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 Wayne Anthony Lowe

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

a) The identity of the deceased is Wayne Anthony Lowe, date of birth 9 September 1964.

b) Mr Lowe was 58 years of age and lived by himself in Deloraine. He has three children with his former wife. He had a long history of alcohol dependency and mental health issues. His past medical history included diabetes, pancreatic insufficiency, pneumonia, intravenous drug use and recurrent falls. He was a heavy smoker of cigarettes.

On 16 January 2023, Mr Lowe was admitted to the Launceston General Hospital ("LGH") due to having a fall whilst intoxicated. In hospital, he was assessed as having suffered a right proximal humeral fracture. This was treated on 17 January 2023 by the orthopaedic team with an open reduction and internal fixation (ORIF) which included fixing a metal plate and screws. He was advised not to weight bear for a minimum of six weeks and to remain in hospital. However, on 23 January 2023, Mr Lowe discharged himself against medical advice.

Two days later, on 25 January 2023, Mr Lowe was re-admitted to the LGH after falling over whilst crossing the road near his home. He re-fractured his proximal humerus requiring surgical revision on 26 January 2023 by the orthopaedic team. During this hospital admission, Mr Lowe had a progressive decline in his general health, including the onset of hospital-acquired pneumonia, hypoalbuminemia, peripheral oedema and pleural effusion.

Mr Lowe also had an unwitnessed fall in hospital on 28 January 2023 when he was found next to his bed. Hospital staff then completed the first falls risk assessment for Mr Lowe indicating that he was at high risk of falling. The hospital implemented mitigation strategies, including having a Patient Safety Assistant sit with Mr Lowe when such an assistant was available.

On 3 February 2023, whilst still an hospital inpatient, Mr Lowe suffered a further fall attempting to walk to the toilet. He suffered injury to his left humerus and underwent surgery on 8 February 2023 whereby the metal plates and screws were required to be removed and the wound debrided. His condition continued to deteriorate with acute kidney injury, shortness of breath with oxygen desaturation, hypotension and slow respiratory rate. He commenced decompensating with liver failure, delirium and an altered conscious state.

On 12 February 2023, Mr Lowe was assessed as having a new wound with the humerus protruding through the skin in the left upper arm. He underwent further surgery the following day. Despite care and treatment by the medical teams, nursing staff and allied health professionals, his condition became critical by 16 February 2023. Mr Lowe became disorientated, confused and agitated. He constantly attempted to remove his indwelling devices and oxygen therapy.

In the morning of 17 February 2023, a discussion occurred between medical staff and Mr Lowe's family regarding his very poor prognosis. An end-of-life care plan was commenced with medications administered by syringe driver. Mr Lowe passed away in the morning of 20 February 2023.

c) Mr Lowe's cause of death was multiorgan failure due to sepsis as a result of repeatedly fracturing of the left humerus in falls in and out of hospital.

Dr Anthony Bell, Coronial Medical Consultant, reviewed Mr Lowe's medical trajectory. He reported that Mr Lowe presented with pre-existing major medical issues which allowed his body to "*just*" function. He stated in his report that *"the trauma of the repeated fracturing of the left humerus and development of pneumonia led to Mr Lowe's large-scale decompensation. Although the medical teams, nursing staff and allied health professionals expended a lot of time and energy, in the end further treatment became futile."* I accept Dr Bell's categorisation of the circumstances surrounding Mr Lowe's death.

d) Mr Lowe died on 20 February 2023 at Launceston, Tasmania.

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

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

- An opinion of the State Forensic Pathologist regarding cause of death;
- Tasmanian Health Service Records;
- Medical review by Dr Anthony Bell MD FRACP FCICM;
- Tasmanian Health Service Root Cause Analysis (RCA) report;
- Review by Kevin Egan, Coronial Nurse; and
- Report from Acting Executive Director Quality and Patient Safety, Tasmanian Health Service – Hospitals North.

Comments and Recommendations

In this case, I have considered whether any issues regarding Mr Lowe's care and treatment whilst a hospital inpatient may have been connected to his death.

I have had the benefit of considering the Tasmanian Health Service Final RCA Report, a medical review by the Coronial Medical Consultant, a nursing review by the Coronial Nurse and correspondence from the Acting Executive Director Quality and Patient Safety Tasmanian Health Service Hospitals North.

Upon the evidence in the investigation, including the expert evidence as mentioned above, I am satisfied that there were no deficits in Mr Lowe's medical treatment during his lengthy admission before his death.

The investigation also focused upon the issue of whether his serious fall in hospital on 3 February 2023 should have or could have been prevented. Mr Lowe's falls risk should have been assessed upon his admission to hospital with considered prevention strategies put in place. This did not, in fact, occur until after his first fall.

Further, an issue identified by the RCA panel was the lack of a detailed assessment of Mr Lowe's state of delirium which was a significant contributing factor in his fall. Additionally, a Patient Safety Assistant (or other staff member) was not in attendance with Mr Lowe at the time of his fall due to unavailability. The presence of a Patient Safety Assistant, as was recommended, may well have prevented Mr Lowe's fall. Given his existing poor physical state, it is unlikely that his death could have been prevented. However, the fall hastened his decline.

The RCA panel made various recommendations, including relating to falls risk assessments and implementation of prevention strategies, communication with a patient's family, delirium and cognitive impairment risk screening; and documenting the attendance of Patient Safety Assistants.

All recommendations from the RCA report have been actioned by the Tasmanian Health Service.

In particular, the Acting Executive Director Quality and Patient Safety, Dr Morag McPherson, noted that new care plan documents and falls risk screening and assessment tools have been introduced across all Tasmanian Health Service inpatient acute beds to support improved falls risk identification and implementation of prevention strategies. She commented that Tasmanian Health Service data shows that falls resulting in serious harm are below the national average as compared to peer hospitals.

Dr McPherson indicated that internal audit data demonstrated an improvement in the areas of completing risk screening and assessment and documenting implementation of strategies to prevent falls. The work undertaken by the Tasmanian Health Service in this regard is to be commended.

I recognise that many falls in hospital are unable to be reasonably prevented, even with appropriate assessment and prevention measures. However, it is important that such measures are taken and reviewed at appropriate intervals.

The circumstances of Mr Lowe's death are not such as to require me to make any recommendations pursuant to Section 28 of the *Coroners Act* 1995.

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

Dated: 20 January 2025 at Hobart in the State of Tasmania.

Olivia McTaggart

Coroner