IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 001348

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Ingrid Giles
Deceased:	Winifred Jean Carpenter
Date of birth:	16 February 1941
Date of death:	11 March 2023
Cause of death:	1a: PERITONITIS DUE TO LEAKAGE OF BOWEL CONTENTS FROM BOWEL ANASTOMOSIS FOLLOWING ELECTIVE HEMICOLECTOMY FOR CANCER OF ASCENDING COLON.
Place of death:	Bairnsdale Regional Health Service, 122 Day Street, Bairnsdale, Victoria, 3875
Keywords:	Right hemicolectomy, anastomotic leak, anastomosis, improper discharge, family concerns, RAISE call, Statewide escalation policy, record-keeping

INTRODUCTION

1. On 11 March 2023, Winifred Jean Carpenter[1] was 82 years old when she died 11 days after an abdominal procedure. At the time of her death, Winifred lived in Johnsonville in Victoria. She is fondly remembered as a *'stoic'* woman and the loving partner of Norman Carpenter (**Norman**) for over 60 years.

Background

2. Winifred was diagnosed with cancer of the right ascending colon and had lost approximately 10 kilograms in the six months prior to her death.

3. On 28 February 2023, Winifred underwent a right hemicolectomy – an operation to remove a portion of the large bowel, which contained the cancer. The operation was performed at the Bairnsdale Regional Health Service (**BRHS**).

4. Winifred's family recall that she *'experienced pain in her abdomen the first day following the procedure'* and that she *'continued to experience ongoing pain until her passing'.* Over the ensuing days, Winifred rated her pain between a 6-9 out of 10 and at times, experienced faecal incontinence.

5. Between 1 March and 9 March 2023, Winifred's abdomen was physically examined daily by the clinician who performed the operation.

THE CORONIAL INVESTIGATION

6. Winifred'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, unnatural or violent or result from accident or injury.

7. 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.

[1] Referred to throughout this finding as 'Winifred' unless more formality is required.

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

9. Coroner Simon McGregor initially held carriage of the investigation into Winifred's death until it came under my purview in July 2023 for the purposes of obtaining additional material, finalising the investigation and handing down this finding.

10. This finding draws on the totality of the coronial investigation into the death of Winifred Jean Carpenter. 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.[2]

CIRCUMSTANCES IN THE LEAD-UP TO WINIFRED'S DEATH

11. On 6 March 2023, a dietician reviewed Winifred and concluded she was experiencing *'severe malnutrition related to catabolic state'*. The dietician recommended refeeding precautions and to introduce daily vitamin tablets. Winifred's family recall she could only eat a few *'spoonfuls'* of food and frequently struggled to swallow her tablets.

12. On 7 March 2023, Winifred reported abdominal discomfort however, this later subsided, and she rated her pain at a 0/10.[3] Her blood glucose level was tested, and she was diagnosed with diabetes mellitus Type 2. At 3:38pm, a diabetes educator spoke with Winifred and Norman and explained diabetes management.

13. On 8 March 2023, at approximately 8am, a consultant clinician reviewed Winifred and noted that her white blood cell count was increasing.[4] He recorded that clinical observations were stable – she didn't have a fever, her abdomen was soft and not tender. The consultant created a plan to *'continue [antibiotics] x 2'*.

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[2] 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.

[3] I note the recollection of the Winifred family, and corresponding acknowledgment of the BRHS that Winifred reportedly felt pressured to 'downgrade' her pain.

[4] A high white blood cell count, can indicate a range of conditions, including infections, inflammation, injury and immune system disorders. High white blood cell count can also have causes that aren't due to underlying disease. Examples include normal individual variation, recent surgery, steroid use, medication side effects or stress. For clarity, I note that Winifred's white blood cell count was initially raised in the days following her procedure, lowered, before beginning to climb again.

14. Due to Winifred's weight loss, clinicians considered commencing Total Parenteral Nutrition – a feeding method where a patient's entire nutritional needs are delivered via intravenous access. However, as she had opened her bowels, clinicians and the BHRS dietician decided to instead transfer her to the *'soft ward diet'* comprising soft food only.

15. Clinicians planned to discharge Winifred on 10 March 2023. The day prior, on 9 March 2023, at 2:04pm, a Nurse entry reads: *'spoke with dietician, who stated would NOT be happy with discharge tomorrow until levels corrected and also noted [white blood cell count] elevated at 27, [potassium] 3.4 and concerns about phosphate (lower end of normal). Discussion with surgical intern who will raise concerns with consultant and let family know about [white blood cell count]. Patient has reported to have refused IV flagyl [an antibiotic], however, promised to take her meds but disappointed discharge may not be tomorrow'.*

16. At an unknown time, an intern involved in Winifred's care sent a text message to a surgery team group chat querying whether Winifred should be discharged despite a raised white blood cell count. These concerns were not added to Winifred's medical record, and they were not verbally raised to any senior clinician. The intern did not receive a response to their question, and so decided to proceed with discharge as planned.

17. On 10 March 2023, Winifred was scheduled to be discharged from the BRHS into her family's care. On this day, Winifred's care was transferred from the clinician who performed her surgery, to a locum general surgeon. At approximately 8am, during morning ward rounds, the intern made a note in Winifred's medical records that her white blood cell count was still increasing. During the rounds, *'Winifred endorsed feeling discomfort from bloating and denied bowel movements since the previous day'.* The locum general surgeon told Winifred that the surgical team was satisfied with her progress and that discharge would continue as planned. Her abdomen was not examined.

18. Winifred's husband, Norman, expressed concerns that she was not ready to be discharged. Nursing notes of 1:56pm indicate that Winifred's abdomen was very distended with *'bowel sounds + +'*. At 3:41pm, clinicians proceeded with their initial plan and Winifred was discharged.

19. The following day, 11 March 2023, Winifred returned to the BRHS emergency department (**ED**) and was *'hypotensive'* and *'clinically in shock'*. A computed tomography (**CT**) scan revealed an anastomotic leak.[5]

20. Resuscitation was commenced and a central right femoral venous line and left radial line were inserted. Winifred's condition continued to decline, with reduced consciousness, poor respiratory effort and worsening hypocapnia[6] and hypoxia.[7]

21. Clinicians provided Winifred with increased inotropic support.[8] However, she continued to deteriorate and was transitioned to an end-of-life pathway.

22. On 11 March 2023, at 5:23pm, Winifred was declared deceased.

IDENTITY OF THE DECEASED

23. On 11 March 2023, Winifred Jean Carpenter, born 16 February 1941, was visually identified by her daughter, Kerry Oakley, who completed a formal Statement of Identification.

24. Identity is not in dispute and requires no further investigation.

MEDICAL CAUSE OF DEATH

25. Fellowship trainee Forensic Pathologist Dr Norbu Norbu (**Dr Norbu**) of the Victorian Institute of Forensic Medicine (**VIFM**), under the supervision of Dr Paul Bedford, Forensic Pathologist, conducted an autopsy on the body of Winifred Carpenter on 17 March 2023. Dr Norbu considered materials including the Victoria Police Report of Death for the Coroner (**Form 83**), e-Medical Deposition Form completed by the BRHS, medical records provided by the BRHS and Macleod Street Medical Centre and post-mortem CT scan, and provided a written report of their findings dated 18 May 2023.

26. The post-mortem examination revealed severe faeco-purulent peritonitis and leakage of bowel contents from the ileo-colonic anastomosis, bilateral pleural effusions and moderate to severe steatosis of the liver – also known as *'fatty liver'*. There were 1.8 litres of feculent fluid noted in the peritoneal cavity.

[5] An anastomotic leak occurred where a surgical anastomosis (a surgical connection between adjacent blood vessels, parts of the intestine or other channels of the body) fails and contents of the reconnected body leak from the surgical connection.
[6] Reduced carbon dioxide in the blood.
[7] Low oxygen levels in the body tissue.
[8] Medications to stabilise circulation and optimise oxygen supply.

27. Dr Norbu explained that peritonitis is the inflammation of the membranes of the abdominal cavity and organs. They stated it can be spontaneous or secondary and indicated in this instance, it was secondary to the leakage of bowel contents into the peritoneal cavity. It was hypothesised that the developing peritonitis was the cause of Winifred's post-operative pain.

28. There was no evidence of any injuries which may have cause or contributed to the death.

29. Dr Norbu provided an opinion that the death was due to natural causes and ascribed the medical cause of death as 1(a) *peritonitis due to leakage of bowel contents from bowel anastomosis following elective hemicolectomy for cancer of ascending colon.*

30. I accept Dr Norbu's opinion.

FAMILY CONCERNS

31. Throughout my investigation, Winifred's daughter, Janette Mumford (**Ms Mumford**) submitted concerns on behalf of her family regarding the medical care provided by BRHS. The majority of these concerns were submitted on 28 April 2025 and cover many aspects of Winifred's admission.

32. I note at the outset that my powers of investigation are limited under the Act to matters proximate and causally related to Winifred's death; they are not all-encompassing. Some of the concerns expressed by Ms Mumford, such as the communication styles of clinical staff, fall outside of this scope and will not be the subject of my findings.

33. However, amongst Ms Mumford's concerns regarding BRHS' management of Winifred that are relevant to the coronial investigation, the following themes emerged:

    a) The frequency and adequacy of physical examinations conducted by clinicians in relation to Winifred;

    b) Winifred's recent weight loss and whether this was considered appropriately by clinicians;

    c) BRHS' management of diabetes which Winifred developed while hospitalised;

    d) Whether junior clinicians who cared for Winifred were *'comfortable relaying any concerns they had'* to more senior staff; and

e) Whether clinicians appropriately considered the family's concerns prior to Winifred's discharge on 10 March 2023.

CORONERS PREVENTION UNIT

34. Following receipt of the family concerns, and to better understand the circumstances of Winifred's death, the Court sought the assistance of the Coroners Prevention Unit (**CPU**) and requested that it assess the appropriateness of the care provided by BRHS.[9]

35. The CPU reviewed the available material including Ms Mumford's concerns, and identified four primary issues regarding BRHS' treatment of Winifred:

    a) *Failure to recognise and respond to the Winifred's deterioration and the onset of new pain;*
    b) *Failure to respond to Winifred and her family's concerns about pain and safety of discharge;*
    c) *Failure of junior medical staff to escalate concerns to senior medical staff; and*
    d) *Failure to recognise the impact of Winifred's nutritional deficiency;*

36. I will turn to consider each of these issues in light of the evidence gathered during the course of my investigation.

FAILURE TO RECOGNISE AND RESPOND TO WINIFRED'S DETERIORATION

37. Winifred's death constituted a sentinel event category 11 – an adverse patient safety event resulting in serious harm or death – according to the Safer Care Victoria model. Accordingly, a panel of internal and external team members completed a Root Cause Analysis of her death and submitted the resulting report, the SAPSE Report (**SAPSE Report**), to Safer Care Victoria.[10]

38. In the SAPSE Report, the panel identified that clinicians *'did not take into consideration [Winifred]'s (. . .) deterioration since the morning ward round'* of 10 March 2023.

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[9] The Coroners Prevention Unit (**CPU**) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health; as well as staff who support coroners through research, data and policy analysis.

[10] The *Health Services Act 1998* (Vic), which governs SAPSE reviews and reports, prescribes various requirements including the scope of the review and SAPSE review panel membership. According to section 128Q, the SAPSE review panel is required to include an individual not employed by or engaged by the health service entity that appointed the panel.

39. To better understand the events that surrounded BRHS' failure to consider Winifred's deterioration, I sought a statement from the hospital on the matter. In response, Dr Mau Wee (**Dr Wee**), then-Chief Medical Officer at BRHS, provided a series of comprehensive statements addressing clinicians' actions in this regard, and more broadly.

40. Dr Wee stated that *'it is highly likely that Ms Carpenter's condition deteriorated after the morning ward round on [10 March 2023]*'. Prior to Winifred's discharge on 10 March 2023, her treating surgeon reviewed her each day between 1 and 9 March 2023. Dr Wee acknowledged, however, that Winifred was not physically examined on 10 March 2023.

41. On 10 March 2023, medical records indicate that the final clinical observations occurred at 12:06pm – approximately three and a half hours before her discharge. Despite nursing observations that Winifred's pain was increasing, this was not appreciated by clinicians as an indicator of her deterioration. On the basis that Winifred refused pain relief medication, Dr Wee acknowledged, *'this may have given the false sense of assurance that [Winifred was] fit for discharge, we also note the family's statement that [Winifred] was made to feel that her pain was disproportionate, and hence, she downplayed her pain'.*

42. Following the SAPSE review, BRHS outlined the efforts it has made to improve its discharge process since Winifred's death, noting a plan to review and amend its discharge planning process in a number of ways to *'ensure patient centred discharge is achieved'.* This is addressed further below.

FAILURE TO RESPOND TO WINIFRED AND HER FAMILY'S CONCERNS ABOUT PAIN AND SAFETY OF DISCHARGE

43. In her correspondence to the Court, Ms Mumford made clear her perception that Winifred and the family's concerns about discharge were not considered by BRHS staff. Ms Mumford recalled conversations between the Carpenter family and BRHS staff in which they raised their concerns regarding Winifred's presentation and the appropriateness of discharge. Indeed, it appears that clinicians did not appreciate these concerns and corresponding medical record entries state *'no concerns'*.

44. In its Sentinel Event Report, BRHS acknowledged the same: *'patient and husband concerns [were] not recognised by staff as a RAISE call.'*

45. A *'RAISE call'* is a reference to the BRHS process to *'encourage patients and their loved ones to be actively involved in their care and treatment'*.[11] The RAISE (your hand for help) campaign outlines three steps for families to follow in order to raise their concerns: (i) *'talk to the nurse looking after you or your loved one',* (ii) *'ask to speak to nurse in charge and request a clinical review',* (iii) *'call the numbers on the poster [next to the patient bed] to reach the Clinical Coordinator and say "this is a RAISE call"'.*

46. Dr Wee informed the Court that '*during the review and following the open disclosure with Ms Carpenter's family, it became apparent that the family's concerns were either dismissed or downplayed by both nursing and medical staff*'.[12]

47. Indeed, in the SAPSE Report, the panel wrote that BRHS staff had a *'lack of understanding'* of the RAISE process and accordingly, they interpreted Norman's concerns as a *'"refusal" to take his wife home, rather than a RAISE request'*. The report also identified that Norman was likely *'unaware'* of the RAISE process.

48. Dr Wee continued and stated that following the findings of the SAPSE review, *'BRHS has made a considerable push to reinforce the "RAISE call" awareness. While information about a RAISE call was readily available within the wards (including posters on the wall, information brochures within inpatient admission packs and patient bedside), BRHS noted there was limited awareness of what it is and how to activate a RAISE call amongst consumers and hospital staff. Since then, we have seen evidence of improved patient outcomes as patients, their families and hospital staff are now more acutely aware of the RAISE call.'*[13]

[11] BRHS, *'You Know Them Best – RAISE Campaign Encourages Patient, Families to Raise Their Hand for Help'*. Accessible at: You Know Them Best – RAISE Campaign Encourages Patients, Families to Raise Their Hand for Help | Bairnsdale Regional Health Service.

[12] For completeness I note that the Carpenter family and individual staff at BRHS have provided the Court with different recollections regarding their interactions with one another. This finding does not attempt to reconcile these individual differences, but rather, attempts to address the cause for the BRHS dismissal of their concerns as a whole.

[13] I note for completeness that Winifred's family subsequently attended BRHS for a medical appointment for another family member in May 2025 and on 14 July 2025 raised the following concerns with the Court: (i) issues as to the adequacy of the flyer in the waiting room that outlined the RAISE call procedure; (ii) it was observed following a conversation with a staff member with a 'Speaking Up' badge that a parallel process called 'Speaking Up' appeared to exist at BRHS, without that staff member being aware of the RAISE call process; and (iii) the BRHS RAISE Call video was not playing on any televisions around the waiting room. While making no adverse comment in this regard, I have considered it appropriate to provide these concerns to BRHS to assist it in its efforts to promote, reinforce and improve the RAISE call process.

FAILURE TO ESCALATE TO SENIOR MEDICAL STAFF

49. As Ms Mumford recounted, two intern clinicians were part of Winifred's treating team. They had been doctors for approximately six weeks at the time of Winifred's episode of care.

50. On 9 March 2023, the interns were requested to review Winifred due to concerns about her abdominal distension. At the time, senior staff including the surgical registrar and consultant were in theatre. At 2:04pm, a nurse entry to Winifred's medical record reads: *'discussion with surgical intern who will raise concerns with consultant and let family know about [her raised white blood cell count]'*. Subsequently, a message was sent to the surgical group chat querying whether Winifred should be discharged despite her raised white blood cell count. The message sent to the group chat and their specific concerns were not recorded in Winifred's medical records.[14]

51. Dr Wee acknowledged that *'when there was no answer, [the interns] followed the discharge plan and did not escalate their concerns to senior staff'*. He noted that *'the standard procedure requires interns to obtain verbal confirmation regarding critical decisions and then document this in the notes. This did not occur on this occasion'.*

52. Dr Wee explained that, in response to Winifred's death, the interns have since been reminded of proper protocol:

> *'Both [interns] were counselled against using text messages to convey critical patient information and decision-making. The standard procedure requires the interns to obtain verbal confirmation either via phone call or physically entering the operating room if a decision is critically required. The decision must then be documented in the clinical notes'.*

53. And further,

> *'It was identified that junior medical and nursing staff at various points were contacted by the family regarding their concerns. These were managed individually by the junior staff and were not escalated to the senior medical staff. It was also identified that there were instances where the senior medical staff were not notified of*

[14] I note that pursuant to the *Telecommunications Act 1997* (Vic), I do not have the ability to access copies of these stored communications via a telecommunications provider, which was something requested by family. This is simply noted for completeness.

these concerns in a timely manner (i.e. via the use of text messages while the senior staff were in theatre).'

54. Dr Wee stated that BRHS has provided education and support to all junior medical staff regarding when escalation is required, escalation pathways and effective handovers. As of June 2024, BRHS reported that it has also introduced an additional surgical registrar to provide support to intern clinicians and address the increase in inpatient numbers.

55. On 21 July 2025, in response to a request for clarification from the Court, BRHS confirmed that, in terms of education to support junior staff, clinical documentation is included as part of junior medical staff orientation. In addition, the Deputy Executive of Medical Services provides an education session for junior medical staff on 'Medicine and the Law', emphasising the importance of accurate and contemporaneous medical record keeping.

FAILURE TO RECOGNISE THE IMPACT OF NUTRITIONAL DEFICIENCY

56. In a statement to the Court, Dr Wee addressed the weight loss that Winifred experienced prior to and during her hospitalisation. While Winifred was referred to a dietician, this did not occur immediately following the procedure and was indeed delayed. It was not until 6 March 2023 that she was referred to a BRHS dietician and by this time was *'found to be in severe malnutrition related to a catabolic state secondary to her newly diagnosed bowel cancer. She was assessed as high risk of refeeding syndrome, but it was also acknowledged that her progress was slow due to an evolving post-operative ileus'.*

57. I note the Carpenter family's recollection that Winifred struggled to consume her tablets and ate only a few *'spoonfuls'* at a time, along with concerns that medical records did not consistently record her eating patterns. On this point, Dr Wee acknowledged that Winifred's oral intake was not clearly documented, nor was she regularly weighed. He stated that, *'various nursing staff entries and verbal acknowledgement that she has eaten to the medical staff have resulted in the medical staff concluding her progress as improving'.*

58. In addition to the changes implemented by BRHS outlined above, Dr Wee stated Winifred's death *'highlighted the lack of awareness of potential post-operative complications that may occur in a nutritional deficient patient'* and acknowledged that BRHS *'[did] not have an existing policy for low BMI patients'.* Consequently, BRHS has established a High-Risk Assessment Clinic for patients with a low BMI and who are at risk of post-operative

complications with the view to *'coordinate optimisation of the patient's pre-surgical status or organise additional post-operative supports'.*

ADDITIONAL COMMENTS OF THE CPU

59. The CPU opined that Winifred's deterioration most likely began prior to her discharge but, as has been discussed in this finding, was not appropriately identified nor managed by BRHS staff.

60. Owing to her deterioration on 10 March 2023, the CPU concluded that Winifred should not have been discharged that day. The CPU qualified that Winifred nonetheless experienced a serious and unpredictable complication from the procedure, and even if she had remained in hospital, her death at or around that time may not ultimately have been able to be prevented.

61. The CPU further noted that the continuity of staffing in rural and regional centres can be very challenging.

ACTIONS TAKEN BY BRHS SINCE WINIFRED'S DEATH

62. Since Winifred's death, and in line with the recommendations of the SAPSE review, BHRS has implemented a suite of reforms to improve the care provided to patients with presentations similar to Winifred, some of which I have already referred to in this finding. These include:

    a) Reviewing and amending the discharge planning process to ensure that *'patient centred discharge is achieved'*;

    b) Revising education provided to BRHS staff on patient escalation;

    c) Increase awareness regarding the hospital's RAISE process, including to make information on the process easy to locate and accessible for patients and their families;

    d) Developing amendments to their Electronic Medical Record to include pain scale ratings as an escalation trigger;

    e) Introduction of pre-admission screening to include pre-operative patients with a low BMI or extreme protracted weight loss; and

    f) Ensuring that dietician input is sought as early as possible by flagging a need for early referrals and intervention(s) post-operatively.

63. In addition to the actions taken following the SAPSE Review recommendations, BRHS has also implemented the High-Risk Assessment Clinic described above at paragraph 58.

64. The CPU has opined that the SAPSE Review was of a reasonable standard, and it appropriately identified areas for learning where care can be improved. Having considered the CPU advice, the SAPSE Report and the series of statements provided by Dr Wee and other BHRS clinicians, I find that all prevention opportunities have been canvassed. However, the circumstances of Winifred's care, treatment and discharge give rise to pertinent comments connected with her death that I now turn to.

COMMENTS

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

65. The circumstances of Winifred's death bring to the fore the utility of a Statewide escalation policy relating to family concerns in healthcare settings. Currently, each Victorian health service has an individual escalation policy, such as the RAISE process used at Bairnsdale Regional Health Service (**BRHS**).

66. In considering the three steps of the RAISE campaign as outlined above, it is apparent that patients and their families bear the burden of having their concerns acknowledged in the particular formula outlined. I consider this to be wholly unacceptable. It is important that all family concerns are identified and actioned appropriately by hospital staff, whether or not they strictly follow the RAISE steps and explicitly highlight to staff that they are making a 'RAISE call'. This did not occur in Winifred's case, and has been acknowledged by BHRS as a significant failing. I agree.

67. In New South Wales and Queensland, the respective government bodies have implemented Statewide escalation processes. The NSW Clinical Excellence Commission developed the REACH program – "*Recognise, Engage, Act, Call, Help is on its way"*. REACH is designed as an *'easy-to-use system that helps patients, carer/s, and families to escalate their concerns with staff about worrying changes in a patient's condition'*. The benefit of a standardised system is that patients and families do not have to first acquaint themselves with the escalation process specific to the hospital in which they find themselves. It provides them, and healthcare workers, with greater clarity when submitting, identifying and responding to family concerns.

68. I note that in Victoria, Safer Care Victoria has developed the Safer Care for Kids project. The aims of the project are threefold: (i) to mandate the use of a single platform all children and

young peoples' vital signs are recorded; (ii) to design a centralised parental and carer escalation process; and (iii) to implement a system of 24/7 virtual paediatric emergency consultation.

69. Regarding the escalation processes, the project established the 'Urgent Concern Helpline' which is intended to provide an escalation process for consumers, their families and/or carers of paediatric patients in acute health services to escalate any concerns about a deterioration in health, of themselves or a loved one, when they feel their concerns are not being heard or addressed.

70. As of August 2024, the project entered its pilot phase, and the Urgent Concern Helpline was being piloted across 'key sites'. The pilot is being assisted by the Victorian Virtual Emergency Department, operated by Northern Health.

71. Minister for Health, the Honourable Mary-Anne Thomas stated, *'the new Urgent Concern Helpline will support families and patients and ensure they have somewhere to turn if they feel their concerns aren't being heard'.*

72. While the Urgent Concern Helpline applies only to paediatric cases and is currently in its pilot phase, it is a promising step in the direction of a standardised escalation process across the State for all patients, that may have assisted in Winifred's case for family concerns to be heard, acknowledged, and appropriately responded to.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Winifred Jean Carpenter, born 16 February 1941;

    b) the death occurred on 11 March 2023 at Bairnsdale Regional Health Service, 122 Day Street, Bairnsdale, Victoria, 3875, from 1(a) *peritonitis due to leakage of bowel contents from bowel anastomosis following elective hemicolectomy for cancer of ascending colon*; and

    c) the death occurred in the circumstances described above.

74. Having considered all of the circumstances, including the treatment provided to Winifred Jean Carpenter by the Bairnsdale Regional Health Service, I find that clinicians' actions on 9 and 10 March 2023 were concerningly suboptimal in that they did not properly identify that

Winifred Jean Carpenter's condition had seriously declined, improperly dismissed family concerns and did not appropriately escalate their own concerns, contrary to the hospital's protocols.

75. I accept the opinion of the Coroners Prevention Unit and find that Winifred Jean Carpenter should not have been discharged on 10 March 2023. That being said, on the evidence before me, including that her death occurred due to a serious and unpredictable complication of the hemicolectomy, I am unable to definitively find that remaining in hospital would have prevented Winifred Jean Carpenter's death at or around that time.

76. I acknowledge the concessions that have been made by the Bairnsdale Regional Health Service and acknowledge the various actions it has taken to strengthen its delivery of care on various fronts, including strengthening staffing, providing supports and education for junior staff and bolstering awareness of the RAISE process. I consider that these preventative measures obviate the need for further coronial comment or recommendation.

NATURAL JUSTICE PROCESS

77. I note for completeness that Bairnsdale Regional Health Service (**BRHS**) was provided with a copy of my proposed adverse findings and comments in relation to the care provided to Winifred, including those based on advice I had received from the Coroners Prevention Unit (**CPU**). On 24 July 2025, BRHS indicated that it was accepting of the findings and had no further comments to make in response thereto.

78. In a similar vein, Winifred's family were provided with an outline of the advice provided by the CPU and were furnished with the opportunity to make submissions on the care provided to Winifred on a number of occasions. All concerns within the scope of my investigation have been carefully considered in the course of preparing these findings, and referred to where appropriate.

79. Finally, I note that Winifred's family sought review of previous operations undertaken by the surgeons involved in Winifred's care, and referral of the surgeons to the Royal Australasian College of Surgeons (**RACS**).

80. Having considered the evidence, including the report of Dr Norbu (forensic pathologist) and medical records, I did not consider there to be a basis for such referral to occur. However, I note that the surgery performed upon Winifred will be reviewed as part of the Victorian Audit of Surgical Mortality (**VASM**) process. I understand that some delays have occurred in this

process, which appears unusual, noting that it is now over two years since Winifred died. I am hopeful that, despite this delay, this peer-reviewed process will provide a further independent avenue of investigation to complement my own. I intend to provide my finding to VASM to assist it in its own review functions.

ACKNOWLEDGMENTS

81. I convey my sincere condolences to Winifred's family for their immeasurable loss, and thank Janette, Kerry and Kimberley for their detailed, considered and ongoing involvement in the coronial investigation, which has assisted in ensuring a comprehensive coronial investigation has taken place. Their extensive contributions would have taken many hours of their time and demonstrate the family's deep love, care and concern for Winifred.

82. I also acknowledge the proactive approach of Bairnsdale Regional Health Service to my investigation. In so doing, I have revisited the accounts provided by the junior doctors involved in Winifred's care, and encourage them to read and reflect upon the present finding as part of a continued commitment to strengthened patient outcomes, respectful communication and maintaining the confidence to escalate concerns to keep their patients safe.

ORDERS AND DIRECTIONS

Pursuant to section 73(1A) of the Act, I direct 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:

Mr Norman Carpenter, Senior Next of Kin

Ms Janette Mumford

Ms Kerry Oatley

Ms Kimberley Young

Bairnsdale Regional Health Service *(inclusive of copies of the Family Concerns of July 2025 regarding RaiseCall referred to in footnote 13 of this Finding)*

Eastern Health

Safer Care Victoria

Victorian Audit of Surgical Mortality

Sergeant Geoffrey Burnett, Coronial Investigator

Signature:

INGRID GILES

CORONER

Date: 4 August 2025

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.