MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

(These findings have been de-identified in relation to the name of the deceased and family by the direction of the Coroner pursuant to s 57(1)(c) of the Coroners Act 1995)

I, Olivia McTaggart, Coroner, having investigated the death of XT

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

a) The identity of the deceased is XT, date of birth 14 July 1938.

b) XT was 86 years of age and, since August 2024, she had been a resident of Meercroft Care Inc residential aged care facility (RACF) in Devonport. XTs medical conditions included cognitive impairment associated with Alzheimer's dementia, chronic back issues, hearing impairment and frailty. She had been appropriately assessed for falls risk at the RACF and various prevention measures had been implemented.

At 10.30pm on 25 January 2025 XT had an unwitnessed fall in the hallway outside her room. She was found by care staff lying on her back, distressed and agitated. An injury assessment was conducted. Weakness and pain were noted in the right leg/groin region, but she was able to move the left leg independently. It was not identified at that stage that she had suffered fractures. She was lifted from the floor to the bed using a hoist, this process caused her obvious pain. The general practitioner was contacted and did not consider that XT should be taken to hospital at that stage. However, XT remained highly distressed with pain in her right leg/hip and limitation of movement. An ambulance was called and, about four hours after her fall, she arrived at the emergency department of the North West Regional Hospital. Imaging revealed that she had sustained a right pubic rami fracture, which was not suitable for operative intervention. She was transferred back to the RACF in the afternoon of 26 January 2025. She

remained agitated and refused oral intake. Staff struggled to provide her with appropriate analgesia.

On 28 January 2025, after specialist review of XT's hospital x-rays, it was identified that she had also sustained a fracture of her right hip in the fall. Given her poor prognosis, she was not transferred back to hospital for surgery but was commenced on palliative care medications. She passed away on 1 February 2025.

c) XT's cause of death was hypostatic pneumonia due to the consequences of a right pubic rami fracture and right neck of femur fracture, being injuries suffered in an accidental fall at the RACF. Her advanced dementia and frailty of age contributed to her death.

d) XT died on 1 February 2025 at Devonport, Tasmania.

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

- The Police Report of Death for the Coroner;
- Affidavits confirming identity;
- Opinion of the forensic pathologist regarding cause of death;
- Meercroft Care Inc records, report to Coroner and Root Cause Analysis; and
- Independent Falls Review Report of Clinical Nurse Consultant to the Coroner.

Comments and Recommendations

In this investigation, several issues were identified in connection with XT's fall. These are as follows:

- The RACF's post-fall documentation outlining the details of the fall, the position of XT and the physical findings of the assessment were insufficient. I accept the opinion of the independent Clinical Nurse Consultant, Ms Angela Duncan, reviewing this case that this led to a gap in the clinical record for the purpose of informing further care and treatment decisions.

- There were inadequate staffing levels in the dementia ward at the time of night when XT fell. This was identified by a Root Cause Analysis conducted by the RACF, with a plan to remedy the issue.

- XT's pain was not managed optimally by the RACF after the fall. The RACF has now amended its falls policy to require that a resident in severe pain should not be moved and an ambulance should be called for appropriate management.

In her report, Ms Duncan, suggested that the RACF should consider utilising pain assessment tools such as PainChek to assist with the pain, assessment and management of residents with cognitive impairments.

Further, Ms Duncan suggested that the RACF should develop a post-falls assessment template to be created within the electronic medical record. This would ensure consistency in practice and would prompt staff members to perform all the required post fall assessments and actions. I agree that the RACF should consider adopting this suggestion.

I do not make formal recommendations in this case. Upon the evidence, the falls prevention strategies for XT were largely effective for the duration of her residency at the RACF. Her advanced age, frailty, cognitive impairment and propensity to wander meant that it was unlikely that her fall could have reasonably been prevented, even with additional staffing.

As a result of this case, the RACF has taken steps to identify and remedy systemic issues in order to reduce falls and alleviate post-fall pain.

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

Dated: 14 October 2025 at Hobart, in the State of Tasmania.

Olivia McTaggart
Coroner