



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 Jane Ann Chapman

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

- a) The identity of the deceased is Jane Ann Chapman, date of birth 31 March 1948.
- b) Mrs Chapman was 74 years of age. She lived in Zeehan with her daughter, Tracie Chapman, and her daughter's partner. Her medical conditions included Type 1 diabetes, epilepsy, atrial fibrillation, hypertension and osteoporosis.

On Saturday 25 June 2022, Tracie Chapman called an ambulance with concerns regarding her mother's sudden onset of confusion and incontinence. Ambulance Tasmania personnel attended Mrs Chapman's home address and transported her to the North West Regional Hospital where she was admitted to the Emergency Department. Mrs Chapman was assessed as having a fever, delirium and possibly a urinary tract infection. Following her assessment, Mrs Chapman fell from her trolley bed which resulted in a fracture to her right neck of femur. She was further evaluated as having diabetic ketoacidosis and pneumonia, also eventually testing positive for influenza A.

On 28 June 2022 Mrs Chapman was declared medically fit for surgery and underwent surgery to have her hip fracture repaired. After surgery she was monitored on the medical ward. On 29 June 2022, her condition deteriorated and she was transferred to the Intensive Care Unit due to high blood sugar from her diabetes and influenza symptoms. Mrs Chapman's condition stabilised and she was transferred back to the medical ward on 2 July 2022. However, her condition again began to decline on 3 July 2022, suffering post-operative exacerbation of delirium and terminal functional deterioration. She passed away on 4 July 2022 in hospital.

- c) Mrs Chapman's cause of death was post-operative exacerbation of delirium and terminal functional deterioration due to right hip hemiarthroplasty following a

right neck of femur fracture due to a fall from bed in hospital. Her other contributing medical conditions included influenza A and diabetes mellitus.

d) Mrs Chapman died on 4 July 2022 at Burnie, Tasmania.

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

- The Police Report of Death for the Coroner;
- Tasmanian Health Service Death Report to Coroner;
- Affidavits confirming identity;
- Opinion of the State Forensic Pathologist regarding cause of death;
- Affidavit of Tracie Chapman, daughter of the deceased;
- Notes made by Carol Peters, friend of the deceased;
- Medical review by Coronial Medical Consultant, Dr Anthony Bell;
- Tasmanian Health Service Final Root Cause Analysis Report; and
- Medical records from North West Regional Hospital.

Comments and Recommendations

Despite Mrs Chapman's illnesses, the major cause of her death was the consequences of her fall from the bed in the hospital's Emergency Department on the day of her presentation.

Mrs Chapman presented to hospital with delirium, a history of falls, limited mobility and advanced age. Staff were therefore aware that she was at significant risk of falling.

The occurrence of Mrs Chapman's fall was the subject of an independent Root Cause Analysis (RCA) Report as well as a review by the coronial medical consultant. It is apparent from the detailed RCA Report that the expert panel considered that there were four matters associated with the hospital environment and safety processes that contributed to the fall. These were as follows:

- Hospital-wide access block (bed blockage) which resulted in Mrs Chapman being in an area of the Emergency Department with reduced visibility for staff and more difficult for effective supervision;
- Staffing shortages which limited the capacity to provide close supervision of Mrs Chapman in accordance with her level of falls risk;
- A Hi-Lo bed was unavailable for use in the Emergency Department and therefore Mrs Chapman remained on an Emergency Department trolley which may have increased the risk of her falling; and

- Mrs Chapman's fall occurred only minutes after a staff member reviewed her and departed the room leaving the bed rails down and Mrs Chapman unsupervised.

I accept this analysis. I comment that the failure to lift Mrs Chapman's bed rails back into place, together with leaving her unsupervised, was perhaps the most significant and preventable cause of Mrs Chapman's fall. This omission itself may have partly been a product of a high hospital patient load at that time.

The RCA panel made various recommendations in response to the contributory causes. These included:

- Changing procedures to place patients with delirium or cognitive impairment in a high visibility Emergency Department area, or utilising a patient sitter;
- Sourcing additional Hi-Lo adjustable beds to accommodate patients in the Emergency Department with delirium or cognitive impairment; and
- Directions to staff for familiarisation with bed rail usage in the Emergency Department.

The RCA Report recommendations were accepted by the hospital and, I assume, were completed by 30 January 2023 in accordance with the timeframe specified in the report.

I **recommend** that the North West Regional Hospital re-visits the RCA recommendations and considers whether there is a current need to reinforce those recommendations and/or take any additional safety measures in order to prevent falls in the Emergency Department similar to the fall suffered by Mrs Chapman.

I convey my sincere condolences to the family and loved ones of Mrs Chapman.

Dated: 12 September 2024 at Hobart in the State of Tasmania.

Olivia McTaggart
Coroner