MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Robert Webster, Coroner, having investigated the death of John Neville Howse

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

a) The identity of the deceased is John Neville Howse (Mr Howse);

b) Mr Howse died in the circumstances set out below;

c) Mr Howse's cause of death was a subdural haemmorrhage (haematoma) following a fall at a residential aged care facility; and

d) Mr Howse died on 7 May 2020 at Sandy Bay, Tasmania.

Introduction

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Mr Howse's death. The evidence includes:

- The Police Report of Death for the Coroner;
- Affidavits as to identity and life extinct;
- An opinion of the forensic pathologist Dr Andrew Reid;
- Affidavit of Ms Joanna Macalpine;
- Emails between the Coroners' office and Ms Macalpine;
- Records obtained from the Sandown Residential Aged Care Facility;
- Mr Howse's medical records obtained from the Royal Hobart Hospital (RHH); and
- Report of the coronial medical advisor Dr Anthony Bell MB BS MD FRACP FCICM.

Background

Mr Howse was born on 25 November 1927 in India. At the date of his death he was 92 years of age, a widower and he resided at the Sandown Apartments and Residential Aged Care Facility (Sandown) in Sandy Bay. Mr Howse joined the Army when he was 16 years of age and during his first 3 years he was stationed in North Africa.

In 1957 Mr Howse graduated as a veterinary surgeon in London and in 1959 he met his future wife Vivian and they moved to Australia in 1963. Mr Howse bought a veterinary practice in Rainbow Street, Coogee in New South Wales. Mr and Mrs Howse subsequently returned to England and in 1979 Mr Howse graduated from the University of Liverpool with a Master's degree in veterinary science and that same university awarded him a PHD in 1987. In 1993 Mr and Mrs Howse moved to Tasmania to retire.

Mrs Howse died in 2001 and from that point until 31 March 2020 Mr Howse resided alone in their home in Sandy Bay. When Mr Howse married he became a step father to 2 daughters. His own daughter to Mrs Howse, Joanna Macalpine, was born in 1960.

Health

Mr Howse was a very fit man. He took up bushwalking when he moved to Tasmania and he was still a member of the Hobart Walking Club in 2019. He walked extensively. During the last 2 years of his life his walks were closer to his home and they were shorter.

In or about 2018 on a trip to Tasmania Ms Macalpine noticed her father did not look well and so she took him to the doctor. He came to consult Dr Chamberlen and over the next few weeks a number of tests were conducted and Mr Howse was diagnosed with early stage Alzheimer's disease. A home support package was organised and he continued to live at home.

Mr Howse continued to see Dr Chamberlen regularly but he did not see his general practitioner, Dr Halliday, as regularly as Dr Chamberlen wanted him to. Mr Howse was keeping a daybook or diary to keep abreast of what he had to do and what he had done each day, he had been suffering from back pain and he had been seeing a physiotherapist. On or about 4 March 2020 Ms Macalpine noted her father had lost weight and from the diary he appeared not to be going out anymore. He was not walking due to increased back pain. The next day Dr Chamberlen was consulted, some tests were organised and it was determined Mr Howse had an infection in his spine. He was admitted to St John's Hospital on 10 March 2020 and treated with antibiotics and he responded well. He gained some weight and his mobility improved. On the 31 March 2020 he moved into Sandown.

Circumstances Leading To Death

On 4 May 2020 Mr Howse had an unwitnessed fall. Staff at Sandown attended a call bell at which time Mr Howse advised of the fall and it was noticed he had blood on his right brow and on the bridge of his nose. On assessment he was alert and responsive, he was responding to verbal commands and there was no change to his level of consciousness. Mr Howse advised staff when he got up from bed and stood up he felt dizzy and he fell on the floor hitting his head. He complained of pain at the base of his neck. A head to toe assessment was done and skin tears on the right brow area and nose were noted. These wounds were treated. He was able to mobilise both upper and lower extremities without difficulty and he had a strong grip strength.

On 6 May 2020 Mr Howse was transferred to the RHH by Ambulance Tasmania at the direction of the general practitioner due to a deterioration in his condition. After an assessment and a CT scan of the brain it was determined Mr Howse had suffered a subdural haemorrhage. The RHH notes suggest Ms Macalpine was spoken to by a doctor who advised that this was likely a life ending event. The notes say:

> "*aim at present is to keep John comfortable and support him in the terminal phase. Daughter understandably upset but in agreeance. Advised that this can happen at the RACF (confirmed nursing home regarding this). Daughter happy with same. Discussion on likely progression*."

Palliative care was commenced and Mr Howse was transferred back to Sandown at approximately 13:32 hours on 7 May 2020. He passed away at Sandown at approximately 17:15 hours on that day.

Investigation

The forensic pathologist Dr Andrew Reid conducted a post mortem examination on 8 May 2020. He noted a history which he says includes the view of the RHH that the subdural haematoma was inoperable. Dr Reid says the cause of death was the subdural haemorrhage which was caused by the fall. I accept Dr Reid's opinion.

Subsequent to Mr Howse's death Ms Macalpine determined her father had visited the pharmacy on Sandy Bay Road by himself on 4 May 2020. Mr Howse was a long time customer of that pharmacy. The assistant, who knew Mr Howse, helped him buy a nail brush. A receipt has been obtained from the pharmacy which proves that purchase on that day.

Sandown were therefore asked whether they had any records of Mr Howse leaving the nursing home on that day, whether he was kept in a secure ward or unit due to his dementia and an explanation of the process if he wished to leave the nursing home. In response Sandown advised it had no record to show Mr Howse left the home to visit the pharmacy on Sandy Bay Road on 4 May 2020. In addition Sandown has no specific wing for residents with dementia and Mr Howse was not at a stage where he needed to be in a secure wing. Finally Sandown advised:

> "*[a]ged care is about 'choice' for our residents. If John wished to go for a walk and he had capacity to do so, then that would be his choice. As stated on his diagnosis he had early Alzheimer's disease and was still making independent judgement about his health care needs. As a nursing home we were here to support his choices, provide encouragement and care as required.*"

In correspondence to the Coroners' office Ms Macalpine says the response of the nursing home is "wholly unsatisfactory". She says the response ignores the fact the nursing home was in COVID lock down at the relevant time. She says:

> "*that a lockdown was meant to be in place is evidenced by the fact that I was not permitted to visit my father in the month leading up to his death – until his final couple of hours.*"

Ms Macalpine expresses her disappointment that this office appears unable to make what she says is the simple connection between a Government mandated lockdown of the Tasmanian nursing home sector and its lack of implementation by this particular facility. She also says this investigation was opened at the instigation of the coroner not at her request.

Dealing with the second point Ms Macalpine raises first. A coroner has jurisdiction to investigate a death if it appears to the coroner the death is or may be a reportable death.[1] A reportable death includes a death where the body of a deceased person is in Tasmania or the death occurred in Tasmania or a cause of the death occurred in Tasmania – being a death that appears to have been unexpected, unnatural or violent or to have resulted directly or indirectly from an accident or injury.[2] I accept this investigation was not opened at Ms Macalpine's request. My predecessor determined Mr Howse's death was a reportable death and therefore his duty was to investigate it. I agree with that determination.

Mr Howse's death occurred when Tasmania, like the rest of the world, was dealing with the ravages of the COVID-19 pandemic. It caused and continues to cause amongst other things

[1] Section 21(1) of the *Coroners Act 1995*.
[2] Section 3 of the *Coroners Act 1995*.

grief, heartache, restrictions on a person's liberty, isolation and economic hardship. The effects of the pandemic will probably be felt for many years to come. In Tasmania the Director of Public Health (the Director) has the power to declare the existence of a public health emergency.[3] My research suggests a public health emergency was first declared in Tasmania on or about 17 March 2020.[4] That declaration, for the purpose of this case, was extended to cover the period 28 April until 4 May 2020.[5] The declaration was extended beyond this date.[6]

While an emergency declaration is in force the Director may take any action or give any directions to:

> *"(a) [Section 16 Subsection (1) amended by No. 4 of 2015, s. 9, Applied:01 Jul 2015] manage a threat to public health or a likely threat to public health; or*
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> *(b) [Section 16 Subsection (1) amended by No. 4 of 2015, s. 9, Applied:01 Jul 2015] quarantine or isolate persons in any area; or*
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> *(c) evacuate any persons from any area; or*
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> *(d) prevent or permit access to any area; or*
>
> *(e) control the movement of any vehicle."*[7]

Accordingly in order to manage the threat to public health posed by COVID-19 the Director made many directions under s16 of the *Public Health Act* 1997. The relevant directions in this case are the gatherings direction, the stay-at-home requirements direction and the direction with respect to residential aged care facilities. Gatherings direction number 7 covered the period from 14 April 2020 until 10 May 2020. It prohibited people who owned, controlled or operated certain specified premises from opening and/or operating those premises; e.g. restaurants, cafes, hotels and motels. This direction also prohibited people who provided a specified service from providing that service; e.g. religious gatherings or ceremonies, services provided by beauticians and the like, auctions and open homes provided by real estate agents, exercise services and social sporting activities. Finally it limited the number of people who could gather on premises. Pharmacies and residential aged care facilities were not prohibited from operating during this period and the gathering limits did not apply to either pharmacies or residential aged care facilities. Stay-at-home direction number 3 covered the period from

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[3] Section 14 of the *Public Health Act 1997*.
[4] Tasmanian Government Gazette dated 24 March 2020 at page 147.
[5] Tasmanian Government Gazette dated 6 May 2020 at page 315.
[6] Tasmanian Government Gazette dated 13 May 2020 at page 329.
[7] Section 16(1) of the *Public Health Act 1997*.

14 April 2020 until 10 May 2020. That direction required each person in Tasmania to remain in, or on, the person's primary residence unless the person leaves the primary residence for a number of specified purposes such as attending medical appointments or to shop for supplies or services at premises which are lawfully operating while the direction is in force.[8] A direction with respect to residential aged care facilities was also in force. Direction number 3 covered the period between 21 April 2020 and 4 May 2020 and direction number 4 covered the period from 5 May 2020 until 11 May 2020. Directions 3 and 4 were in exactly the same terms. Those directions prohibited people from entering or remaining on the premises of a residential aged care facility unless they fell within certain specified exceptions. One such exception was if the person was a resident of the residential aged care facility and another was if the person was present at the premises for the purposes of end of life support for a resident of the residential aged care facility. Under those directions the operator of the residential aged care facility was obliged to take all reasonable steps to ensure a person does not enter, or remain on, the premises of the residential aged care facility if the person was prohibited from doing so. In summary on 4 May 2020 there was therefore no direction in force which prohibited Mr Howse from leaving Sandown and attending his local pharmacy to purchase items after which he was permitted to return to Sandown.

The coronial medical consultant Dr Anthony Bell has considered this matter. He notes Ms Macalpine is concerned the walk to the pharmacy and return contributed to her father's fall and death. Dr Bell notes that prior to the fall Mr Howse had a falls risk assessment at which he was assessed as a low risk of falling. Dr Bell notes Mr Howse fell at 23:30 hours on 4 May 2020 and what occurred thereafter. He says the neurosurgical team at the RHH considered the lesion sustained in the fall was inoperable. The distance to the pharmacy from Sandown is approximately 450 m. Mr Howse would have walked approximately the same distance on the return journey. Given that distance and the fact the fall occurred at approximately 23:30 hours Dr Bell does not believe the walk contributed to the fall. In addition he says given the age and condition of Mr Howse the walk was good for him. I accept Dr Bell's opinion.

Comments and Recommendations

The circumstances of Mr Howse's death are not such as to require me to make any comments or recommendations pursuant to Section 28 of the *Coroners Act* 1995.

I convey my sincere condolences to the family and loved ones of Mr Howse.

[8] There were a number of other specified purposes for which a person in Tasmania could leave their primary residence such as for undertaking personal exercise, seeking veterinary services, attending school, study and the like.

Dated: 20 January 2023 at Hobart in the State of Tasmania.

Robert Webster

Coroner