MAGISTRATES COURT
TASMANIA

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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 Anthony Neville Kerr

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

a) The identity of the deceased is Anthony Neville Kerr.

b) Mr Kerr was born on 19 August 1939. At the time of his death, he was 81 years of age and was a resident at Toosey Aged and Community Care nursing home. He was widowed and had two children.

Mr Kerr suffered from Parkinson's disease, dementia, heart disease, respiratory disease, and several other medical conditions. In the nursing home, he would sometimes forget to call for assistance, would sometimes refuse assistance and engage in behaviour that caused risk to himself and others. He was under the regular care of his general practitioner.

Mr Kerr commenced residency at the nursing home in early March 2021, at which time he was assessed as being a high falls risk. Because of his lack of insight, agitated behaviour and his medical conditions, he suffered numerous falls, including two separate falls on 28 April 2021. He did not suffer significant injuries in these falls. The nursing home reviewed his falls risk after each fall and implemented a range of falls prevention measures. He was also subject to mobility and falls risk review by a physiotherapist.

On 6 June 2021, Mr Kerr suffered an unwitnessed fall at the nursing home. At 7.40am Mr Kerr was found by staff (who had heard the fall) on the floor in the middle of his bedroom. He appeared to have slight bruising and low blood pressure. At 11.00am his doctor was contacted. Mr Kerr's daughter was also contacted and she visited him at 1.30pm. At 3.00pm, staff noted that Mr Kerr had developed swelling in his chest. An ambulance was called and Mr Kerr was transported to the Emergency Department at Launceston General Hospital.

Mr Kerr was diagnosed with a right-sided chest wall haematoma (traumatic internal bleeding). He was treated with medication and a blood transfusion but he subsequently developed a chest infection and deteriorated quickly. After discussions with medical staff and family members, it was agreed that Mr Kerr should be provided with palliative care. Mr Kerr's condition deteriorated and he passed away on 10 June 2021 in the Launceston General Hospital.

c) Mr Kerr's cause of death was pneumonia due to traumatic internal bleeding of the chest wall sustained in his fall on 6 June 2021.

d) Mr Kerr died on 10 June 2021 at Launceston, Tasmania.

In making the above findings, I have regard to the evidence gained in the investigation into Mr Kerr's death. The evidence includes;

- The police and hospital reports of death for the Coroner;
- Affidavits confirming life extinct and identification;
- An opinion of the forensic pathologist regarding the cause of death;
- Report reviewing nursing home care by the coronial forensic nurse;
- Affidavit from Mr Kerr's daughter, Ms Cindy Hollis;
- Records from the Tasmanian Health Service;
- Records from Northern Midlands Medical Services; and
- Records from Toosey Aged and Community Care nursing home.

Comments and Recommendations

In this investigation, I have received a helpful report from the coronial forensic nurse, Ms Libby Newman, reviewing the care provided to Mr Kerr at the time of the relevant falls before his death. Ms Newman identified that the nursing home's falls review process appeared sound.

One issue requires comment. On 8 April 2021, a motion sensor alarm was placed in Mr Kerr's room. However, the alarm appears to have been removed by 26 April 2021. Notes from the nursing home state that this was done because Mr Kerr would tamper with the alarm. The notes indicate that regular checks upon Mr Kerr were required in place of the sensor. Ms Newman was of the view that another type of detector, possibly a bed alarm, should have been trialled because of the difficulty of busy staff performing more regular checks. It is possible that another type of alarm may have assisted in preventing Mr Kerr's fall but I recognise that falls prevention in the case of a high risk resident such as Mr Kerr is very difficult to achieve, despite the implementation of multiple strategies.

Ms Cindy Hollis, Mr Kerr's daughter, raised concerns regarding the delay between the fall and the staff calling an ambulance. Ms Newman noted that, in hindsight, the response might have been quicker, but that he was monitored by staff throughout the day. She said that when it was apparent that Mr Kerr was deteriorating, he was transported to hospital by ambulance. Ms Newman stated that the delay was unlikely to have changed Mr Kerr's outcome.

Ms Newman was of the view that there were no significant failures on the part of the nursing home that contributed to Mr Kerr's death. I agree with her conclusions.

I invited the nursing home to comment on Ms Newman's report and the issues raised by her. In its response, the nursing home acknowledged opportunities for improvement in relation to a timelier Falls Risk Assessment and an update of the staff's Visual Observation Chart in situations where the resident removes or chooses not to have sensor monitoring alarms in their rooms. The General Manager of the nursing home stated that the Staff Development team will address these issues.

The circumstances of Mr Kerr'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 Mr Kerr.

Dated: 8 November 2022 at Hobart Coroners Court in the State of Tasmania.

Olivia McTaggart
Coroner