MAGISTRATES COURT TASMANIA

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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 Patricia Mary Webberley

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

a) The identity of the deceased is Patricia Mary Webberley (Mrs Webberley);

b) Mrs Webberley died as a result of the complications which resulted after she fractured her left wrist in a fall;

c) Mrs Webberley's cause of death was pneumonia; and

d) Mrs Webberley died on 12 November 2021 at Lindisfarne, Tasmania.

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

- The Police Report of Death for the Coroner;
- Affidavits as to identity and life extinct;
- Report of the forensic pathologist Dr Donald Ritchey;
- Affidavit of Pamela MacFarlane;
- Medical records obtained from the Tasmanian Health Service (Royal Hobart Hospital-RHH);
- Records and correspondence obtained from the residential aged care facility Queen Victoria Care (the RACF);
- Report of the coronial medical consultant Dr Anthony Bell MB BS MD FRACP FCICM; and
- Report of the Forensic Medicine Coronial Nurse Mr Kevin Egan.

Background

Mrs Webberley was 87 years of age (date of birth 19 November 1933), a widow and she resided at the Queen Victoria Care nursing home in Lindisfarne at the date of her death. Her parents were Eileen Bower and John Dare. Mrs Webberley grew up in the Montagu Bay area of Hobart and qualified as a nurse at Calvary Hospital. She married Eric Webberley on 30 July 1955. Mr and Mrs Webberley had four children of their own and they adopted another two children.

Mrs Webberley predominately performed home duties after she had her children, however, she did work in a number of other jobs over the years which included scallop splitting, home cleaning, as a butcher's assistant, working at the airport and as an electoral official. She last worked in a second-hand and baby and children's wear shop in Bellerive which she and her daughter, Mrs MacFarlane, owned.

Mrs MacFarlane says her father and mother moved into the RACF in 2015. Mr Webberley died in April 2020 and Mrs Webberley took his death quite hard. She was sad for a long period of time. Mrs MacFarlane says her mother's health started to decline after she sustained some mini strokes at the start of 2021. It was noted Mrs Webberley would spend a lot more time in bed and would not answer the telephone. Her daughter believes her mother suffered some depression for which she was prescribed antidepressants. However, Mrs Webberley experienced bouts of delirium and psychotic symptoms brought on by vascular dementia. Her quality of life was poor.

Circumstances leading to death

On 1 November 2021 at approximately 9:00pm, Mrs Webberley was located on the floor of her bathroom by staff at the RACF. The fall was unwitnessed and the time at which the fall occurred was not known. Mrs Webberley was assessed by a registered nurse who determined it was likely she had fractured her left wrist but had sustained no other injuries. Ambulance Tasmania was contacted and they attended at around 1:00am the next day, however, Mrs Webberley was not transferred to the RHH but was rather placed under observation at the RACF. A subsequent assessment by a geriatrician recommended a transfer to the RHH which took place at around 12:45pm on 2 November 2021.

Mrs Webberley was transferred from the RHH back to the RACF with the hospital confirming the fracture and two rectal bleeds. Mrs Webberley's wrist had been placed in a cast. Her condition deteriorated and she received pain medication via a syringe driver because she refused to take oral medication. On 6 November 2021 Mrs Webberley

commenced palliative care. She passed away at approximately 5:47pm on 12 November 2021.

Investigation

At approximately 6:15pm on 12 November 2021 police attended the RACF and located Mrs Webberley in her room. After examining the scene and Mrs Webberley, no suspicious circumstances were uncovered. Accordingly, officers from the Criminal Investigation Branch and Forensic Services of Tasmania police were not tasked to attend. Mrs Webberley was identified to the mortuary ambulance officer, Anthony Cordwell, by Tasmania police. He then wrote the name and date of birth of Mrs Webberley on an identification tag and attached it to the body. He then conveyed that same body to the mortuary at the RHH where he identified the body to another member of the mortuary staff.

The forensic pathologist Dr Donald Ritchey conducted a post-mortem examination and considered photographs and medical records on 15 November 2021. He noted Mrs Webberley had fallen at the RACF, had fractured her left wrist which was put in a cast, and she subsequently declined and was then provided with palliative care. He determined the cause of death was a fractured left wrist which was sustained in the unwitnessed fall and subsequently Mrs Webberley contracted pneumonia and died. Finally, Dr Ritchey noted Mrs Webberley suffered from dementia, atherosclerotic and hypertensive cardiovascular disease and frailty of age. I accept Dr Ritchey's opinion.

I arranged for the coronial medical consultant Dr Anthony Bell to examine this file. He was asked to examine and comment on the medical care Mrs Webberley received. He noted her past medical history of significance was as follows: Girdlestone's procedure (fusion of hip joint) and collagenous colitis; watery diarrhoea for many years. In 2019 Mrs Webberley sustained a lumbar spinal fracture and she was diagnosed with spinal canal stenosis in 2020. A CT of the lumbar spine in 2021 identified multiple abnormalities which caused back pain. Dr Bell also noted from November 2020 Mrs Webberley exhibited depression following the death of her husband. She became withdrawn, was teary, experienced auditory and visual hallucinations and became dependent on others for personal hygiene. She was experiencing worsening falls and she mobilized with a 4-wheel walker. A falls plan in action was in place.

At a geriatric review on 26 October 2021, Mrs Webberley was thought to be suffering from delirium that fluctuated depending on events happening around her. Medication changes were made to try and relieve that condition. On 1 November 2021 she was found on the floor of the bathroom. The fall was unwitnessed. There was a left wrist deformity. Mrs Webberley remained at the RACF overnight. The geriatrician reviewed her the next day and recommended a transfer to hospital. Mrs Webberley was taken to the RHH by ambulance.

The clinical assessment and radiology taken at the RHH confirmed a distal comminuted left radial fracture (Colles' fracture). A Bier's block was administered, and the fracture reduced and a plaster cast applied. A CT scan of the brain showed no acute injury. After the reduction of the wrist Mrs Webberley passed frank blood (volume 500 ml) from her rectum. A CT scan of the abdomen and an aortic angiogram were performed. There was severe diverticulosis in the sigmoid colon with dilation due to air and an air fluid level. There was no ongoing bleeding. Mrs Webberley was admitted to hospital.

Mrs Webberley was reviewed by geriatrics and surgery teams. A family and patient discussion was held with medical staff and a decision was made that no further investigations be carried out. The bleeding settled. Medications were adjusted. Mrs Webberley was discharged back to the RACF on 5 November 2021.

Mrs Webberley deteriorated significantly. She refused oral medication and therefore subcutaneous medication was administered as palliative comfort care after which she passed away.

Dr Bell concludes by saying Mrs Webberley was appropriately assessed and managed, and there are no medical issues with respect to the medical care she received. The trauma of the fracture and significant bleed were pre-terminal events. I accept Dr Bell's opinion.

Finally, I arranged for the coronial nursing consultant Mr Kevin Egan to review the falls strategies in place at the RACF, review the documentation provided and review that institution's responses to enquiries which were made. Mr Egan noted the chronology of events was as follows:

- 6 October 2015 – Admitted to RACF. She was admitted with her husband.
- 17 November 2017 – Fall in the RACF, no injury sustained.
- April 2020 – Mrs Webberley's husband passed away. Significant deterioration in mental health, depression, delirium, hallucinations.
- 22 June 2020 – Fall in the RACF, no injury sustained.
- 19 July 2021 – Fall in the RACF, no injury sustained.
- 13 October 2021 – fall in the RACF, no injury sustained. Paramedics attended and she was assessed but not transported to hospital.
- 1 November 2021 – unwitnessed fall in the RACF. Wrist/arm fracture. Paramedics attended that evening, not transported at that time. Reviewed by treating doctor in the morning and transported to hospital.
- 2 November 2021 – Transported to hospital after RACF review. Presented to emergency department and subsequently admitted for two nights. The treating

doctor was contacted by hospital staff while an inpatient and palliation / comfort care plan was agreed to.

- 5 November 2021 – retuned to RACF. Doctor review after which comfort/end of life care was initiated.
- 6 November 2021 – unwitnessed fall at RACF, nil injury. Mrs Webberley was refusing oral medications. Accordingly, there was a change to intravenous and subcutaneous medication delivery.
- 12 November 2021 – Mrs Webberley died.

Mr Egan noted Mrs Webberley's past medical history and Dr Ritchey's opinion with respect to her cause of death. He advised falls prevention is difficult with residents suffering from advanced dementia. It is not possible to supervise those residents continuously. For impulsive residents and those lacking insight, it is almost impossible to prevent falls and other incidents on all occasions. Even when under supervision, impulsive residents will act independently and without warning despite the best efforts of staff.

Responses from the RACF to the initial and subsequent questioning from my office still raise issues for Mr Egan with respect to the implementation of system and facility wide changes to the RACF's falls mitigation and prevention strategy as well as clinical governance and oversight. It would appear from the information provided by the RACF they are addressing identified clinical oversight issues, shortfalls in documentation, clinical oversight and monitoring and implementation of risk mitigation strategies across the facility. However, based on this information, Mr Egan has concerns with the RACF's management of clinical risks at the time of Mrs Webberley's falls. Suitable strategies may have been in place and being acted on by staff, however, the documentation of these is wanting, with clear gaps and areas of concern raised by the RACF's clinical governance and executive members.

The RACF provided additional information in May 2022. The Aged Care Quality and Safety Commission (the Commission) standards and mandatory facility responsibilities came into effect from 2023, with additional requirements being implemented later in 2023 and in 2024. The RACF would have to report to the Commission any failure to comply with the standards and any facility mandatory requirements.

Mr Egan listed the following issues, points of note or concerns:

- Dr Bell has undertaken a review of the medical treatments and decisions made and he has found no issues with the medical treatment and management provided.

- In the RACF's original response to the falls questionnaire, deficiencies in the falls assessment completed on 1 November 2021 were noted.[1] Specifically, the listed risk prevention strategies were not completed and did not include all the necessary strategies. It is unclear if the strategies were actually in place and implemented or not. There is insufficient information provided to assess this.
- The falls risk scoring progressing from low to high risk is not unusual and reflects the natural progression of dementia and progressive frailty.
- In the response to questions from my office of 3 May 2022, regarding the fall on 6 November 2021 (after the return from hospital), the response to question 8 identifies that *"[o]n night shift, residents are to be checked at least hourly."* However, responses to questions 5 & 6 both identify that the fall occurred around 12:36am (not 02:26am as originally documented) with the response to question 6 stating, *"I can confirm from the CCTV footage that care staff last attended to her at [10:36pm-10:38pm]."* This is over 2 hours between checks and clearly not in accordance with the RACF's requirement of residents being checked at least hourly on night shift.
- The RACF does not undertake residential rounding (frequent checks) during the day and afternoon shifts despite the fact that this is when most staff are available. The RACF says this was to be discussed at the next falls meeting (after this response was provided in May 2022) to *"further decrease the risk of residential falls."* Residential rounding is not just a falls mitigation strategy, it informs clinical monitoring, provides social interaction, continence management, pressure injury prevention and reduced anxiety and loneliness with regular, planned interactions. Not all residents can attend the social interactions in open spaces at the facility, so essentially excluding these residents with infrequent interaction is not, in Mr Egan's opinion, good clinical oversight. Additionally, as most falls in the RACF occur between 4:00pm and 8:00pm, then afternoon rounding may be an easily implemented mitigation strategy.
- In the *"Multi-D Falls Management Meeting Minutes"* dated 1 February 2022, the discussion at the meeting included looking at individual falls cases and an in-depth analysis to identify potential causes, which would indicate cases were not reviewed independently but rather as statistics and data.
- Additionally, those minutes note the RACF currently had 3 coroners' cases under investigation due to deaths post fall but they then indicate that the cause of death was unrelated to the falls. As this case demonstrates, that is not usually

[1] Letter from the RACF dated 2 February 2022.

the case. A fall involving an elderly person which results in a fractured hip, for example, ordinarily leads to that person's death.

- Another issue of note is that staff did not include sufficient information in falls assessments (e.g. the initial assessment provided for the 1 November fall), [2] and whether there was any way to amend these electronically after the fact. These appear to be chronic issues that possibly have not been addressed until my inquiry. I query whether this is a documentation quality exercise, and educational and staff development opportunity or a strategy to appear to have implemented strategies.
- The Minutes of the Clinical Governance Committee meeting of 27 January 2022 note some concerns in relation to clinical monitoring, and that the clinical monitoring is *"not at a level it needs to be with the current structure in place."* Additionally, it is noted in those minutes that the number of cases (falls) were not *'standard for a facility of this size'*, and it is an *'area of concern.'* Minuted falls numbers are 27 in November 2021, 20 in December 2021, and 30 in January 2022. There appears to be a small number of residents with repeat falls per month. Most falls have minimal or no injury, however, in about 20-25% of cases there is a documented injury.
- The staffing overnight is a concern, with a 1:24 staff to resident ratio.[3] This is noted in the RACF's response to be a 10-hour shift at the RACF. [4] The literature suggests that the time period 11:00pm – 7:00am (overnight) is least likely to have a fall (16%), with most falls (27%) occurring between 4:00pm and 8:00pm. Attending to falls however, is not the primary requirement for staff during overnight and evening shifts, and having such low staffing overnight is a concern given the comment made during the Clinical Governance Meeting about the lack of clinical monitoring and overnight care with continence management, pressure injury management, medications and resident reorientation and settling. Given the size of the facility (124 residents) I note there are distinctive 'wings' and units, or areas of separation with presumably one (1) staff member allocated to each section of the facility overnight and the one (1) registered nurse covering the facility as a whole.
- The answer to question 11 in the response of 3 May 2022 highlights corrective action to be undertaken for falls prevention. The only action appears to be staff education, which, from a systems viewpoint, is a weak preventative action as a standalone commitment. There is no mention of staffing changes, models of

[2] See page 6 of the RACF's letter of 2 February 2022.
[3] See page 5 of the RACF's letter of 2 February 2022.
[4] See page 3 of the RACF's letter of 3 May 2022.

care, rounding, teams working, medication and nutrition discussions, facilities upgrades, or staff alert systems as part of the system wide facility response.

- The workforce related responsibilities regulatory bulletin released by the Aged Care Quality and Safety Commission in 2023 summarises the responsibilities of an RACF which is to ensure 200 minutes of direct patient care per resident per day, with a registered nurse on site 24 hours per day and, the registered nurse providing 40 minutes of care per day per resident. At the staffing levels provided by this RACF at the time of Mrs Webberley's death the RACF would not meet this regulatory requirement. Given her death occurred in 2021, I note no such parameters were in place but the response to the falls questionnaire indicates the RACF was fully staffed on the day of Mrs Webberley's fall.
- There appears to be action planned to address some of the clinical supervision, documentation, and risk mitigation to residents in the documentation provided by the RACF. Given two and a half years have passed since the meeting of 1 February 2022 where the strategies are documented, I am interested to see what has transpired since, what strategies have been put in place and whether there has been a reduction in falls and other clinical incidents. In addition, the Clinical Governance Committee minutes from 27 January 2022 indicate a root cause analysis needed to be undertaken as the current issues have been ongoing and that a stronger model of care needed to be implemented with a recommendation to be provided to the Board. Again, I am interested to see whether the root cause analysis was conducted, what recommendation was made to the Board and what, if anything, has been implemented, when it was implemented and with what result. The responses to these queries will dictate what, if any, recommendations are made or indeed whether it is necessary to hold a public inquest.

RACF's Response

Given the issues raised in this decision, in particular those set out in the last dot point on page 8, a copy of my decision was forwarded to the RACF for comment prior to publication. A response was received from Kelly Moore, the Director of Care of the RACF, on 22 August 2024.

The regulatory requirements released by the Aged Care Quality and Safety Commission in 2023, which are set out in the first dot point on page 8, were noted and I was advised they were not in place at the RACF at the time of Mrs Webberley's death. Ms Moore says the RACF was fully staffed on the day of her fall in accordance with the standards and regulations applicable at that time. Since then the RACF has made improvements so that the

current regulatory requirements are now complied with. Additional positions have been created in clinical management and governance roles. This has resulted in positions which support the quality of care and allow the director of care role and two additional clinical manager roles to focus on improvement in services. The governance system results in a deeper reporting and analysis of incidents and clinical indicators which has resulted in better outcomes for the residents. A clinical needs facilitator has been appointed and that person promotes a coaching and mentoring approach to a resident's needs and identifies changes in a resident who are then identified as high-risk which results in a comprehensive case review with the multidisciplinary team. The breakdown of the facility into smaller communities and an increase in care staff with training in medication has assisted in greater clinical monitoring and supervision of residents with changing care needs. The RACF also has a pharmacist who participates in their clinical governance operational committee. In addition there is a GP who is committed to this facility.

Following the February 2022 meeting the RACF implemented several actions to enhance clinical supervision, improve documentation practices and strengthen the risk mitigation efforts for residents as follows:

- Enhanced clinical supervision: additional senior clinical leaders were appointed to oversee daily operations which ensures supervision is rigorous and that staff are supported in delivering high quality care. Although the 2023 regulations were not then in place the RACF increased staffing levels in order to move towards compliance including increasing RN coverage.
- Improved documentation systems and processes: the second stage of a best practice policy and procedures, quality assurance, incident management, competency and learning platform was implemented. All clinical and care staff received extensive training that is competency-based and there has been training on the new documentation and protocols which has focused on accuracy, thoroughness and timely updates to a resident's records which it is suggested has ensured a skilled competent workforce.
- Falls mitigation strategies: a comprehensive falls prevention program, which includes risk assessments for residents, individualised care plans, and the use of assistive devices as needed has been introduced. Regular audits are conducted to ensure adherence to the care plans and to identify areas for improvement. Falls champions have been introduced and staff have been trained in that regard. A governance quality and risk manager role and quality business partner role have been created to focus on risk management. Regular risk meetings have been held in order to conduct regular reviews of all clinical incidents, including

> falls to identify trends and implement targeted interventions. A clinical indicators and emerging risks reporting system has been implemented which permits the analysis of trends and which guides improvement.

Since the implementation of these strategies the RACF reports it has observed a significant reduction in falls and other clinical incidents within the facility. This improvement has been attributed to the enhanced supervision, tailored care plans and preventative measures which are now in place. A continuous monitoring system has been established to track all clinical incidents which has enabled the RACF to respond swiftly and effectively to any emerging risks, which it is said, has contributed to overall improvements in residents' safety and well-being.

In addition there has been a strengthening of communication channels across various staff groups by the provision of opportunities to meet in person and/or attend meetings. This has been done by the introduction of snapchats, regular briefings, needs rounding meetings, case reviews or toolbox meetings via a communication chart which has improved interdepartmental coordination and information flows.

The root cause analysis (RCA) directed by the clinical governance committee in January 2022 was conducted. It focused on:

- Clinical care delivery;
- Staffing and supervision;
- Resident risk profiles; and
- External auditor skill and capabilities.

The findings of the RCA were presented to the Board together with a set of recommendations which included the adoption of a stronger model of care, enhanced staffing ratios, leadership and an organisation structure review, and an investment in staff training and development. The Board approved and recommended an initial increase in clinical roles to model of care, which was implemented in March and April 2022 with further adjustments made to align with the 2023 reforms which were implemented in April 2024. This model, I am told, emphasises person centred care, proactive risk management and continuous improvement.

Since the implementation of the stronger model of care the RACF has observed marked improvements in both clinical outcomes and resident satisfaction. The care model has addressed the problems identified in the RCA and ongoing evaluations indicate sustained positive trends. Ms Moore says the RACF remains *"committed to ongoing evaluation and refinement of our practices to ensure the highest standards of care"*. Full accreditation of the

RACF was received in March 2023 and there were no recommendations for improvement made by the accreditation body. She says the RACF is *"dedicated to maintaining a culture of excellence and accountability, ensuring that the concerns raised in the investigation are fully and permanently addressed."*

Comments and Recommendations

Given the very comprehensive response by the RACF and the improvements in the care provided there is no need to make any comments and/or recommendations pursuant to s28 of the *Coroners Act* 1995. In addition I have determined an inquest is not necessary.

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

Dated: 27 September 2024 at Hobart in the State of Tasmania.

Robert Webster
Coroner