IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2019 4989

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
*Section 67 of the **Coroners Act 2008***

Findings of:	Coroner Leveasque Peterson
Deceased:	Eileen Violet Smith
Date of birth:	9 September 1931
Date of death:	13 September 2019
Cause of death:	1(a) Head injury in a fall 1(b) Atrial fibrillation on anti-coagulants
Place of death:	Mildura Base Hospital, 216 Ontario Avenue, Mildura, Victoria 3500

INTRODUCTION

1. On 13 September 2019, Eileen Violet Smith (**Eileen**) was 88 years old when she died at Mildura Base Hospital following a witnessed fall at the hospital the previous day.

2. Eileen had an extensive and complex medical history which included atrial fibrillation[1], for which she was prescribed anti-coagulants.

3. In the months prior to her death, Eileen was diagnosed with acute cholecystitis[2] for which she underwent insertion of a cholecystostomy drain[3] on 24 May 2019. Over the following two and a half months, she received care at Mildura Base Hospital, tertiary hospitals, and at her home through Hospital in the Home (**HITH**).

4. On 8 August 2019, Eileen sustained a fractured neck of femur in a fall at her home and was readmitted to hospital. She underwent surgical treatment the following day, but her recovery was complicated by acute cholecystitis and a new cholecystostomy drain was inserted at Alfred Hospital on 21 August 2019. Following this procedure, Eileen was transferred back to Mildura Base Hospital on 24 August 2019 for in-patient rehabilitation pending an elective cholecystectomy procedure.[4]

THE CORONIAL INVESTIGATION

5. Eileen's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (the Act). Reportable deaths include deaths that are unexpected or result from accident or injury.

6. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

7. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of

[1] Atrial fibrillation is an irregular and often rapid heart rate that commonly causes poor blood flow.
[2] Cholecystitis is inflammation of the gallbladder.
[3] A cholecystostomy is a procedure where a stoma is created in the gallbladder which can facilitate placement of a tube for drainage.
[4] A cholecystectomy is the surgical removal of the gallbladder. It is a common treatment of symptomatic gallstones and other gallbladder conditions.

comments or recommendations in appropriate cases about any matter connected to the death under investigation.

8. This finding draws on the totality of the coronial investigation into the death of Eileen Violet Smith, including statements from the nursing student involved in Mrs Smith's care and the Director of Nursing at Mildura Base Hospital, Mrs Janet Hicks, as well as relevant falls prevention, assessment and management policy documents and legal correspondence from Mildura Base Hospital.

9. After considering all the material obtained during the coronial investigation, I determined that I had sufficient information to complete my tasks as coroner and that further investigation was not required.

10. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[5]

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

11. On 12 September 2019, at approximately 9.00am, Eileen rang her nurse call bell to request assistance to the toilet.

12. At the time, a registered nurse and second-year nursing student were completing a set of observations and administering morning medications to another patient under their care in the room next to Eileen's. The nursing student, who was completing the third day of her second placement at Mildura Base Hospital, offered to go to Eileen to see what she needed.

13. The nursing student went into Eileen's room and Eileen told her she needed to go to the toilet. The nursing student assisted Eileen in walking slowly towards the shared bathroom. Eileen used her two-wheeled walking frame, and the nursing student walked next to her, with her hand placed on Eileen's back.

14. Approximately halfway to the bathroom, the nursing student realised that the bathroom was occupied. At the same time, Eileen's knees gave way, she lost her balance and fell to the floor.

[5] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

The Nurse Unit Manager and physiotherapist heard the fall and immediately attended and rendered assistance.

15. On initial examination, Eileen did not lose consciousness, her vital signs were stable and her Glasgow Coma Scale (**GCS**)[6] was 15/15 immediately following the fall. There were no obvious injuries other than swelling over the right occiput. Eileen was alert and oriented and able to move all of her limbs freely. She was transferred back to her bed with the use of a lifting machine and a medical review was arranged.

16. At approximately 9.30am, Eileen underwent a medical review and was referred for a computerised tomography (**CT**) scan of her brain. The Nurse Unit Manager contacted Eileen's family and informed them of the fall and planned management.

17. The CT brain was reported at 1.00pm and indicated Eileen had suffered a significant subdural haemorrhage. These results were discussed with the neurosurgical team at St Vincent's Hospital and the haematology team at the Alfred Hospital who advised that surgical intervention was not appropriate due to Eileen's poor baseline function and poor outlook considering her anticoagulation status.

18. At 1.43pm, Eileen's condition deteriorated, and a Code Blue was called for decreased conscious state. Her GCS was assessed at 10/15 and she developed right sided weakness. In consideration of the advice received from St Vincent's Hospital and Alfred Hospital, and in discussion with Eileen's family, a conservative management plan was developed.

19. At 6.45pm, Eileen's condition deteriorated further, her GCS dropped to 3/15 and a second Code Blue was called. Following consultation with Eileen's family, a decision was made to provide comfort care only.

20. Eileen passed away peacefully in the presence of her family at 4.30am on 13 September 2019.

Identity of the deceased

21. On 13 September 2019, Eileen Violet Smith, born 9 September 1931, was visually identified by her son, Shane Searle. Identity is not in dispute and requires no further investigation.

[6] The Glasgow Coma Scale (**GCS**) is used to objectively describe the extent of impaired consciousness in all types of acute medical and trauma patients. The scale assesses patients according to three aspects of responsiveness: eye-opening, motor, and verbal responses. The maximum score of 15 indicates a fully awake patient.

Medical cause of death

22. Forensic Pathologist Dr Michael Burke from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an external examination on the body of Eileen Violet Smith on 16 September 2017 and provided a written report of his findings dated 19 September 2019. Dr Burke reviewed the e-medical deposition from Mildura Base Hospital, Police Report of Death for the Coroner (Form 83) and the post-mortem CT scan.

23. The post-mortem CT scan showed parasagittal subdural haemorrhage and intraventricular haemorrhage with coronary calcification.

24. Dr Burke provided an opinion that the medical cause of death was *'1(a) Head injury in a fall, 1(b) Atrial fibrillation on anti-coagulants*'. I accept Dr Burke's opinion.

FAMILY CONCERNS

25. Eileen's daughter, Ronda Smart wrote to the Coroners Court to express concerns about the care Eileen had received at Mildura Base Hospital in the days leading up to her death. The concerns related to the level of patient care provided to Eileen at the hospital, as well as falls risk management and compliance with interventions in place to prevent falls. Specifically, Ronda noted that at the time of her fall, Eileen was only being assisted by one nurse, not two, as was required under Eileen's falls management plan and documented on the communications board next to Eileen's bed.

REVIEW OF CARE

26. In response to Ronda's concerns, I requested statements from Mildura Base Hospital regarding Eileen's clinical course, the circumstances surrounding the fall on 12 September 2019 and the falls risk assessment and management plans in place for Eileen.

27. Mrs Janet Hicks, Director of Nursing at Mildura Base Hospital, provided me with a copy of the hospital's 'Falls prevention: Risk Screening, Risk Assessment and Management of a patient fall' policy, guidelines, protocols, risk screening tools and relevant forms. I was informed that Mildura Base Hospital has undertaken a number of initiatives over the past few years regarding risk screening for falls and falls prevention and management of clients after a fall. This has included an Annual Falls Prevention study day with a focus on the completion of the Falls Risk Assessment Tool (**FRAT**); posters placed throughout the clinical areas regarding the completion of the FRAT, development and implementation of lanyards

prompting nursing staff on post fall observation requirements; review of the 'Falls Sticker' placed in the patient's medical record post fall; trial and subsequent purchase of extra low beds, trial and implementation of new movement sensor alert mats with a paging alert directly to nursing staff; hourly patient rounding in the Sub-acute Unit; introduction of a new Health Care Worker role to supervise and assist with High Falls Risk Patients; and the establishment of a multidisciplinary falls working party to review and make recommendations regarding falls prevention and management. I commend these initiatives.

28. Mrs Hicks informed me that Eileen was assessed as 'at risk of falling' upon her admission to the rehabilitation ward at Mildura Base Hospital on 30 August 2019. A multidisciplinary falls management plan was implemented for Eileen with involvement from nursing, physiotherapy, dietician, and occupational therapy staff. At the time of her last fall, Eileen was able to ambulate using a two wheeled walking frame, and her management plan included that she have a call bell within reach, be assisted by two people when ambulating and transferring, and be assisted with her activities of daily living including toileting. Eileen's current falls risk and mobility status, and the directive that she be assisted by two people when transferring, was documented on the communications board next to her bed and in nursing staff handover documentation.

29. Mildura Base Hospital acknowledged that, on this occasion, its falls risk assessment policy was not followed, and that, in accordance with her falls risk assessment, Eileen should not have been assisted to ambulate by just one person. Mildura Base Hospital and its staff, including the nursing student assisting Eileen at the time of her fall, wished to convey their sincere condolences to Eileen's family for their loss. Mildura Base Hospital has also apologised to Eileen's family for the fact that one person, and not two, assisted Eileen to the bathroom.

30. I was informed that Mildura Base Hospital investigated and completed a root cause analyses of the events and circumstances leading up to Eileen's fall (**the review**). This was reportedly completed by a team of experienced clinicians and included a clinical expert from another Victorian health care service.

31. The review identified issues in relation to the orientation provided to nursing students. It also identified that nursing staff in the rehabilitation unit at the time were choosing to implement an ambulation plan based on their own assessment.

32. In her statement to the court, the nursing student acknowledged that, with the benefit of hindsight, she should not have assisted Ms Smith to the bathroom on her own. She was aware that Ms Smith was a falls risk as she was recovering from an operation and was aware that she needed to use a walking frame when walking and had previously been assessed as needing the assistance of two people when ambulating. Whilst she knew this, she had directly observed other staff members on each of the days she had cared for Ms Smith, assisting Ms Smith to move on their own. She understood that the nursing staff she observed moving Ms Smith on their own were making their own assessments of Ms Smith's capacity and the level of support she required at the time they assisted her.

33. Prior to her placement at Mildura Base Hospital, the nursing student had completed an online education program. She could not recall being provided with any information in the training program related to falls prevention training. She had attended an hour-long nurse education program at the commencement of her first shift at Mildura Base Hospital on 10 September 2019 but could not recall being provided with any specific information at that time in relation to managing patients at risk of falls.

34. Eight recommendations were made as a result of the review and were adopted in full by Mildura Base Hospital management. The recommendations included:

    (a) review of the format of handover sheets with a view to developing one standardised template across the organisation;

    (b) review of the current nursing resource availability and work processes within the rehabilitation unit;

    (c) review of the orientation program for nursing students with a view to including awareness of the nursing handover sheet;

    (d) review of the process surrounding the development of a multidisciplinary care plan;

    (e) review the model of care for patients admitted to the rehabilitation unit to ensure patients with medical issues are reviewed by a geriatrician;

    (f) review of the allocation of preceptors to support students and their awareness of the scope of practice of nursing students;

    (g) ensuring preceptors and nursing students are aware and follow the contents of the delegation and supervision framework for Victorian nurses and midwives; and

(h) increase nursing staff awareness of the role of the physiotherapist and consider their expertise in the development of a fall mitigation and ambulation plans for elderly patients.

35. In response to these recommendations, Mildura Base Hospital has undertaken a significant review of its orientation program for nursing students to: ensure continuity in the supervision provided to nursing students whilst on hospital placement; implement practical face to face exercises in orientation; highlight the importance and function of the communication board and nursing handover sheets; and, provide better support to students by ensuring preceptors are aware of the nursing students scope of practice. Mildura Base Hospital has also conducted on site education with nursing staff and allied health staff to ensure that all staff are aware of the role each discipline has in the development of the patient care plan.

36. I note that there have been delays in implementing some of the recommendations, such as the review of current nursing resource availability and work processes within the rehabilitation unit. These delays have been due to the COVID-19 pandemic and Hospital Transition. Mildura Base Hospital's Patient Care Review Committee continues to monitor the status of implementation of each of the recommendations and has established plans to recommence this important work.

FINDINGS AND CONCLUSION

37. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

(a) the identity of the deceased was Eileen Violet Smith, born 9 September 1931;

(b) the death occurred on 13 September 2019 at Mildura Base Hospital, 216 Ontario Avenue, Mildura, Victoria, from head injury in a fall due to atrial fibrillation on anti-coagulants; and

(c) the death occurred in the circumstances described above.

38. Having considered all of the circumstances, I am satisfied that Mildura Base Hospital had adequate falls prevention policies in place at the time of these events. Eileen was appropriately assessed upon her admission to the rehabilitation as at risk of falls, and relevant strategies were implemented to reduce her risk of falls, including a requirement that Eileen be assisted by two people when ambulating and transferring. This was documented clearly in nursing staff handover documentation and on the communications board next to her bed.

39. It is however, apparent that Eileen's falls management plan was not adhered to on 12 September 2019 as she was being assisted to ambulate by one person, rather than two. The evidence before me indicates that nursing staff in the rehabilitation unit were implementing ambulation plans based on their own assessment of risk, rather than following the directives set out in Eileen's falls management plan. It appears that the nursing student who was assisting Eileen at the time of her fall was, whilst acting in good faith and in the context of her training and experience, acting in accordance with her observations of these suboptimal practices when she elected to assist Eileen to the bathroom alone.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death:

40. Falls-related injury is one of the leading causes of morbidity and mortality in older Australians and remains a major safety and quality risk in health service organisations.[7] The Australian Commission on Safety and Quality in Health Care is charged with leading and coordinating improvements in the safety and quality of health care nationally, and has consequently developed a range of resources for Australian hospitals, residential aged care facilities and community care to help reduce the number of falls and resulting harm experienced by older people in care.[8] These resources include best practice guidelines, guidebooks, fact sheets and strategies for falls prevention, managing falls risk and responding to falls.

41. I acknowledge and commend the efforts of Mildura Base Hospital to improve patient safety through its falls prevention initiatives and the implementation of recommendations following the internal review of Eileen's death. I particularly commend the work undertaken by Mildura Base Hospital to review and amend its orientation program for nursing students to provide better support and supervision to nursing students.

42. However, I consider that further education and monitoring is warranted to support behavioural change and ensure staff compliance with falls management plans. Consequently, I have made recommendations consistent with this.

RECOMMENDATIONS

Pursuant to section 72(2) of the Act, I make the following recommendations:

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[7] Kannus, P, Khan K and Lord S (2006) 'Preventing falls among elderly people in the hospital environment' *Medical Journal of Australia*, 184(8): 372-373.

[8] See https://www.safetyandquality.gov.au/our-work/comprehensive-care/related-topics/falls-prevention.

1. I recommend that Mildura Base Hospital provide further education to its nursing and allied health staff on the importance of adhering to patients falls management plans. Such education should be incorporated into its online and in-person orientation and education programs for nursing students.

2. I recommend that Mildura Base Hospital develop and implement a system to monitor, review and report on compliance with fall prevention practices within the hospital. Such a system may involve regular observational audits and provision of feedback to nursing and allied health staff to increase awareness and to identify areas for improvement in falls prevention practices.

I wish to convey my sincere condolences to Eileen's family. I acknowledge the grief and devastation that you have endured as a result of your loss.

Pursuant to section 73(1A) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

I direct that a copy of this finding be provided to the following:

Ronda Smart, Senior Next of Kin
Lara Larking, Ball+Partners, on behalf of Mildura Base Hospital
Australian Commission on Safety and Quality in Health Care

Signature:

Coroner Leveasque Peterson

Date: 30 November 2021

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.