



# MAGISTRATES COURT of TASMANIA

## CORONIAL DIVISION

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### **Record of Investigation into Death (Without Inquest)**

*Coroners Act 1995  
Coroners Rules 2006  
Rule 11*

I, Olivia McTaggart, Coroner, having investigated the death of Janet Patricia Oates

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

- a) The identity of the deceased is Janet Patricia Oates;
- b) Mrs Oates died in the circumstances described in this finding;
- c) Mrs Oates died as a result of injuries from a fall after the failure of a mobility hoist; and
- d) Mrs Oates died on 4 July 2019 at Hobart, Tasmania.

In making the above findings, I have had regard to the evidence gained in the comprehensive investigation into Mrs Oates' death. The evidence includes:

- The police report of death to the coroner;
- Affidavits confirming life extinct and identification;
- Royal Hobart Hospital death report to the coroner;
- Ambulance Tasmania records;
- Opinion of the forensic pathologist regarding cause of death;
- Records from Respect Aged Care St Anns (St Anns);
- Incident reports prepared by St Anns;
- St Anns' records relating to the hoist;
- Affidavit of the General Manager of St Anns;
- Records of Tasmanian Health Service;
- Affidavits of attending and investigating police officers, including a forensics officer;
- Affidavit of Garry Oates, son of Mrs Oates;
- Affidavit of staff members of St Anns who witnessed Mrs Oates' fall or who attended after the incident;
- Affidavit of the Maintenance Supervisor of St Anns;
- Calibration report for the scales on the hoist dated 3 May 2019;

- Service records for the hoist from Aidacare Healthcare Equipment and Tasmanian Scale Company Pty Ltd;
- Affidavit of Philip Sherston, scale technician;
- Information from the supplier of the hoist, Advanced Life Care;
- Affidavit of Paul Copleman of Medical and Disabled Equipment Services Tasmania, who inspected the hoist after the incident.

### **Background and circumstances of death**

Mrs Janet Patricia Oates was born on the 3 December 1935 and was aged 83 years at the time of her death. She was a retired cook. She had been residing at Respect Aged Care St Anns (St Anns) nursing home since September 2017. Prior to becoming a resident of St Anns, Mrs Oates had spent most of her life living at her home in South Hobart. Mrs Oates was a widow, and had been married to her husband, Roland Oates, for 50 years. There were three children of the marriage. Mrs Oates is survived by her two sons, with daughter passing away in 2017 due to cancer.

Mrs Oates suffered declining health over the last 15 years of her life. Her medical conditions included osteoporosis, atrial fibrillation, hypertension and peripheral vascular disease. In 2016, she broke her right leg as a result of falling out of her wheelchair. Following that incident, she did not regain her full mobility, and shortly afterwards became a resident of St Anns.

Mrs Oates was assessed by St Anns as being a resident who required high care needs as a result of her poor mobility. A care plan for Mrs Oates prepared on 29 March 2019 stated that Mrs Oates was unable to safely bear her own weight without the need of assistance from two staff members. It was noted that Mrs Oates would require full hoist for transfers, with the use of two staff members to assist with any transfers required. Accordingly, the moving or transporting of Mrs Oates was undertaken by staff who used the in-house resident hoists. At the time, St Anns owned a total of four hoists that were used for resident transfers.

At 8.00am on 3 July 2019, Mrs Oates was in her room. Present were two staff members, Ms Naina Thapa and Ms Gail Percey. Both were experienced carers who had been employed by St Anns for five years or so before this date. Ms Thapa and Ms Percey were undertaking the transfer of Mrs Oates by hoist from her bed to her shower chair in her room so that she could have a shower.

The hoist being used for Mrs Oates on this date was an Allegro hoist, serial number 4745 with scale serial 18060, manufactured in 2011. The hoist was electrically operated and able to lift a maximum load of 200 kilograms. Its metal frame comprised two horizontal metal legs on four casters with a high central mast continuing to an overhead curved jib. Descending from the jib was a scale unit and descending from the scale unit was a spreader bar with two horizontal arms. The sling to transfer the resident attached to hooking points on each arm of the spreader bar. The hoist contained a battery control box on the mast and was operated by carers using a remote control. Relevantly, there was a single bolt attaching the spreader bar to the scale unit and therefore to the main frame of the hoist.

Both Ms Thapa and Ms Percey said that prior to using the hoist for the day, they had conducted a visual inspection of it and noted that nothing appeared out of place. Ms Percey said that as well as the visual check, she checked the hoist's battery. Prior to attending Mrs Oates, both staff members had used the same hoist on two other patients that morning with no mechanical or operational issues.

In beginning the hoist transfer process, Ms Thapa raised Mrs Oates' bed into an upright sitting position. Both Ms Thapa and Ms Percey then placed the sling behind Mrs Oates' back and around her legs. The sling was then hooked to the spreader bar of the hoist. Mrs Oates then held onto the strap section of the sling. I note that Mrs Oates was very familiar with the process of hoist transfer given the regularity with which it occurred.

Ms Thapa then began to operate the controls of the hoist and lifted Mrs Oates from the bed. After she was lifted, the hoist was moved about one metre from the bed and Mrs Oates was suspended mid-air with the hoist bearing her weight. Mrs Oates weighed 58.4 kilograms and was 1.58 metres in height. Ms Thapa and Ms Percey were positioned at different sides of the hoist to respectively operate it and to support Mrs Oates' legs and feet. Neither carer took any of Mrs Oates' body weight at that stage, as was the correct procedure. The hoist's controls were then passed to Ms Percey, whilst Ms Thapa briefly turned away in order to obtain the shower chair which was located just outside the bathroom in Mrs Oates' room.

It was at this stage that the hoist failed, and Mrs Oates was dropped approximately one metre to the floor. Ms Percy said in her affidavit for the investigation that Mrs Oates landed partly on her bottom and she saw her shoulder or neck area strike one of the legs of the hoist. Ms Percy stated that she believed that Mrs Oates suffered shock as she became quiet but nevertheless remained conscious. As discussed below, the detachment of the spreader bar which bore the weight of Mrs Oates was caused by a failure of the

retaining nut and bolt combination that held the bar to the frame of the hoist.

Mrs Oates was observed to still be secure in her sling as she lay on the floor after the incident. She was conscious and was complaining about pain to her rear. Other staff members were called to assist, and Mrs Oates was then transported by ambulance to the Royal Hobart Hospital.

At the hospital, Mrs Oates was assessed as having sustained T1 and T4 vertebral fractures as a result of the fall. The neurosurgical team considered that surgery was not indicated. Mrs Oates remained in hospital overnight and on the following day, 4 July 2019, her level of consciousness abruptly deteriorated. In light of her poor prognosis, and after consultation with her family, palliative care was determined to be the best course of treatment. Mrs Oates was therefore transferred to the Whittle Ward. She passed away at 7.40pm that evening as a result of hospital-acquired pneumonia caused by her injuries. Her frailty and osteoporosis also contributed to her death.

As a result of her death, Tasmania Police was notified and investigating police officers attended St Anns on the same day to commence the coronial investigation. It was noted that whilst Mrs Oates had been in hospital, the hoist in question had been removed from her room and taken into the workshop room with an "out of order" sign placed on the machine. Subsequently, the investigating officers and the associates within the Coroner's Office gathered a significant quantity of evidence (as set out above) with particular difficulties encountered in investigating the issue of the servicing of the hoist. Unfortunately, these difficulties significantly extended the period of investigation.

### **Issues with the hoist and its service history**

#### *Inspection by expert*

On 10 and 12 July 2019 the hoist was inspected by an independent expert, Mr Paul Copleman, of Medical and Disability Equipment Services Tasmania. Mr Copleman has many years of occupational experience in servicing and preventative maintenance and repair of medical and disabled equipment. I fully accept his expertise to provide an opinion in respect of the hoist.

After his inspection, Mr Copleman provided an affidavit for the investigation in which he outlined the workings of the hoist, details of his inspection and the issues that he detected. He observed that the hoist was in reasonable condition overall with the electrical controls in good order.

Most relevantly for this investigation, Mr Copleman found that:

- The lower bolt under the hoist's scale was worn. He stated that the threads on this bolt should be sharp but the lower threads were shiny and smooth to touch, with the last two threads being quite worn; and
- The nyloc nut used in association with the above bolt also had some wear to the back of the threads.

Mr Copleman formed the opinion that the nyloc nut had been loose and wearing on the thread of the lower bolt of the scale unit. He said that the cause of the incident was the loose nut causing detachment of the spreader bar section which held Mrs Oates in her sling. He was of the view that the nut and bolt under the scale unit had not been checked or properly maintained.

#### *How the hoist failed*

I accept the opinion of Mr Copleman regarding how the hoist failed. I find that as the hoist took the weight of Mrs Oates, the worn nut finally detached from the bolt below the scale unit, thereby causing the spreader arm (with the sling attached holding Mrs Oates) to completely separate from the main part of the hoist and drop suddenly to the floor.

#### *Servicing of the Hoist*

I initially observed that the hoist underwent regular servicing by two separate service providers outside St Anns. The general maintenance and servicing of the hoist was conducted by Aidacare Healthcare Equipment on an annual basis. The scales were serviced and calibrated at approximately six monthly intervals by the Tasmanian Scale Company.

The general servicing conducted annually by Aidacare was designed to ensure that the hoist was in full working order and safe for use. In the servicing, the Aidacare technician worked through a checklist involving the checking and testing of most aspects of the frame and hardware - the control system and electrical components, castors, load testing and labelling. Specifically, the technician was required under the checklist to check all fasteners for wear and security, to check all moving parts for wear, and to check moving mechanisms for safe operation.

The hoist had last had an annual service on 30 May 2018, just over 13 months before the incident. The next service was due on the 30 May 2019, a month before Mrs Oates suffered her fatal injuries. If the hoist had been subject to an annual service on or before that date, it is quite feasible that the defects with the crucial nut and bolt would have been apparent and remedied by the service technician. However, there is no evidence as to when the issue occurred and thus when it could reasonably have been detected. The failure to have the

hoist serviced on or before the due date nevertheless represented a lost opportunity to have prevented the failure of the hoist and Mrs Oates' death.

St Ann's Quality Manager, Judi Baker, explained the delay in annual servicing as being due to the facility's decision to transition to having one service provider to service all components of the hoists. She said that the transitioning process caused a short delay in reinstating the annual servicing. Ms Baker stated that St Anns is continuing with the annual servicing of its hoists, together with an additional process of monthly hoist checks by on-site maintenance staff.

#### *Servicing of the scales*

The scale on the hoist was last serviced by Mr Philip Sherston of Wedderburn Scales on 3 May 2019, two months before the incident involving Mrs Oates. Mr Sherston provided a detailed affidavit regarding his work on that date.

This service occurred at the request of St Anns because the scale on the hoist was malfunctioning and showing an error message on the LED screen. After numerous attempts to correct the issue on site at St Anns, Mr Sherston removed the scale component from the arm of the hoist and took it to the workshop to conduct tests. After locating and fixing the issues with the scale, Mr Sherston returned to St Anns and reattached the scale to the arm (jib) of the hoist.

In his affidavit, Mr Sherston stated that he had no need to touch the bottom nut, being the nut that failed in the incident. He explained that he removed and replaced the scale by only removing the top nut. I accept his evidence. He said that he did not overtighten that nut upon replacement due to it being a "captive" nut. He said that to the best of his recollection, the bottom nut on the scale was tight and there was no wear causing the bottom bracket to become loose. It does not appear that his recollection was clear on this point or that his specified work extended to checking the bottom nut, even though it was attached to the bolt in the scale. Given that his task was limited to the scale malfunction, I make no criticism of him.

#### **Concluding comments**

There is no indication upon the evidence that the failure of the hoist in the manner described has ever occurred previously, either at St Anns or in other facilities in Tasmania. Both Mr Coppleman and Mr Sherston, with their many years of experience, had not known of such an occurrence. However, both commented that the integrity of any critical nut and bolt combination could be effectively reinforced by a split pin and/or Loctite adhesive. The

investigating officer commented in his report that a properly rated split pin would have held the nut in place and prevented the tragic incident.

### **Recommendations**

1. I **recommend** that all facilities using mobility hoists review their maintenance schedules to ensure that they are serviced at intervals which are appropriate to detect and prevent failure of the components.
2. I **recommend** that technicians responsible for servicing mobility hoists use thread locking adhesive (such as Loctite) and/or split pins to provide additional security to critical, load-bearing nuts and bolts.

### **Acknowledgements**

I extend my appreciation to investigating officer Constable Shane Walters and to the Coroner's Associates for their assistance in this case.

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

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

**Olivia McTaggart**  
**Coroner**