MAGISTRATES COURT TASMANIA

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 Leslie Bruce Whish-Wilson

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

a) The identity of the deceased is Leslie Bruce Whish-Wilson, date of birth 8 December 1947.

b) Mr Whish-Wilson was 76 years of age, was married and was a retired carpenter. Since January 2023, he had been a resident of the Toosey Aged and Community Care facility in Longford. His multiple medical conditions included ischaemic heart disease and atrial fibrillation, dementia, chronic obstructive lung disease, chronic kidney disease and transient ischaemic attacks. Mr Whish-Wilson was mostly independent in caring for himself and mobilising. He did not use a walking aid. However, at times he was confused and resisted care. He was also known to wander and his movements were monitored by a GPS watch and wandering alarm. Since his admission to the nursing home, he has had six falls with minimal injuries.

In the late evening of 21 January 2024, Mr Whish-Wilson had an unwitnessed fall in his room next to his wardrobe, possibly caused by entanglement in clothes. He was immediately attended to by staff and was transported to the Launceston General Hospital. In hospital, he was assessed as having sustained a fracture of the right neck of femur. He underwent surgical repair of the fracture but suffered from significant post-operative delirium and worsening dementia. On 27 and 28 January 2024, there were MET (medical emergency team) calls for hypoxia, severe agitation and respiratory distress. It appeared that he had pneumonia. Given his poor prognosis, his treating team and family members decided to withdraw active treatment and implement comfort measures. He was provided with palliative care and passed away in hospital on 29 January 2024.

c) Mr Whish-Wilson's cause of death was hospital-acquired pneumonia, age-related frailty, the consequences of a left neck of femur fracture and surgery, and his multiple medical comorbidities.

d) Mr Whish-Wilson died on 29 January 2024 at Launceston, Tasmania.

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

- The Police Report of Death for the Coroner;
- Tasmanian Health Service Death Report to Coroner;
- Affidavit confirming identity;
- Opinion of the forensic pathologist regarding cause of death;
- Review of care by Coronial Nurse Specialist; and
- Nursing home records and report to Coroner.

Comments and recommendations

Upon the evidence in the investigation, including an independent review by the Coronial Nurse, it appears unlikely that Mr Whish-Wilson's fall could have been prevented. Although he had a prior fall on 8 January 2024 (when he rolled from the bed) his falls had not escalated in the months before his death nor was there a noticeable change in his condition.

Mr Whish-Wilson's care in the nursing home appears to be of a generally good standard. However, there was limited information made available by the nursing home in this investigation as to what falls prevention strategies were in place for Mr Whish-Wilson. A falls risk assessment had not been completed since 2 February 2023 which resulted in him being assessed as a high falls risk.

The policy of the nursing home in performing falls assessments for residents annually (or as needed) is outside the Aged Care Safety and Quality Commission guidelines that recommend at least six-monthly falls assessments or after a change of resident status. In this case, good practice would also have required a falls risk assessment to be completed and fully documented after Mr Whish-Wilson's fall on 8 January 2024. Further, appropriately responsive prevention strategies should also have been immediately documented and implemented based upon that assessment. It is not possible to say, however, whether any additional prevention strategies may have reduced his chances of a further fall.

I **recommend** that Toosey Aged and Community Care reviews its practices and procedures relating to the frequency and documenting of falls risk assessments for residents and ensures that those practices and procedures comply with guidelines made by the Aged Care Safety and Quality Commission.

I **recommend** that Toosey Aged and Community Care reviews its practices and procedures relating to documenting and implementing falls prevention measures arising from a falls risk assessment for a resident.

I convey my sincere condolences to the family and loved ones of Mr Whish-Wilson.

Dated: 22 October 2024 at Hobart, in the State of Tasmania.

Olivia McTaggart
Coroner