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 Pamela Ila Paynter

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

a) The identity of the deceased is Pamela Ila Paynter.

b) Mrs Paynter was born on 5 October 1941 and was aged 80 years when she died. She was married and was a retired stenographer. She was a resident of Queen Victoria Care nursing home in Lindisfarne, having resided at that facility since June 2016. Although she had been in reasonable health for most of her life, she suffered a debilitating stroke in 2005 which caused incapacity. She also suffered hypertension. Her health and mobility gradually deteriorated during her time at the nursing home.

During the afternoon of 3 March 2022, Mrs Paynter rang her call bell in her room. When a member of the care staff entered the room, she was on the floor on her right side, having fallen. She was conscious and assessed by the Clinical Coordinator, who noted that she had bruising on her right hand but appeared to have a normal range of movement in her upper and lower limbs and no evidence that she had suffered a head strike. Mrs Paynter was transferred back to her bed and indicated that she did not wish to have any treatment or to be transported to hospital. Her doctor was notified of her fall and referred Mrs Paynter for assessment by geriatrician, Dr Jane Tolman. Dr Tolman considered that Mrs Paynter may have fractured her right neck of femur and, in light of her refusal to attend hospital and her deteriorating state, palliative care in the nursing home was appropriate. A meeting between family members and doctors occurred, and subsequently, Mrs Paynter was administered pain-relieving medications via syringe driver. She passed away in the early hours of 10 March 2022.

c) Mrs Paynter's cause of death was terminal exacerbation of congestive cardiac failure due to a fracture of the right neck of femur following her fall in the nursing home.

d) Mrs Paynter died on 10 March 2022 at Lindisfarne, Tasmania.

In making the above findings, I have had regard to the evidence gained in the investigation into Mrs Paynter's death. The evidence includes: the police report of death for the coroner, affidavits confirming life extinct and identification, an opinion of the forensic pathologist regarding cause of death, a report, correspondence and records from the nursing home.

Comments

I note that Mrs Paynter, at the time of her fall on 3 March, was assessed by the nursing home to be a low falls risk. This assessment occurred on 18 February and it was noted on the assessment documentation that she had not suffered a fall in the previous 12 months. Mrs Paynter wore a call bell pendant and had access to the call bell at bed height. She was also subject to frequent checks. I am satisfied that appropriate falls assessment and prevention measures were implemented by Queen Victoria Care nursing home in respect of Mrs Paynter. No other action could reasonably have been taken to prevent her fall.

In the nursing home's report for the investigation, it was noted that due to a previous coronial investigation of a falls-related death within the nursing home, an audit was conducted of all residents' falls risk assessments to identify any gaps and to ensure the assessments had been actioned and reviewed. This initiative is to be commended. It was in the course of this audit that the nursing home specifically updated Mrs Paynter's falls risk assessment two weeks before her death.

The circumstances of Mrs Paynter'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 Paynter.

Dated: 10 August 2022 at Hobart Coroners Court in the State of Tasmania.

Olivia McTaggart
Coroner