FORM 38

Rule 60(2)

FINDING INTO DEATH WITHOUT INQUEST

*Section 67 of the **Coroners Act 2008***

Court Reference: 60/2011

In the Coroners Court of Victoria at Morwell

I F A Hayes, Coroner having investigated the death of:

Details of deceased:

Surname:	Dunne
First name:	Cecil John
Address:	55 Dell Circuit MORWELL VIC 3840

without holding an inquest:

find that the identity of the deceased was Cecil John Dunne

and death occurred on 5 January 2011

at Latrobe Regional Hospital, Traralgon

from

1a) Head injury

In the following circumstances:

Mr Cecil John Dunne was aged 86 years when on 27 December 2010 he was conveyed to the Latrobe Regional Hospital after a fall at home.

On 29 December 2010, Mr Dunne had an unwitnessed fall outside his hospital room where he was found at 2.35am, after which he was medically assessed and placed on neurological observations. These continued half-hourly for four hours, then hourly for 2 hours, but did not continue after 7.00am, although general observation did continue. Mr Dunne was seen by doctors at 9.50am and a CT scan was requested. The CT scan revealed the presence of two areas of acute intracerebral haemorrhage and subarachnoid haemorrhage.

Mr Dunne's condition deteriorated and after discussion with family members, palliative care was instituted. Mr Dunne passed away on 5 January 2011.

The Latrobe Regional Hospital provided a statement, from Helen Sambell, Registered Nurse as to the falls risk management plan in place in relation to Mr Dunne. A Falls Risk Assessment Tool (F.R.A.T.) was completed for Mr Dunne on his admission to hospital on 27 December 2010.

Ms Sambell states that Mr Dunne was assessed with a Score of 11/20 which placed him as a low risk of falls, based on information provided by Mr Dunne to the admitting nurse. However, the notes made in the Emergency Department: "Recurrent falls with ? cognitive impairment worsening over past 6/12 daughter worried brought patient to ED."

Ultimately, the assessing nurse assessed Mr Dunne as a medium risk and placed a "falls risk" label on his care plan. Although his status was not printed on the relevant handover sheet, as is required, Ms Sambell states that it "may have been handwritten and would have been discussed at handover."

The falls risk plan for Mr Dunne provided the following interventions:

- Gait aid within reach
- Appropriate seating
- Promote safe foot wear use
- Document transfer mobility requirements
- Do not leave unattended in bathroom or toilet
- Appropriate footwear
- IV pole sited clear of bed
- Bed brakes on
- Bed at correct height for exit
- Call bell accessible working
- Orientate patient to environment
- Ensure safe access to bathroom/toilet
- Establish toileting regime
- Pharmacy assessment

After his fall, Mr Dunne was reassessed. Respiridone was prescribed for increasing agitation and confusion. Mr Dunne was transferred to a high/low bed and air mattress, but continued to get out of bed. He was brought to an area where he could be continually visually observed and side rails placed up. Mr Dunne continued to try to get up. On 31 December he was transferred to a single room.

Mr Dunne's death occurred as a result of a fall which took place outside his hospital room. Mr Dunne had a history of falls, sufficient for him to be assessed as a medium falls risk, with relevant interventions put in place. Those interventions permitted him freedom of movement, with supervision in place for toileting.

Ms Michelle Morrison, Mr Dunne's daughter, has submitted that the falls risk interventions put in place on his admission were not sufficient, namely that bed rails ought to have been put in place from the outset.

Having reviewed the falls risk plan, it is not clear whether the F.R.A.T. was accurate as to the number of falls Mr Dunne had experienced prior to his admission. The number and frequencing of those falls may have affected the risk rating that he was given.

I recommend that F.R.A.T assessments include, where possible, speaking to family members to ensure accuracy of information in relation to a patient's falls history.

An external examination was performed on Mr Dunne by Doctor Michael Burke, Senior Pathologist at the Victorian Institute of Forensic Medicine, who formulated the cause of death as "head injury." Mr Dunne had a previous medical history of chronic obstructive airways disease, atrial fibrillation on warfarin therapy, hypertension and diabetes. Doctor Burke stated "it would seem highly likely the intracranial findings are secondary to trauma and warfarin therapy."

Recommendation: That Falls Risk Assessments include, where possible, obtaining information additional to the patient's, from relevant family members.

Signature:

Fiona Hayes

Date: 29/7/11