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 Gilbert Raymond Mundy

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

a) The identity of the deceased is Gilbert Raymond Mundy.

b) Mr Mundy was born on 23 October 1951 and was 69 years of age when he died. Since 2015, he had been a resident of Snug Village (Christian Homes Tasmania Ltd) nursing home. He was severely compromised by numerous medical conditions, including end-stage chronic obstructive pulmonary disease, congestive cardiac failure, epilepsy, incontinence and anxiety and depression. He was assessed as being at very high falls risk due to his fatigue, shortness of breath, anxiety and impulsiveness. He required assistance with nearly all of his activities of daily living and needed to be supervised or assisted with all aspects of mobilising. He was unsteady on his feet and variously used a four wheeled walker, wheelchair and motorised scooter. Mr Mundy did not generally request the necessary assistance from staff in order to mobilise, although he was encouraged to do so. He tended to be withdrawn, with low mood. He did not use his motorised scooter frequently. However, when he did use his scooter for outings, it provided him with some quality of life. He had been assessed as being safe to use his motorised scooter and his sister encouraged him to use it for outings. His outings on the scooter were generally only for short periods of time. In light of his degree of agitation when staff persisted in trying to help him, it was accepted by the nursing home that Mr Mundy should continue his outings on the scooter in order to maintain some independence.

On the morning of 27 September 2021, Mr Mundy travelled to the local post office from the nursing home on his motorised scooter. He had parked the scooter and was walking without assistance on the ramp at the post office when

he fell. He was assisted by members of the public and complained of pain to his left arm and his left hip. The nursing home was contacted and staff members attended to assist him. Mr Mundy was transported by ambulance to the Royal Hobart Hospital with decreasing level of consciousness. In hospital, he was assessed as having sustained a sub-capital left neck of femur fracture and a fracture to his left humerus. Due to his existing severe heart and lung conditions, Mr Mundy continued to deteriorate rapidly, with a very poor prognosis. In light of his Advance Care Directive and after discussions with his sister, he was not actively treated but provided with analgesia and comfort care until he passed away the following evening.

c) Mr Mundy died as a result of chronic obstructive pulmonary disease, congestive cardiac failure and the injuries suffered in his fall.

d) Mr Mundy died on 28 September 2021 at Hobart, Tasmania.

In making the above findings, I have had regard to the evidence gained in the investigation into Mr Mundy's death. The evidence includes: the police and hospital reports of death; an opinion of the forensic pathologist as to cause of death; affidavits confirming life extinct and identification; medical records for Mr Mundy; nursing home reports and records for Mr Mundy; and a review report by the Coronial Nurse Consultant.

Comments and Recommendations

In this investigation, I examined whether there were any issues associated with Mr Mundy leaving the facility alone in his motorised scooter. I was assisted by helpful information from the nursing home and a report by the Coronial Nurse Consultant. The evidence indicates that, despite Mr Mundy's high falls risk and existing medical conditions, it was reasonable for his well-being for him to be able to have outings by himself in his motorised scooter. His ability to do so if he felt well enough had been previously confirmed by his general practitioner and an occupational therapist. Although it was foreseeable that he may suffer a fall whilst absent from the nursing home, I do not consider in the circumstances that restrictions should have been placed upon him in this regard.

I do observe that Mr Mundy had signed out prior to leaving the nursing home on 27 September 2022. However, he did not have personal contact with any member of staff (as he usually would). Staff members were first alerted of the fact that he had left the nursing home when they received a call to advise he had suffered a fall. It may be prudent for the nursing home to consider whether its procedures for resident absences in similar situations, particularly those with a high falls risk, require review.

The circumstances of Mr Mundy'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 Mundy.

Dated: 4 October 2022 at Hobart Coroners Court in the State of Tasmania.

Olivia McTaggart
Coroner