



MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Leigh Mackey, Coroner, having investigated the death of Alan Noel Sheedy

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

- a) The identity of the deceased is Alan Noel Sheedy. Mr Sheedy was 86 years of age (date of birth 13 June 1926) when he died. He was a retired fire fighter, married to his wife for 58 years and a father of four children. As a younger man he was a talented bike rider and competed in road racing events.
- b) On 2 December 2022, Mr Sheedy was admitted to Sandhill Nursing Home (RACF) for respite care after he had fallen, on a couple of occasions, at home. He had previously received respite care at the RACF in October 2022 for a few weeks, also following a fall at home.

For most of his life Mr Sheedy had been a healthy man, however particularly in the six months leading up to his death his health had declined, as had his mobility and steadiness on his feet generally. Following his arrival at the RACF, an assessment was conducted to assess Mr Sheedy's falls risk on 3 December 2022. This was in accordance with the RACF's policy that all residents are assessed for their falls risk within 24 hours of their admission into the home and following a fall. The result of the assessment identified Mr Sheedy as a moderate risk of falling. Strategies identified to reduce that risk and which were put in place for him at the RACF included a within reach call bell, easy access to a mobility aid,¹ reinforced instruction to wait for assistance before mobilising and to assist and be present when Mr Sheedy was mobilising.

On the morning of 6 December 2022, at approximately 8.00am, Mr Sheedy was observed to be standing outside his bedroom door. He appeared to be intending to take a walk. Shortly after he was found lying, on his right-hand side, on the

¹ Mr Sheedy used a four-wheeled walker at home and at the RACF.

floor of the corridor having fallen. The fall was not witnessed. It is believed that he fell due to suffering a stroke at that time. This is based on the symptoms complained of by Mr Sheedy following the fall which were consistent with him having suffered a stroke. Mr Sheedy was returned to his bed by staff of the RACF and assessed and observed. He had a small skin tear at his right elbow. The record of the observations taken of him at 8.20am and 9.10am reflects that he was eye opening either spontaneously or to sound, his verbal responses were confused, he was obeying commands with motor responses, he had increasing weakness in his right arm, normal strength in his left arm and mild weakness in both legs. His pupils were both equal, reactive and accommodating to light stimulus. He did not report that he had hit his head. Considering his deteriorating condition, the decision was made to call an ambulance and transfer him to hospital. He was accordingly transported by ambulance to the Launceston General Hospital (LGH) arriving there at 9.30am.

Mr Sheedy was assessed at the LGH as having stroke like symptoms. Investigations undertaken at the LGH revealed a 5mm acute subdural hematoma (SDH), and a Deep Vein Thrombosis (DVT) in the right leg. This presented a conundrum given the typical treatment approach for DVT is via anticoagulation therapy which is contraindicated by the SDH given the risk of intracranial bleed. The medical approach was to treat the DVT by an IVC filter insertion. This was successfully undertaken on 8 December 2022. Post operatively Mr Sheedy suffered seizures. Further scanning demonstrated a small frontal temporal bleed like the scan findings of the previous day. Mr Sheedy's seizures continued. A code blue was called at 4.40pm and he was administered Keppra and midazolam. His seizures continued.

On 9 December 2022, Mr Sheedy's condition was discussed with his family and in consultation with his medical team the decision was made to cease medical intervention and to provide comfort and end of life care. Mr Sheedy died the following morning.

- c) Mr Sheedy's cause of death was traumatic closed head injury suffered in the fall. Prior to the fall, Mr Sheedy had tested positive at the RACF to COVID-19. The State Forensic Pathologist, Dr Ritchey, in his report, attributes Mr Sheedy's fall/collapse after peri-terminal stroke with resultant subdural haematoma and the DVT subsequently identified at the LGH, as all COVID-19 related. I accept his opinion.

d) Mr Sheedy died on 10 December 2022 at Launceston, Tasmania.

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

- Police Report of Death for the Coroner;
- Hospital Report of Death for the Coroner;
- An opinion of the forensic pathologist;
- Affidavit confirming identity;
- Affidavit of Senior Next of Kin, Keryn Marston;
- Medical records of the LGH;
- Records of the RACF including response to the falls questionnaire and record of neurological observations of Mr Sheedy; and
- Review of the RACF records by the Coronial Nurse, Kevin Egan.

Comments and Recommendations

I have been assisted by the coronial nurse, Mr Egan, who on reviewing the records of the RACF concluded that the RACF had in place a falls prevention strategy for Mr Sheedy that was appropriate. Whilst he observes that Mr Sheedy's falls assessment required him to be accompanied when mobilising and that this did not occur at the time of his fall, nevertheless in his opinion no level of supervision would have prevented the fall given the fall was likely due to an acute ischemic stroke. I accept that assessment.

The care provided by the LGH to Mr Sheedy was responsive and appropriate.

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

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

Dated: 24 January 2025 at Hobart in the State of Tasmania.

Leigh Mackey
Coroner