MAGISTRATES COURT TASMANIA

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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 Steven Basil Bradley

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

a) The identity of the deceased is Steven Basil Bradley, date of birth 3 November 1958.

b) Mr Bradley was 65 years of age and lived with his wife in Risdon Vale. He had a number of medical conditions including metastatic prostate cancer, ischaemic heart disease, diabetes, gastro-oesophageal reflux disease, anxiety and depression, hypercholesterolaemia and tinnitus. On 20 February 2024, Mr Bradley was admitted to the Royal Hobart Hospital for chest sepsis. A CT scan of his brain also identified a subacute subdural haemetoma believed to be from a fall at home several weeks earlier. During his hospital admission, Mr Bradley became more fatigued and drowsy and was noted to have poor oral intake. He was increasingly vague during medical reviews. His guarded prognosis was discussed with his family.

   Overnight on 6 March 2024, Mr Bradley had an unwitnessed accidental fall in his bathroom on the oncology ward which resulted in extending his pre-existing subdural haematoma. On that date, he was transferred to the Whittle Ward and, following discussions between his doctors and family members, he was provided with end-of-life care. He passed away on 9 March 2024.

c) Mr Bradley's cause of death was acute on chronic subdural haematoma (bleeding to the brain) caused by accidental falls. His metastatic prostatic adenocarcinoma and atypical pneumonia significantly contributed to his death.

d) Mr Bradley died on 9 March 2024 at Hobart, Tasmania.

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

- The Police Report of Death for the Coroner;
- Tasmanian Government Death Report to Coroner;
- Affidavits confirming identity;
- Tasmanian Health Service and general practitioner records;
- Opinion of the forensic pathologist regarding cause of death;
- Report from Kevin Egan, Clinical Nurse Specialist; and
- Reports to the Coroner (dated 29 September 2025 and 19 November 2025) from the Clinical Director and Deputy Clinical Director of Medical and Cancer Services Tasmanian Health Service-South.

Comments and Recommendations

The Coronial Nurse, Mr Kevin Egan, commented in his review that there was a lack of falls, mobility, functional or strength assessments in the two weeks from Mr Bradley's hospital admission to the time of his fall on 6 March 2024, despite Mr Bradley having a history of falls at home. Specifically, Mr Egan said that the comprehensive care plan (a multidisciplinary assessment form), was not completed on admission or at any time during the admission. In addition, Mr Egan stated that there was no hourly rounding of staff overnight at the time of the Mr Bradley's fall. I accept Mr Egan's opinions contained in his report.

In this case, I cannot determine whether Mr Bradley's fall on 6 March 2024 could have been reasonably prevented, even with adequate falls assessment and prevention measures in place. It is also very difficult to determine the contribution of that fall to his death, in light of his significant medical conditions and his prior fall. However, in accordance with the opinion of the forensic pathologist, it is reasonable to consider that it played a role in his decline and death.

The Director and Deputy Director of Medical and Cancer Services[1] agreed in substance with Mr Egan's criticisms and indicated that since Mr Bradley's fall there have been substantial hospital wide improvements in falls recognition, prevention and management. Intentional rounding has been rolled out across the hospital. Other quality improvement projects have focussed upon comprehensive care plan completion, falls risk recognition, documentation and management plans.

[1] Tasmanian Health Service-South.

I comment that the hospital appears to have taken significant measures since Mr Bradley's death towards preventing patient falls.

I **recommend** that the Royal Hobart Hospital, at appropriate intervals, reviews the operation and efficacy of its falls assessment and prevention strategies.

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

Dated: 24 February 2026 at Hobart, in the State of Tasmania.

Olivia McTaggart
Coroner