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 OQ

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

a) The identity of the deceased is OQ, date of birth 8 January 1940.

b) OQ was 84 years of age, was a retired engineer and businessman, and lived with his wife, PR, in West Hobart. OQ had three adult sons. In about 2019, OQ had been diagnosed with Parkinson's disease. He was under the treatment of a geriatrician and was prescribed medication which assisted in the prevention of falls.

On 5 June 2024, OQ had his first major fall whilst walking with his wife. He was transported to the Emergency Department of Calvary Hospital in Lenah Valley ("Calvary Lenah Valley"). He sustained superficial facial injuries, but the CT scan showed no brain injury. The following day, 6 June 2024, OQ had a fall in hospital whilst returning from the bathroom. He did not suffer injuries from this fall. OQ remained an inpatient at Calvary Lenah Valley and, on 12 June 2024, a mini mental state examination showed a score of 13/30 consistent with moderate dementia. He was cleared for discharge from Calvary Lenah Valley but preparations were made to refer him to the Calvary St John's Rehabilitation Unit in South Hobart ("the Rehabilitation Unit").

On 19 June 2024 OQ was transferred to the Rehabilitation Unit. At 8.20pm on that day, OQ was discovered by Calvary staff shuffling on his bottom into the hallway. He told staff that he had fallen backwards and hit the back of his head on the floor and was unable to get up. His fall was not witnessed. Following a medical review and hourly observations, he was found not to have any discernible injury. The following day, OQ was noted to have deteriorated, with disorientation and confusion. The following day, 21 June 2024, OQ was transferred back to Calvary

Lenah Valley following a decreased Glasgow Coma Scale score.[1] A CT scan was performed which revealed a significant brain injury. Due to his poor prognosis, OQ was transitioned to palliative care. On 22 June 2024 OQ tested positive for the Covid-19 virus. OQ passed away on 28 June 2024.

c) OQ died of a head injury[2] sustained in a fall in the Rehabilitation Unit. Parkinson's disease, atrial flutter and Covid-19 infection were contributors to his death.

d) OQ died on 28 June 2024 at Lenah Valley, Tasmania.

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

- The Police Report of Death for the Coroner;
- Calvary Hospital Death Report to Coroner;
- Affidavits confirming life extinct and identity;
- Opinion of the forensic pathologist regarding cause of death;
- Calvary records, incident review and report to Coroner;
- Affidavit of PR, wife of OQ; and
- Medical review by Dr Anthony Bell, MD FRACP FCICM, Coronial Medical Consultant.

Comments and Recommendations

An issue arose in this investigation regarding whether OQ's fall in the Rehabilitation Unit which led to his death could have reasonably been prevented.

Whilst an inpatient at Calvary Lenah Valley, he was assessed as being a high falls risk. Following his fall on 6 June 2024, comprehensive falls prevention strategies were put in place. These included supervised self-care and toileting, low bed height, mobility aids and buzzer within reach. He was also assessed as requiring a patient sitter (or supervisor) for night duty. Shortly after his arrival at the Rehabilitation Unit, he was also assessed by a nurse and physiotherapist as being at high risk of falls. The same (or very similar) comprehensive falls prevention measures were put in place. However, a sitter/supervisor was not included and the need for a sitter was not communicated in the handover between Calvary Lenah Valley and the Rehabilitation Unit.

[1] A Glasgow Coma Scale score measures a person's level of consciousness after a head injury or neurological condition.
[2] Left lateral convexity acute subdural haematoma with (2mm) midline shift right.

In reports provided by Calvary for this investigation, Calvary indicated that the failure to communicate OQ need for a sitter was an oversight at the time and should have been included in the handover information, together with observations regarding OQ's cognitive decline.

Calvary also identified that he may have benefited by the use of a bed/chair alarm as a strategy to alert staff when he was mobilising. Calvary also found in its Serious Clinical Incident Investigation that OQ was allocated a room on the Rehabilitation Unit that was not ideal for high falls risk patients.

In correspondence for the investigation, Calvary Director of Clinical Services, Leah Magliano, also indicated that OQ's admission to the Rehabilitation Unit should have been delayed until his cognitive status had been further investigated. She stated:

> "*On reflection, we believe that by strengthening the critical information received at the time of handover from the transferring unit and this information being sought from a nurse who knows the patient, coupled with the completion of an enhanced pre-admission assessment process, in particular the addition of the presence of a patient supervisor and current cognitive assessment (either CAM/4AT) will ensure appropriate decisions are made prior to acceptance.*
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> *In incidences whereby the patient is identified as currently under supervision and/or current cognitive assessment will be flagged with the Rehabilitation VMO and only accepted if able to participate in their rehabilitation program. If the patient is accepted with these co-morbidities, then the Rehabilitation nursing leadership team will complete a risk assessment to determine the appropriate room allocation and continuation of patient supervision until it is deemed clinically appropriate to withdraw the patient supervisor.*
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> *On this occasion we believe OQ's admission to Rehabilitation Unit should have been delayed until his cognitive status had been further investigated*".

I find that the handover information regarding OQ provided to the Rehabilitation Unit was inadequate and, because of this, the Rehabilitation Unit did not put in place sufficient measures to mitigate the risk of OQ falling. In particular, a patient sitter/supervisor should have been present with OQ at the time of his fall. If this measure had been in place, his fall would likely not have occurred.

Calvary is in the process of adding an alert to its electronic systems regarding patients who require patient supervisors so that this critical information may be communicated as

handover information between nursing shifts and upon transfer of care to another clinical area.

Calvary has also revised the Rehabilitation Pre-Admission Assessment Screening Tool to include a specific question regarding whether the patient is currently under supervision by a patient supervisor and the results of any recent cognitive assessment of the patient. Patients who currently require a patient supervisor are now excluded from participation in the dedicated rehabilitation program.

In addition to the above responses, Calvary is also implementing, or has implemented, other related recommendations from its Serious Clinical Incident Investigation relating to this case.

I **recommend** that Calvary Hospital continues to review at appropriate intervals its processes for assessing the need of a patient for a patient supervisor; and also reviews the efficacy of procedures and communication at handover times relating to a patient's requirement for a supervisor.

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

Dated: 13 June 2025 at Hobart, in the State of Tasmania.

Olivia McTaggart
Coroner