



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 Dennis Edward Wragg

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

- a) The identity of the deceased is Dennis Edward Wragg, date of birth 3 December 1927.
- b) Mr Wragg was 95 years of age, widowed and lived independently in Somerset. He was a retired farmer. He had a medical history involving deep vein thrombosis, heart failure, prostate cancer and chronic kidney disease. On 11 October 2023, Mr Wragg was admitted to the North West Regional Hospital with fluid overload and possible cellulitis in the setting of heart failure. Although his immediate medical issues resolved, it was deemed unsafe for him to be discharged directly home and the plan was for him to remain in hospital until a respite placement became available. Unfortunately, on 22 October 2023, Mr Wragg had a fall in his hospital room, apparently whilst he was trying to walk to the bathroom without his four wheeled walker and unassisted by staff. He suffered a head strike and was assessed as having sustained multiple skull fractures complicated by a subarachnoid haemorrhage. The neurosurgical team at the Royal Hobart Hospital was consulted but did not recommend any intervention. Over the following ten days, Mr Wragg gradually deteriorated and was provided with comfort care in consultation with his family. He passed away on 2 November 2023.
- c) Mr Wragg died of head injuries (subarachnoid haemorrhage, frontal bone fracture and contrecoup) sustained in an accidental fall whilst a patient at the North West Regional Hospital.
- d) Mr Wragg died on 2 November 2023 at Cooe, Tasmania.

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

- The Police Report of Death for the Coroner;
- Tasmanian Health Service Death Report to Coroner;

- Affidavits as to identification;
- Opinion of the State Forensic pathologist regarding cause of death;
- Review by Coronial Nurse Specialist, K Egan;
- Medical records from North West Regional Hospital; and
- Tasmanian Health Service Final RCA Report.

Comments and Recommendations

As a patient, Mr Wragg was assessed as being orientated and cooperative. It appears that his decision to walk to the bathroom without supervision or his walking aid was an impulsive action on his part. I am satisfied that, prior to his fall, the nursing care plans for Mr Wragg were of a very good standard. Additionally, he was seen on five occasions by the physiotherapist and a mobility plan was documented in conjunction with the nursing care plan.

However, a *Falls Assessment Management Plan* should have been prepared following his admission in accordance with the correct processes required by the applicable *Falls Prevention and Management* protocol. Further, a *Falls Evaluation Team Review* was not undertaken following Mr Wragg's fall in accordance with that protocol to determine contributing factors.

It is unlikely in this particular case, where the care and documentation were already of a good standard, that even adhering to the correct procedures could have prevented Mr Wragg's fall.

I note that the panel authoring the *Tasmanian Health Service RCA Final Report* concerning this incident made recommendations to improve adherence to the *Falls Prevention and Management* protocol.

I **recommend** that the North West Regional Hospital provides education to staff on a regular basis regarding understanding and implementing the *Falls Prevention and Management* protocol.

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

Dated: 3 July 2024 at Hobart, in the State of Tasmania.

Olivia McTaggart
Coroner