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 Barry Neil Munnings

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

a) The identity of the deceased is Barry Neil Munnings.

b) Mr Munnings was born on 29 August 1935 and was 86 years of age at his death. He was married and, since June 2020, he had been a resident of Corumbene nursing home in New Norfolk. Mr Munnings had a number of significant health conditions, including emphysema, heart issues and frailty. He also suffered cognitive impairment which resulted in a lack of judgement and insight, especially in relation to his mobility requirements. In the year of his death he had three falls, all unwitnessed, with minor or no injuries sustained on each occasion. In both September and October 2021 Mr Munnings had admissions to hospital for pneumonia.

In the early hours of 1 December 2021 Mr Munnings was heard by nursing home staff to be calling out. He was discovered on his bathroom floor and said to staff members that he had been going to use the toilet and his legs gave way. He was assisted to bed with analgesia and later in the morning, he was reviewed by his general practitioner. As a result of concerns by his general practitioner, he was transported to the Royal Hobart Hospital where investigations revealed acute rib fractures and fracture of the T4 vertebra. He was moving all limbs without pain and his abdomen was not tender. One of the hospital clinicians contacted Mr Munnings' general practitioner who was happy to place Mr Munnings back to the nursing home on the basis that he would be provided with adequate pain relief, physiotherapy and a repeat chest x-ray within a few days. Mr Munnings stayed overnight in the Royal Hobart Hospital emergency medical unit and in the late afternoon of 2 December 2021, was transferred back to the nursing home. His

condition deteriorated the following day and, after discussions with family and his doctor, Mr Munnings was transferred to the New Norfolk District Hospital with a poor prognosis. On 4 December 2021 Mr Munnings became acutely unwell with pneumonia and palliative care was commenced. He died that evening with family members at his side.

c) Mr Munnings died on 4 December 2021 at New Norfolk, Tasmania.

In making the above findings, I have had regard to the evidence gained in the investigation into Mr Munnings' death. The evidence includes the police and hospital reports of death; affidavits confirming life extinct and identification; an opinion of the forensic pathologist regarding cause of death; affidavits of Mr Munnings' wife and daughter; medical records and reports, nursing home report, correspondence and records review by coronial nurse consultant.

Comments and Recommendations

I am grateful for the detailed review by Ms L Newman, coronial forensic nurse, regarding the nursing home's falls management strategies and practices so far as they were relevant to Mr Munnings. From Ms Newman's review and from information received from the nursing home I make two particular comments;

(a) There was difficulty in obtaining clear records from the nursing home regarding the falls prevention strategies put in place for Mr Munnings.

(b) At the time of his fall on 1 December 2021, Mr Munnings had been assessed by the nursing home as having a medium risk of falling, and a range of standard prevention strategies were in place. I am satisfied that, in fact, he should have been assessed as a high falls risk. The assessment of medium risk did not reflect Mr Munnings' risk-taking behaviours and non-compliance with supervision whilst mobilising. It does not appear that a bed sensor had been considered for Mr Munnings, which may have alerted staff to his presence out of the bed. I recognise, however, that even additional falls prevention measures may not have prevented the fall leading to Mr Munnings' death.

I **recommend** that Corumbene nursing home review its falls risk assessment procedures and prevention strategies; and, further, review the manner in which these are documented so as to ensure that the reasoning for any individual assessment and the strategies to be implemented are clearly recorded.

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

Dated: 30 January 2023 at Hobart Coroners Court in the State of Tasmania.

Olivia McTaggart
Coroner