



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 Ross Stuart Blades

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

- a) The identity of the deceased is Ross Stuart Blades, date of birth 5 September 1952.
- b) Mr Blades was 71 years of age, was married and retired from his employment at the Australian Maritime College. He has two children with his wife. In late 2021, Mr Blades was diagnosed with Alzheimer dementia. In 2023, he was diagnosed with squamous cell carcinoma which required ongoing treatment. In January 2024, Mr Blades became a resident of Southern Cross Care Glenara Lakes residential aged care facility ("RACF") in Youngtown due to the progression of his dementia. His condition deteriorated rapidly during his time at the RACF, including the worsening of a pre-existing pressure injury to his sacrum. On the morning of 21 May 2024, Mr Blades was unexpectedly found deceased on the floor beside his bed. He had been sleeping when checked by staff at intervals through the night.
- c) I am satisfied that thorough postmortem investigations were undertaken by the State Forensic Pathologist, Dr Andrew Reid. These investigations included a detailed review of Mr Blades' scalp tumour (squamous cell carcinoma) and sacral pressure injury. A post-mortem CT scan was also undertaken. Dr Reid noted that pneumonia was detected but there were no significant traumatic injuries. I accept Dr Reid's conclusions and find that Mr Blades died as a result of natural causes, being RACF acquired pneumonia and Alzheimer dementia. His lower sacral tissue pressure injury, squamous cell carcinoma and frailty of age were also contributors to his death.
- d) Mr Blades died on 21 May 2024 at Youngtown, Tasmania.

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

- The Police Report of Death for the Coroner;
- Affidavits confirming identity;
- Opinion of the forensic pathologist regarding cause of death;
- RACF records, including Root Cause Analysis; and
- Review by the Coronial Nurse.

Comments and Recommendations

Mr Blades died of natural causes and his fall or roll out of bed did not contribute to his death. Nevertheless, the RACF identified in its Root Cause Analysis several significant areas of deficit in relation to falls assessment and prevention in respect of Mr Blades. Appropriate recommendations have been made to address these issues and should be implemented as soon as reasonably possible.

More relevantly to the coronial investigation, the Root Cause Analysis identified deficiencies in wound care and wound management (including a lack of documentation) for Mr Blades' sacral pressure injury. Again, recommendations were made to address the issues which should now have been implemented. Although the wound was one contributing factor in Mr Blades' cause of death, the evidence does not allow me to find that the wound had obviously been neglected, or that any deficiencies in care of the wound contributed to death. Dr Reid commented in his report that such injuries can progress rapidly for multifactorial reasons, even with optimum care and treatment.

I **recommend** that the RACF reviews its policies and practices relating to wound care, wound management and wound documentation at regular intervals to ensure that the appropriate standards are maintained.

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

Dated: 1 November 2024 at Hobart, in the State of Tasmania.

Olivia McTaggart
Coroner