QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INVESTIGATION

CITATION:	**Non-inquest findings into the death of Mr O.**
TITLE OF COURT:	Coroners Court
JURISDICTION:	CAIRNS
DATE:	10th of December 2024
FILE NO(s):	2022/6419
FINDINGS OF:	Melinda Zerner, Coroner
CATCHWORDS:	CORONERS: Aged Care, and Falls Risk Management Falls in a Residential Aged Care Facility (RACF)

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Background

1. Mr O was born on 20 August 1943 and died on 23 December 2022 at the Cairns Hospital. He was 79 years old.

2. Queensland Police Service (Police) reported Mr O's death to the Coroner because his death was identified as sudden or unexpected within the definition of a reportable death in the *Coroners Act 2003*.

3. The role of a Coroner is to investigate reportable deaths to establish, if possible, the cause of death and how the person died. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability. An investigation is about attempting to find the root cause of the incident that precipitated the death and in appropriate circumstances to analyse systemic failures that contributed to the death and to design remedial responses.

4. In making my findings, they are based on proof of relevant facts on the balance of probabilities. I am guided by the principles outlined in *Briginshaw v Briginshaw* (1938) 60 CLR 336. That is, I am not able to make adverse findings against, or comments about individuals, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

5. Mr O resided in a Residential Aged Care Facility (RACF). He had an extensive past medical history of ischaemic heart disease, myocardial infarction with ventricular tachycardia, coronary artery bypass grafting (2000), atrial fibrillation, posture hypotension, pacemaker (2022), peripheral vascular disease, type 2 diabetes, peripheral neuropathy, obstructive sleep apnoea, osteoarthritis, gout, and previous pulmonary embolism following a fractured neck of femur (broken hip).

6. Mr O had been admitted to the RACF on 16 November 2022 as a respite resident. Prior to being transferred to the RACF, he had been admitted to hospital due to functional decline, increased falls, and a low haemoglobin (low red blood count). The hospital discharge summary indicated it was Mr O's third admission in two months for falls. During his admission, he had a fall in hospital which resulted in a haematoma and extensive bruising to his buttocks.

7. Mr O had been assessed at the RACF as requiring a four wheeled wheelie walker with one staff to assist for mobility, transfers, and self-care, including toileting. His Falls Risk Assessment Tool (FRAT) score was high. The Falls Risk Factors were documented as,

    a. Impulsive with tendency to walk without physical assistance.

    b. Decreased static and dynamic balance.

    c. Shuffling gait.

    d. Stooped posture.

    e. Previous falls history.

    f. Reluctant to use call buzzer.

    g. Walks barefoot.

h. Fast/unsafe walking about corners.

8. On 21 November 2022, Mr O was reviewed by a General Practitioner (GP) as part of the admission process. He was again seen by the GP on 28 November 2022 (left keen pain) and on 2 December 2022 (to review pain).

9. During the admission assessment, the GP had referred Mr O to a Geriatrician and that review was pending prior to his re-admission to hospital wherein he passed away.

10. Mr O had a fall at the RACF on 23 November 2022. He was found on the floor in the bathroom. He had no obvious injuries, but he complained of pain in his left hip but that it was his 'usual' pain. It was noted, Mr O was for 'oversight and governance of falls to be increased following findings'.

11. On 24 November 2022, Mr O was assessed by a physiotherapist. The physiotherapist documented 'Falls and Injury Prevention Strategies'. They included,

    a. Every morning staff to assist me to wear safe fitting clothes, shoes/non-slip socks for all mobility and transfers.

    b. Staff to assist me to turn my lights on and keep my room free from clutter for all mobility and transfers.

    c. Please keep the call bell within reach should I need assistance with my mobility and transfers.

    d. At night staff to ensure that my bed is at the appropriate height when I am in bed.

    e. I will use my 4 wheel walker appropriately when I ambulate.

12. On 5 December 2022, Mr O had a further fall. He was found lying on the floor in the bathroom around 4pm. He advised he was walking from the bed to the toilet and started to feel lightheaded. The fall was not escalated until the next fall. It was revealed work policy had not been followed on this occasion. The incident had not been reported to Mr O's next of kin (NOK) and there had been no GP. Mr O was not reviewed by the physiotherapist and no further referrals were made despite his increased pain.

13. On 12 December 2022, Mr O had another fall. He advised he had been reaching for the water jug and fell out of bed. He complained of severe pain to his right ribs with bruising evident. He waited on the floor for some time for the Queensland Ambulance Service (QAS) to arrive to transfer him to the hospital. Prior to transfer he had been administered his usual medications which included aspirin and rivaroxaban (oral blood thinner).

14. Mr O was subsequently admitted to the Cairns Hospital. A chest x-ray and CT scan revealed he had fractures to the 7th to the 11th ribs, three of which were displaced, along with a moderate volume haemothorax (blood in the chest cavity). He also had signs of possible aspiration (fluid in his lungs). He was ordered intravenous opioid pain medication. His aspirin and rivaroxaban were withheld.

15. On 13 December 2022, Mr O was admitted to the High Dependency Unit in the Cairns Intensive Care Unit (ICU) for closer monitoring due to reduced ventilation from

mild opioid narcosis. A local anaesthetic block was placed to reduce the need for systemic analgesic requirements and to aid in his deep breathing.

16. Mr O developed an acute kidney injury and by 15 December 2022 he had been diagnosed with pneumonia, had signs of a cardiac injury and worsening delirium. His family were consulted, and it was decided the focus of treatment should be on comfort measures.

17. Mr O had a lowered haemoglobin the source of the blood loss was not established, and it was agreed with his family further investigations were not to be carried out. He was administered packed cells (blood transfusion).

18. Late on 22 December 2022, Mr O suddenly deteriorated with hypoxia (low oxygen levels), extreme tachycardia (fast pulse) followed by bradycardia (slow pulse), low blood pressure and unconsciousness.

19. On 23 December 2022 at 12.04am, a medical emergency team (MET) call was made but on the arrival of the team, Mr O had passed away. He was declared deceased at 1.45am. The treating team suspected the cause of his sudden deterioration was a cardiac arrythmia or a pulmonary embolus.

RACF Review

20. The RACF carried out a Root Cause Analysis (RCA) into Mr O's fall.

21. Under the heading, 'Clinical Governance/oversight', the author records,

> *Clinical review meetings were not held as per meeting schedule to discuss fall prevention strategies.*
>
> *One of the Care Managers (CM) was working remotely during November and December 2022, this impacted the workload of the remaining CMs.*

22. Under the heading, 'Workforce', the author records,

> *On 12 December 2022, the Registered Nurse shift was vacant for the community that the resident was in resulting in RNs from other communities requiring to work across communities.*
>
> *Workforce challenges at the time of the incident:*
> - *Recruitment and retention of carers (circa 90 carer unfilled shifts per fortnight)*
> - *High rate of unplanned leave of carers*
> - *Limited Agency resources to fill vacant shifts*

23. Under the heading 'Resident Factors', the author records,

> *The resident was identified as high falls risk and had an extensive history of multiple falls prior to his admission and lacked insight to his safety and functional ability. The resident had three falls in the care home and had diagnosis of multifactorial falls – postural hypotension, balance issues and peripheral neuropathy.*

The resident had been experiencing an increase in pain requiring PRN analgesia, he had decreased appetite and had lost 3.3kg in 21 days.

24. Under the heading 'Assessment and care planning', the author records,

    While resident was admitted as respite, the assessment process and documentation remain consistent with permanent admissions. Admission documentation process did not follow 30-day planner and as a result assessments such as pain assessment and management plan, continence, leisure and lifestyle, medication had not been completed.

    Falls and safety assessment was completed upon admission and the resident was identified as high falls risk, with a physiotherapy review on 24/11/2022 following the first fall. Following the second fall on 05.12.2022 FRAT remained high risk however, no additional fall prevention strategies were added to the care plan such as bed and chair sensor (given both previous falls occurred when the resident had self ambulated to the bathroom without staff assistance).

25. In addition, it was noted,

    a. A complaint from Mr O's daughter on 28 November 2022 (ineffective pain relief) met the criteria for a P2 SIRS notification to the Aged Care Quality Complaints Commission (ACQCC) but was not identified and was not reported.

    b. There was non-adherence to post fall monitoring on each occasion.

    c. Regarding the fall on 12 December 2022, the author has recorded,

    The resident was assessed by the RN prior to moving him from the floor and identified bruise on their rib area. The resident was transferred to the bed using lifting machine. The RN contacted Queensland Ambulance Service (QAS) however, they refused to take the resident to the hospital instead QAS contacted InReach team and then InReach team rang the RN to find out whether they needed to review the resident. The Care Manager insisted that the resident needs to be transferred to hospital after a few discussions with the InReach team and QAS arrived only at 2pm. The resident was transferred to the hospital for further investigation and identified rib fractures.

26. As a result of the RCA, a plan for continuous improvement on falls prevention and management, and pain management was commenced. Actions included the care home starting a fall prevention committee and creating a post fall checklist.

Forensic Medicine Queensland

27. A Senior Forensic Physician was asked to review the case, including the review completed by the RACF. He has advised,

    The RCA correctly identified several resident as well as care factors including the fact Mr O was a high falls risk yet frequently mobilises without asking for assistance. Of note, the review identified that no additional falls prevention strategies were implemented following the fall on 05/12/22, such as bed and chair sensors. Whilst these may not have made a difference had they have

been put in place the investigation also concluded that at the time of the fall on 12/12/22 the water jug was not in easy reach leading to Mr O's fall from bed. The RCA identified a number of areas for improvement. What was not mentioned but did stand out was that despite reports of rib pain and obvious bruising following the fall, staff administered both aspirin and rivaroxaban. Whilst this did not overtly contribute to death, these medications could have potentially exacerbated bleeding and nursing staff should have considered this and withheld them.

28. A response to the concern regarding the medication administration was requested of the RACF. The nurse who had been caring for Mr O states,

> *On the morning shift resident had a unwitnessed fall around 0800am (breakfast time). Resident was found lying on the floor beside the right side of bed when he was being delivered breakfast by a carer. Resident stated he had been leaning forward to reach his jug of water. Observations were taken and readings were slightly hypertensive. Resident was conscious and attempting to pull self up on edge of bed. Skin assessment completed and bruise identified on right rib region. Resident denied any head struck or pain in any other regions. Normal strength and movements in limbs. Resident was then hoisted back to bed while communicating with CCM. CCM stated to call the ambulance due to being prescribe rivaroxaban. Ambulance was contacted and soon after Inreach had contacted to enquire the severity of incident and if worth a hospital transfer. During this time resident was sitting up in bed and had eaten all of his breakfast, however, complaining of pain. This was explained to the Inreach team; apart from uncontrollable pain is appearing asymptomatic and that direction from CCM is to transfer to hospital due to anticoagulant medications prescribed. To memory Inreach had contacted again as most ambulances were busy to transfer resident and didn't feel the incident was a priority due to resident appearing asymptomatic. It was described that resident was having uncontrollable pain and to be transferred. Resident had eaten lunch and was picked up by paramedics soon after. Medications were administered at required times due to resident appearing asymptomatic and the impression given by fellow medical teams that the condition/ incident was not appearing severe.*

29. The forensic physician has advised,

> *It is incongruous to say this man was asymptomatic yet had 'uncontrollable pain'.*
>
> *Whilst administration of blood thinners following the incident may not have directly contribute* (sic) *to death, it is worth noting that the response from* [the RACF] *states, 'that direction from CCM is to transfer to hospital due to anticoagulant medications prescribed'. This suggests there were some concerns that the blood thinners could exacerbate any underlying injuries. For this reason, I would have thought it wise to temporarily withhold these medications pending medical review rather than adopt a somewhat automated approach of 'medications at required times'.*

30. The forensic physician has advised the cause of Mr O's death should be amended to 1(a) Respiratory failure due to or as a consequence of; 1(b) Haemothorax and hospital acquired pneumonia due to as a consequence of; 1(c) Multiple rib fractures, and due to as a consequence of 1(d) Fall.

Conclusions

31. After considering the material obtained during the coronial investigation, I consider I have sufficient information to make the necessary findings in relation to Mr O's death.

32. Mr O's health had been deteriorating. He had been experiencing falls and had been hospitalised on multiple occasions. He was transferred to the RACF as a respite patient. The RACF identified on admission that Mr O was a high falls risk resident. After an initial fall, a physiotherapist listed several fall prevention strategies. Mr O experienced another fall on 5 December 2022, but it was not notified to the appropriate persons, and there was no consideration to what further falls prevention strategies could be implemented to attempt to manage Mr O's risk of falling. For example, a bed or chair sensor mat, and ensuring his water jug was always close by and in reach.

33. The omissions and missed opportunities have been appropriately identified by the RACF and strategies have been put in place to try and improve the management of residents who are at high risk of falls in the future. I accept the evidence of the forensic physician that in the circumstances of this case, while not causative of Mr O's death, it would have been appropriate on 12 December 2022 to withhold Mr O's blood thinning medication.

34. I am not satisfied that it is in the public interest to hold an Inquest (formal court hearing). I have though sought approval from Mr O's family to publish these findings so other clinicians are able to consider and reflect on the events which occurred in this case. Further, that this case may reinforce the importance of managing a high risk falls resident in the aged care setting.

35. I accept the forensic physician's opinion as to the cause of Mr O's death.

36. I extend my condolences to Mr O's family and friends for their loss.

I close the investigations.

Melinda Zerner
Coroner

10 December 2024