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 Kerrie Dawn Grant

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

a) The identity of the deceased is Kerrie Dawn Grant (date of birth 8 July 1950). Mrs Grant was born in Coffs Harbour and lived in Queensland before moving to Tasmania in a major life change in 2018. Her husband, Mr Peter Grant, died in 2014 and her family and friends remained in Queensland. She had no family nor social supports in Tasmania. Mrs Grant's health gradually deteriorated from approximately 2019.

b) Mrs Grant lived independently in her own home. She suffered from pulmonary hypertension, congestive cardiac failure, chronic obstructive pulmonary disease, atrial fibrillation, a blood cancer (myelofibrosis), cellulitis and pitting oedema of the lower limbs and musculoskeletal pain. This caused her to be at a high risk for falls and to have an impaired capacity to get herself up off the floor or ground once having fallen.

   On 12 April 2023 Mrs Grant was found by officers of Tasmania Police whilst performing a welfare check, on the floor of her home having fallen 24 – 48 hours previously and been unable to get up off the floor. She was taken by ambulance to the North West Regional Hospital (NWRH) and admitted with a diagnosis of acute renal failure and sepsis on a background of left leg cellulitis. She was managed with an antibiotic targeting bacterial infection. At a medical review on 18 April 2023 Mrs Grant expressed her wish to have no further treatment and to die. After discussion with her family and noting her wishes, and poor prognosis the medical focus became her comfort care. Her condition rapidly deteriorated and she died as a result of acute on chronic renal failure due to sepsis and chronic left leg cellulitis,

c) Mrs Grant's cause of death was acute on chronic renal failure.

d) Mrs Grant died on 19 April 2023 at Burnie, Tasmania.

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

- The Police Report of Death for the Coroner;
- Tasmanian Health Service Death Report to Coroner;
- Affidavits as to identity;
- Short Final Report of Death to the Coroner of Dr Andrew Reid, State Forensic Pathologist;
- Various medical records;
- Email of Natasha Grant dated 21 May 2023; and
- Nursing Coronial Falls Review Report from Angela Duncan dated 26 July 2025.

The history of falls and discharge planning

On 18 February 2022 Mrs Grant fell at home after getting up from a recliner. She felt her legs give way causing her to fall. She remained on the floor from 5.00am to 11.00am as she was unable to get up.[1] She eventually managed to access her phone and called her sister in Queensland who arranged for an ambulance to attend. On arrival paramedics from Ambulance Tasmania, with the assistance of Tasmanian Police, had to force entry to her home. She was found sitting on the floor. She informed the paramedics that this had been her third fall over the past two weeks and felt that it was unsafe for her to be at home.[2] She was admitted to the NWRH and discharged on 26 February 2022.

A post discharge referral was made to social work and a home visit was undertaken by the social worker to Mrs Grant on 8 March 2022. She was noted at that time as having settled well back in her own home and was organising updates for the home to make things safer for herself. She was seeking a quote for the installation of a lift and was adamant she wished to remain in the home. She did not wish to pursue home help. Options for assistance were discussed however Mrs Grant did not wish to pursue additional supports other than a referral to an occupational therapist for the installation of rails in the toilet.[3]

On 8 December 2022 Mrs Grant fell again, was unable to get herself off the floor and was attended to by paramedics from Tasmania Ambulance. On their arrival she gave

[1] NWRH medical records Tasmania Ambulance VACIS report and Emergency Department Notes, 18 February 2022.
[2] NWRH medical records Tasmania Ambulance VACIS report and Emergency Department Notes, 18 February 2022.
[3] NWRH medical records Social work progress note 8 March 2022.

a history of having fallen at 10.00 am the previous day and was unable to get up off the floor.[4] She described her legs giving way and hitting her head on the arm of a chair with no loss of consciousness. She was conveyed to the NWRH and admitted until discharged on 29 December 2022.

Discharge arrangements made for Mrs Grant were for her to return home and for an occupational therapist to deliver and set up an over the toilet frame in the home. This was done the day following discharge. Mrs Grant was noted at that time as enjoying being home and being able to mobilise within the home independently, slowly but steadily. A request was made by the occupational therapist for a physiotherapy review for the purposes of assessment for a 4 wheeled walker (4WW) for indoor use, and she was discharged from the occupational therapy service.

In response to the occupational therapist request, a physiotherapist called Mrs Grant on 9 January 2023. Mrs Grant reported that she was managing mobilising indoors "*okay*" however had experienced two falls at home since her discharge, one down the front steps of the home "*in the wet*", had decreased mobility since the fall and was using a computer chair on wheels to mobilise indoors but was finding this difficult.[5] A 4WW for indoor use was obtained for her use and a plan made for the physiotherapist to liaise with community physiotherapy for a home visit "*ASAP"*.[6]

The physiotherapist emailed the community physiotherapy team that day and reported a "*significant decline in function*..."[7] of Mrs Grant which had been identified during their contact with her at the request of the NWRH occupational therapist, who had discharged her from their care. A community physiotherapist undertook a home assessment of Mrs Grant in response to the urgent request on 12 January 2023. Mrs Grant told the physiotherapist that she had fallen the previous Tuesday when she slipped down her front steps and suffered a head strike and knock to her right knee. On the Thursday she started to feel unwell and fell a second time when she ran into a doorway. She was noted to have an over the toilet frame but no shower chair/stool. She reported concern that she will run out of some of her medication over the coming days, did not have access to much food prior to that morning when domestic assistance first commenced, no upcoming general practitioner appointments and had not been able to shower since the previous Thursday.[8]

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[4] NWRH medical records Tasmania Ambulance VACIS report 8 December 2022.
[5] NWRH medical records Physiotherapy progress report 9 January 2023.
[6] NWRH medical records Physiotherapy progress report 9 January 2023.
[7] NWRH medical records Physiotherapy progress report 12 January 2023.
[8] NWRH medical records Community Physio progress notes 12 January 2023.

An ambulance was called. On arrival paramedics from Tasmania Ambulance were told that Mrs Grant had fallen two weeks previously resulting in an admission to a hospital emergency department. This is the fall of 8 December 2022. She had a further two falls since discharge and then a third fall when she was unable to get up and spent three days on the floor "*scooting around on her bottom causing abrasions and broken skin to the area*".[9] She had been found by her gardener who assisted getting her up. Following the falls she had experienced a decrease in mobility, increased swelling of her legs and was unable to care for herself as normal. It was noted that she now required a 4WW, to mobilise, and carers to undertake domestic and personal care duties, that she had no social supports and "*requires a more supportive discharge plan*".[10] Paramedics transported Mrs Grant to the NWRH, she was admitted and remained an inpatient until discharge, almost three months later, on 5 April 2023. The admission included a period of transfer to the Launceston General Hospital for right heart catheterisation to investigate pulmonary hypertension during the period 27 to 31 March 2023.

Mrs Grant's discharge from the NWRH occurred two days before Easter Good Friday on 7 April 2023. Whilst she had expressed a wish to leave hospital prior to Easter the timing was unfortunate considering the closure of services over the Easter holiday period and Mrs Grant's mobility limitations, lack of supports and isolation. A medical alert alarm had arrived for her at the post office whilst she had been an inpatient but had not been able to be collected and was not available for her use when discharged.

Medical review of Mrs Grant on 5 April 2023, whilst still an inpatient, found her to be medically fit for discharge with a plan for social worker input for home services. It was noted that Mrs Grant's stepdaughter was "...*coming home after easter...*".[11] Mrs Grant underwent a physiotherapy assessment and was considered to be *"...approaching pre morbid baseline...".*[12] That baseline was, however, unlikely to be an appropriate benchmark for her suitability to return to her pre-admission living arrangements considering her previous falls and admissions history. The physiotherapy discharge plan was for increased provision of services and community physiotherapy follow up.

Mrs Grant expressed that she did not want to remain in hospital waiting an aged care assessment.[13] Social work and physiotherapy were noted to have been happy for her discharge and social work as having organised care forward referrals, albeit not likely

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[9] NWRH medical records Tasmania Ambulance VACIS dated 12 January 2023.
[10] NWRH medical records Tasmania Ambulance VACIS dated 12 January 2023.
[11] NWRH medical records notes 5 April 2023.
[12] NWRH medical records Nursing notes 4 April 2023.
[13] NWRH medical records Nursing notes 4 April 2023.

to be actioned until after Easter.[14] A pre-discharge review of Mrs Grant was not able to be actioned by the occupational therapist at the NWRH, despite referral for this to occur. The occupational therapist noted, based on a review of the medical progress notes, that Mrs Grant was showering independently on ward and would self-source a shower stool "*on [her] way home*..." and was "...*following up on obtaining a personal alarm".[15]* Mrs Grant was discharged from acute occupational therapy services.

Mrs Grant's discharge summary from the NWRH noted that "*The physiotherapists and social work reviewed Kerrie prior to her discharge to ensure all of her community support needs have been addressed with any required follow-up. Outpatient PT referred and some home support rogabnised (sic) by social work"[16]* and included a recommendation to the general practitioner to review Mrs Grant's "*ongoing wellbeing at home*" and medications.[17]

In the days between her discharge from the NWRH on the 5 April 2023, her fall between the 10 – 11 April 2023 and readmission to the NWRH on the 12 April 2023, Mrs Grant had not been reviewed by her general practitioner, nor received the medical alert nor had assessment or received services from community support providers.

Comments and Recommendations

Pursuant to s 28 of the *Coroners Act* 1995 ("the *Act*") I make comment and recommendations regarding Mrs Grant's death specifically concerning her discharge from the NWRH on 5 April 2023. The purpose of doing so is to, within the meaning of s 28 of the *Act*, identify ways of preventing future deaths in circumstances which may arise like those which gave rise to Mrs Grant's death.

Mrs Grant had a well-documented history for frequent falls and long periods being unable to get up from the floor. She was isolated with no local family or social supports. Given her history of recurrent falls, it was predictable that a return to her living arrangements, as had occurred when previously discharged, with ad hoc referral for community-based physiotherapy and domestic support, would not be sufficiently protective of her risk of falling and of being unable to get up off the floor after having fallen.

Assessments undertaken leading up to her discharge on 5 April 2023 do not sufficiently consider Mrs Grant's falls risk, given the history, nor the extent to which

[14] NWRH medical records Nursing notes 5 April 2023.
[15] NWRH medical records Occupational Therapy Progress notes 5 April 2023.
[16] NWRH medical records Discharge Summary 5 April 2023.
[17] NWRH medical records Discharge Summary 5 April 2023.

external community services would protect her from that risk, and the lack of availability of services at the time Mrs Grant was discharged, being days within the Easter holiday period. At the minimum, the discharge of Mrs Grant ought to have been subject to her possession of a medical alert which would act to notify authorities of her falling, avoiding the potential of a long period of being left on the floor, and the assurance that appropriate services and facilities were in place to support Mrs Grant's independent living. Transfer to a rehabilitation or nursing home facility in preference to a return to independent living also ought to have been investigated and pursued.

An assessment of Mrs Grant's service needs at home was left to her general practitioner to undertake upon her discharge. Given that Mrs Grant had a history of increasing falls, deconditioning due to a prolonged and medically complicated admission and that she lived alone, a thorough review of her service needs at home should have been conducted prior to her discharge. Mrs Grant was not contacted by her General Practice upon their receipt of the 5 April 2023 discharge summary. Whether the recommendations made in the summary for a general practitioner review of Mrs Grant's living arrangements would have been proactively actioned by the practice is unknown given the short period between discharge and Mrs Grant's final fall and admission to the NWRH.

I have been assisted by Angela Duncan, nurse advising the Coronial Division, who has undertaken a review of the medical records of the NWRH and specifically the discharge assessments and referrals made for Mrs Grant. Ms Duncan identifies omissions in the care provided to Mrs Grant particularly around her discharge as:[18]

1. The absence of a unified falls risk assessment tool for uses by the multi-disciplinary team.

2. Despite the recognition of Mrs Grant's falls risk by a number of the health care professionals involved in her care at the NWRH and the consequent need for community-based support services in the home those services were not able to be commenced given the timing of her discharge.[19]

3. A referral for rehabilitation placement was rejected for an unknown reason.

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[18] Nursing coronial falls review report by Angela Duncan dated 25 July 2025.

[19] The discharge in December 2022 occurred around the Christmas, New Year period and the discharge in April 2023 occurring around Easter.

4. A Medi Alert Pendant was not able to be collected after discharge.

5. Discharge on 5 April 2023 occurred before the occupational therapist completed a final review and without a discharge summary.

6. Despite a mention that home oxygen would be needed it was not organised before discharge and no instructions provided for the general practitioner to follow up the provision of oxygen.

7. Assessment of Mrs Grant's service needs at home and medication was left to her general practitioner for follow up on discharge, however, given her history of increasing falls, deconditioning due to a prolonged and medically complicated admission and that she lived alone, a review of her service needs at home should have been conducted prior to discharge.

It is clear from Mrs Grant's history that she was a risk of falling and that if she fell, she would be at high risk of remaining on the floor for a protracted period which brings with it its own deleterious consequences to her health and wellbeing. She was isolated, lacking any family or social support other than that from her stepdaughter, remotely, from Queensland. She had previously demonstrated an inability to adequately self-care upon her discharge from the NWRH in December 2022. Mrs Grant's penultimate admission to the NWRH had been lengthy. This would have resulted in a degree of deconditioning which would have heightened her falls risk further and impaired her capacity to manage, independently, her own needs. In addition, it provided an opportunity for exploration of transfer to a dependent living environment, rehabilitation centre or, at a minimum, assessment and commencement of assisted services in her own home immediately upon discharge. Her discharge home, without in home supports having been assessed and put in place, without the Medi Alert and over the Easter public holiday period is illogical when viewed through the prism of the recent falls history.

I have been assisted by Ms Duncan's nursing review and make the following **recommendations** for discharge planning and discharge of patients who are at risk of falling:

1. The use of a single validated falls risk assessment tool with appropriate falls prevention strategies and interventions for the varied level of falls risk to be used by all clinicians;

2. Review of discharge planning practices, especially around holiday periods, where at risk individuals may be discharged without appropriate access to supportive services;

3. Discharge planning for persons at high risk of falls and returning to independent living to include direct liaison with their community general practitioner prior to discharge to ensure appropriate supports, appointments and referrals are in place; and

4. The implementation of an alerts system for barriers to discharge which requires resolution or mitigation of each alert prior to discharge.

I have provided these findings and recommendations in draft form to the Department of Health to provide an opportunity for comment. I am advised that since Mrs Grant's death the NWRH have improved patient discharge practices and planning by the implementation of a bi-weekly multidisciplinary discharge planning meeting and are exploring reassignment of the Discharge Planning Coordinator role to enhance oversight and multidisciplinary input.

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

Dated: 22 January 2026 at Hobart Coroners Court in the State of Tasmania.

Leigh Mackey
Coroner

These findings have been amended by an order pursuant to s 58(1)(c) of the *Coroners Act* 1995 dated 10 February 2026 as there are mistakes in the record of the findings, namely mistakes relating to discharge dates.