



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 Lester Basil Bradburn

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

- a) The identity of the deceased is Lester Basil Bradburn, date of birth 3 April 1950.
- b) Mr Bradburn was 73 years of age at the time of his death and was a resident of Respect Aged Care Derwent Views residential aged care facility (the RACF). Mr Bradburn worked as a school bursar prior to his retirement in 2014. He was generally fit and well during his working life. In about 2019, Mr Bradburn was diagnosed with Parkinson's disease. This condition progressed and caused him to have falls at home. In July 2023, Mr Bradburn had a fall at his home. He was admitted to hospital and remained an inpatient awaiting placement in an RACF due to his general deterioration. He was transferred to the RACF on 24 October 2023. He had two falls following his admission without sustaining injury.

On 4 November 2023, at about 4.45am, Mr Bradburn left his room and was wandering around the facility without his walking aid and eyeglasses. A member of the facility's catering staff entered through the unlocked front door of the RACF and Mr Bradburn appears to have used this opportunity to make his way outside. Upon exiting the front door at 5.00am, he tripped on the top step and fell down a set of six stairs. He was transported to the Royal Hobart Hospital where he was assessed as suffering multiple traumatic head, chest and bony injuries. He subsequently developed delirium and deteriorated. He was transitioned to palliative care and passed away in the Whittle Ward five days after his admission.

- c) Mr Bradburn died of traumatic head, facial and chest injuries caused by his fall down the steps of the RACF.
- d) Mr Bradburn died on 9 November 2023 at Hobart, Tasmania.

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

- The Police Report of Death for the Coroner;
- Tasmanian Health Service Death Report to Coroner;
- Affidavits as to identity and life extinct;
- Opinion of the forensic pathologist regarding cause of death;
- Report by Coronial Nurse, Kevin Egan;
- Affidavit of Anne Bradburn, wife of Mr Bradburn; and
- Medical records, report and review from the RACF.

Comments and Recommendations

The significant issue raised by the evidence is whether Mr Bradburn's death could have or should have been prevented by the RACF. In his review, the Coronial Nurse identified four areas of concern which I make comment upon below.

The floor sensor was not activated by Mr Bradburn

Mr Bradburn had chair and floor sensors in place to detect his movements. Relevantly, the floor sensor mat did not activate to signal to staff that he had left the room. I am satisfied that the sensor mat was operational. The RACF provided a report that Mr Bradburn may have left his bed on the opposite side or stepped off the side of the mat. In these circumstances, it would not have activated.

The front door of the facility was unlocked in the early hours of the morning

At the time of Mr Bradburn's fall, the front door to the facility was locked between the hours of 5.00pm and 6.00am. After 6.00am, the front door apparently remained unlocked for any person to freely come and go. The RACF did not provide detailed information as to the usual security arrangements whilst the doors were open. In any event, the RACF has subsequently changed the times for the locking of the front door; this is now occurring between 5.00pm and 7.00am. Staff of the facility (and presumably those with legitimate reason to enter) have access to an intercom as well as the contact number of the nurse in charge if they wish to enter the facility before 7.00am. To exit the facility after hours, a staff member enters a designated code on a keypad located near the exit door. This change was implemented to improve safety measures for residents. These measures appear reasonable. If such measures had been in place on 4 November 2023, Mr Bradburn would not have been able to exit the facility undetected and would not have fallen.

Lack of a wandering alarm for Mr Bradburn

Mr Bradburn had only been admitted to the facility for 10 days before his fatal fall. However, during that time he had already been documented as wandering, falling and rising early. In its report for the investigation, the RACF stated that Mr Bradburn's comprehensive care plan was still being developed. Further, it had received a care plan from the Royal Hobart Hospital which did not indicate any wandering or exit-seeking tendencies whilst he was an inpatient there. The RACF did not therefore consider at that early stage that the restrictive practice of a wandering alarm was necessary for Mr Bradburn. In hindsight, a wandering alarm might have been appropriate in light of his wandering, his lack of orientation to time, and the two falls he had already had.

Adequacy of staff checks of Mr Bradburn and documentation of checks

The RACF, in its report, provided a call bell record indicating that Mr Bradburn was visually checked by staff at 4.42am on 4 November 2023 in response to his call bell activation just prior to that time. This was shortly before he left his room. Additionally, the call bell record indicated that he was attended to on at least two occasions previously during the evening. The RACF staff members did not at that time make contemporaneous entries in the records as to when Mr Bradburn was checked or sighted. The RACF's documentation of checks of residents, particularly those prone to wandering and falls, should be reviewed.

I **recommend** that Respect Aged Care Derwent Views reviews its policies and processes surrounding the safety of residents, particularly those who are prone to wandering and falls including, but not limited to:

- Adequacy and timeliness of risk assessments upon admission;
- Access to and from the facility;
- The adequacy of existing sensors to detect movement; and
- The checking of residents overnight.

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

Dated: 18 November 2024 at Hobart, in the State of Tasmania.

Olivia McTaggart
Coroner