used every resource available to her to mitigate against the risk of Mrs Fowler falling. Specifically, she ensured Mrs Fowler had a nurse call button (and took steps to ensure that she knew how to use it), she raised bed rails when it was appropriate to do so, and she lowered the bed when that needed to happen. RN Ackerley was in the process of obtaining a bed alarm when Mrs Fowler had her fall. I cannot see that there is anything else RN Ackerley could have done on the shift.

58. There is, to my mind, considerable merit in the submissions made on behalf of RN Ackerley by her counsel to the effect that there is nothing that could have been done to have prevented Mrs Fowler falling, short of engaging a sitter – and even the presence of a sitter would not necessarily have stopped a fall. I am affirmatively satisfied that restraining Mrs Fowler or using a catheter would have been extreme, inappropriate and simply not justified. Nor would the presence and use of a catheter actually have prevented a fall either.

59. On the other hand, Mrs Fowler was admitted because she had sustained a fall at home. This alone should have been a significant cautionary factor and should have meant processes could have been put in place early (or perhaps at the start of her admission). Her age should also have been a "red flag". In addition she had already been assessed in October 2015 as a high falls risk, information which was in her digital medical records.

60. It seems to me to overcome the restraints put in place by the FRAT form (needing family to fill out the form if patient is elderly and shows signs of dementia), any elderly patient admitted because of or following a fall, should be automatically deemed a 'high fall risk' until proved otherwise (i.e. the completion of the FRAT form).

61. A significant amount of evidence at the inquest revolved around hospital policies and protocols, both in 2015 and now. Those protocols and procedures have been analysed. Mr Lee submitted, and I accept, that a number of general improvements following Mrs Fowler's death have been put in place. Those improvements involved education of staff in relation to the proper use of the FRAT and PARIS forms, changing the time limit for the completion of those forms to eight hours post-admission, the development of a transfer form in respect of changes in the patient's condition, more sitters being available and the development of a red dot system to assess patients' mobility now being electronic.

62. In addition, of course, the physical environment within which patients are housed has been changed markedly as a result of the extensive building works at the RHH.

63. Accordingly, I do not consider that there is any merit in doing anything other than acknowledging that the RHH has made significant changes in the five or so years following Mrs Fowler's death.

64. As I mentioned earlier in these findings, the *Coroners Act* 1995 obliges a coroner, "whenever appropriate… [to] make recommendations with respect to ways preventing further deaths".[28] In addition, the coroner is able, if she or he thinks fit, to comment on any matter connected with the death including, of particular relevance in this case "public health".[29]

65. The power to make recommendations or comments is not one that exists at large. It is a power which arises from, and is ancillary to, the coroner's obligation to make findings under section 28(1). Any recommendations or comments must have a sufficient connection with the death the subject of the Coronial inquest.[30]

66. It was quite apparent that there were deficiencies in the care afforded to Mrs Fowler at the RHH. Variously, the deficiencies arose from a systems failure with respect to the completion of paperwork associated with assessing falls risk, the lack of availability of a sitter and apparent problems associated with the physical layout of the ward in which Mrs Fowler had her fall. None of the failings are the failings of an individual staff member. Indeed, as I should be very clear, I am quite satisfied that the nurses who gave evidence at the inquest, RN Kennedy and RN Ackerley, both did all that could reasonably be expected of them for Mrs Fowler.

67. I **comment** that, in my respectful opinion, any elderly person admitted to hospital for treatment after a fall, should automatically be deemed a high falls risk, until proven otherwise. All reasonable steps should be taken to mitigate against the risk of fall, immediately it is identified that an elderly person has had a fall (and the fall is either the reason for, or part of the history preceding, their admission). I do recognise, of course, that ultimately it is impossible to protect every elderly patient against the risk of a fall.

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[28] See section 28 (2).
[29] See section 28 (3).
[30] See *Harmsworth v State Coroner* [1989] VR 989 at 996.

68. I wish to express my appreciation to all counsel involved in the inquest, and in particular, Mr Lee, Counsel Assisting. In addition, I recognise and thank Constable J Richardson (Coroner's Associate) and Mr T Cooper (Law Student) for their assistance in ensuring the smooth running of the inquest.

69. Finally, I wish to express my sincere and respectful condolences to Mrs Fowler's family on their loss.

Dated 12 April 2021 at Hobart Coroners Court in the State of Tasmania.

Simon Cooper
Coroner