IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 001943

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Leveasque Peterson
Deceased:	Cornelia Groot
Date of birth:	30 June 1937
Date of death:	11 April 2025
Cause of death:	1a : Complications of head injuries and left proximal femur fracture sustained in a fall
Place of death:	Barwon Health Bellerine Street Geelong Victoria 3220
Keywords:	Residential aged care, unwitnessed fall, fractured hip, head injury, Glasgow Coma Scale, neurological observations, escalation of medical treatment

INTRODUCTION

1. On 11 April 2025, Cornelia Groot was 87 years old when she died in hospital after an unwitnessed fall.

2. At the time of her death, Cornelia lived at Wallace Lodge, a residential aged care facility operated at Barwon Health's McKellar Centre in North Geelong. She began living at Wallace Lodge in mid-December 2024 due to her increasing falls risk, attributed mainly to Parkinson's disease. Her room was fitted with a sling/hoist transfer, and Cornelia was encouraged to use a call bell and required assistance to mobilise.

3. During her residence at Wallace Lodge, Cornelia enjoyed participating in the facility's activity programs and enjoyed knitting and reading. Her family visited her often and would help her go shopping or to medical appointments. She is described as a fiercely independent woman, who had trouble accepting her declining mobility. Cornelia sustained 11 falls in the time she resided in Wallace Lodge; the most recent incidents occurred on 3, 4 and 5 April 2025.

THE CORONIAL INVESTIGATION

4. Cornelia'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.

5. 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.

6. 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.

7. This finding draws on the totality of the coronial investigation into the death of Cornelia Groot. 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.[1]

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

Circumstances in which the death occurred

8. On 5 April 2025, Cornelia wanted to arrange a taxi to take her shopping. Despite being told by Wallace Lodge staff that they did not think it was safe, Cornelia insisted. Staff contacted her son, John Groot, who said he would take her to K-Mart the following day.

9. During the day, staff were alerted by the alarm in Cornelia's room that she was walking independently. Staff attended her room and assisted her to the bathroom to shower. At 8:45pm, staff were alerted again and found Cornelia attempting to move a large recliner chair in her room. Staff offered to assist her to bed, which she declined but agreed to be helped into the recliner.

10. Overnight, at 1:55am on 6 April 2025, Cornelia's alarm sounded. Staff attended and found her on the floor, face down, to her left side. She appeared alert but confused and she initially refused assistance and denied having fallen.

11. A Registered Nurse (**RN**) assessed Cornelia – her pupils were equal and reactive, and her Glasgow Coma Scale (**GCS**) was 14.[2] She had a bruise to her left cheek and eye, and a small lump on her parietal area (top side of the skull) which was red and slightly tender. Cornelia denied pain in her extremities but complained of stiffness in her legs and was escorted to bed using the transfer hoist.

12. At 2am, Cornelia complained of left hip pain and was provided oxycodone with effect.[3] At 3am, she stated the pain had dissipated but her left knee was stiff, so it was repositioned using a pillow. Staff informed Cornelia's general medical practitioner (**GP**) of her fall, and a locum clinician was scheduled to attend Wallace Lodge for a clinical assessment.

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[1] 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.

[2] The Glasgow Coma Scale (**GCS**) is a clinical tool used to assess a person's level of consciousness, particularly after a brain injury. It evaluates three aspects of responsiveness: eye opening, verbal response and motor response with a total score ranging from 3 to 15. The GCS is used to assess and monitor a patient's neurological state and to guide treatment decisions.

[3] I note that in Cornelia's *'Pain Assessment / Management Chart'*, the entry at 2am reads, *'denies pain'*.

13. By 7:00am, Cornelia appeared drowsy but was rousable. The locum clinician had not attended, and records show the appointment was rebooked. Throughout the morning, Cornelia appeared comfortable, tired but rousable. She wanted to sleep and would not open her eyes for neurological observations. She declined her midday medications.

14. At 2:00pm, Cornelia's left hip and lower leg pain re-emerged and she was administered oxycodone. This is the first time her pain was recorded in her pain chart. Staff attended to her hygiene needs and she demonstrated facial grimacing and groaning due to the pain. The RN was informed of Cornelia's pain.

15. At around 4:45pm, Cornelia would not open her eyes and had only a small amount of food and drink. She had a low blood pressure and when staff suggested she be transferred to hospital, Cornelia refused. She eventually agreed to a hospital transfer. An ambulance was booked. By this time, the locum clinician had still not attended Wallace Lodge.

16. Staff continued to monitor her pain – which was described as severe – and administered paracetamol and additional oxycodone. At 8pm, the ambulance arrived, and Cornelia was transferred to the University Hospital Geelong Emergency Department.

17. Upon Cornelia's arrival, at around midnight, clinicians observed that she was confused with a reducing GCS, tachypneic (had rapid breathing) with an increasing respiratory rate. Computed tomography (**CT**) scans performed on 6 and 7 April 2025 showed a right temporal acute intraparenchymal haemorrhage and right frontotemporal, parafalcine and bilateral tentorial subdural haematoma. There was also an acute subdural haemorrhage with midline shift and a left neck of femur fracture (hip).

18. Clinicians liaised with the orthopaedic team and with the Royal Melbourne Hospital neurosurgical team. The neurosurgical team advised to manage the bleed with medication at that stage. In response to the orthopaedic team's suggestion for surgical repair of the femur fracture, the Royal Melbourne Hospital advised that Cornelia was not a suitable candidate for surgery.

19. On the morning of 7 April 2025, clinicians discussed Cornelia's poor condition and prognosis with her family. It was agreed to transition her to an end of life pathway that afternoon. Cornelia was declared deceased at 3:30pm on 11 April 2025.

Identity of the deceased

20. On 11 April 2025, Cornelia Groot, born 30 June 1937, was visually identified by her son, John Groot.

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

Medical cause of death

22. Forensic Pathologist Dr Joanne Ho of the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on 14 April 2025 and provided a written report of her findings dated 15 April 2025.

23. The post-mortem external examination was consistent with the clinical history. A post-mortem CT scan showed no fracture to the base of the skull however there was blood in the sphenoidal sinus, occipital scalp haematoma and right temporal haemorrhage. Dr Ho explained that a subarachnoid haemorrhage is bleeding that occurs into the subarachnoid space (between the brain and its thin covering). Also identified on the CT scan was an older subdural haemorrhage with focal acute haemorrhage and a left proximal femoral (thigh) fracture.

24. Dr Ho provided an opinion that the medical cause of death was 1(a) *Complications of head injuries and left proximal femur fracture sustained in a fall*.

25. I accept Dr Ho's opinion as to cause of death.

FAMILY CONCERNS

26. Following Cornelia's death, John wrote to the Court and expressed his concerns regarding the actions of Wallace Lodge staff following his mother's fall on 6 April 2025. He indicated he was not informed of her fall that morning and said: *'I was merely told that she had a bad night upon which I suggested that they let her sleep as I could return later'*.

27. It was only that afternoon, according to John, that he was informed of Cornelia's fall: *'Sadly, it was only short number of hours later that I was contacted by a concerned nurse to inform me that she was experiencing severe pain due to a heavy fall taken in the early hours of Sunday morning'*.

28. John also considered the length of time between Cornelia's fall and her transfer to University Hospital Geelong was *'too long and severely negated any real chance of her survival'*.

DIFFICULTY OBTAINING COMPREHENSIVE MEDICAL RECORDS FROM BARWON HEALTH

29. My investigation focussed on the 18 hours between 2am and 8pm on 6 April 2024 and the documented observations and actions undertaken during this period.

30. Unfortunately, my investigation was made difficult at times due to the organisation of records by Barwon Health. As its legal representatives explained, aged care records of Barwon Health are stored in system *'separate from the health service's main digital medical record system and do not electronically transmit to the latter as most other records systems in the health service do'*. That is to say, that Barwon Health aged care records are housed separate from its main medical record system and upon receiving a request from the Court,[4] it is only the latter that is provided.

31. Further difficulties arise given that data from the aged care record system cannot be downloaded in its entirety, rather, staff are required to embark on the painstaking task of manually extracting each individual document from the patient's file.

32. Barwon Health's legal representatives acknowledged and apologised for the impact this had on my investigation. I appreciate their transparency. They also informed me that the health service is currently addressing the issue, and I hope that other coronial investigations will not be similarly affected by delay or incomplete materials.

STATEMENT OF WALLACE LODGE AND RECORDS PROVIDED BY BARWON HEALTH

33. At the Court's request, Karen Primmer (**Ms Primmer**), then-Acting Manager of Aged Care at Barwon Health,[5] provided a statement dated 16 October 2025 addressing Cornelia's residence at Wallace Lodge generally and the events of her fatal fall.

Cornelia's history of falls and risk assessments

[4] Or from Coronial Admissions and Enquiries.
[5] Ms Primmer's substantive role is Clinical Manager of Aged Care.

34. On admission to Wallace Lodge, around 19 December 2024, Cornelia was assessed for falls using the Falls Risk Assessment Tool (**FRAT**)[6] and was referred to physiotherapy in accordance with usual procedure.

35. Between mid-December 2024 and Cornelia's death, she sustained 11 falls while at Wallace Lodge and on each occasion, her falls risk was re-assessed using the FRAT. On two occasions she had further physiotherapy assessments.

36. With the intention to manage Cornelia's high falls risk, Wallace Lodge staff implemented prevention strategies including to have her walking aid by her bed and within reach, to ensure her personal items were within reach, her bed brakes were always on, and the bed was positioned at knee-height. Cornelia was not to be left in the bathroom unattended if unsafe and she was encouraged to participate in activities and to develop a lifestyle program that would assist in *'safe physical activities, encourage participation in exercise and activity program to improve muscle strength, balance and gait'*.

37. Evidence indicates that Cornelia had poor insight into her declining mobility, and that she had a strong desire to maintain her independence. As a consequence, she was known to attempt to ambulate without staff assistance and/or supervision, and without her mobility aid(s).

38. In March 2025, Wallace Lodge staff spoke with Cornelia and John degrading a Dignity of Risk Form. The form stated that: *'Cornelia wishes to continue mobilising independently with the use of her 4WF, without staff assistance, at times'*. It continued that as a result of her *'decision to ambulate without waiting for staff assistance or using her mobility aid'* there were risks of an increased frequency of unavoidable falls, significant injuries such as a cerebral haemorrhage and the possibility that these injuries could lead to *'life-limiting severe complications, including death'*.

39. Mr Primmer stated that *'[John] is documented to have discussed the dignity of risk [form] with his mother and she agreed to use the call bell and wait for staff assistance. Both [Cornelia] and her son declined to sign the form at that time, indicating they would do so in the future if the need were to arise'*.

<u>Care provided on 6 April 2025</u>

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[6] The FRAT was developed by Peninsula Health Falls Prevention Service in 1999 and went through a process of validation for use. It is recommended as a screening tool by the Victorian Department of Health

40. When Wallace Lodge staff found Cornelia on the floor in the early morning of 6 April 2025, Cornelia was *'alert but confused'* with a GCS of 14. She *'initially refused to be assisted up and stated that she did not fall'*.

41. A registered nurse assessed Cornelia and identified a wound to her parietal region[7] – a *'small lump'* that was *'slightly tender to touch'*. She also had bruises to her left cheek and eye which records demonstrate were suspected to have been *'?from carpet'*. At this time, she *'denied pain in her extremities but complained of stiffness to her legs and was assisted to bed using a hoist'*.

42. Ms Primmer stated: *'It was noted she was not anticoagulated and neurological observations were commenced, which remains within normal limits during the shift'*. It was around 2:00am, when Cornelia first complained of hip pain, that Wallace Staff contacted her GP via e-mail and booked a locum clinician appointment. Cornelia's pain was documented in the progress notes at 6:20am, entries to her pain management chart between 2 and 10am stated she was not in pain.

43. Ms Primmer stated that at around 7:30am, Cornelia's GCS was 8. The locum clinician appointment had to be re-booked, and they had still not attended by 11:30am. The reason for the re-booking is unclear, and it is also unclear what time the locum was scheduled to arrive.

44. In an entry to Cornelia's records made at 12:23pm, an RN recorded those neurological observations *'have been a challenge to attend as she tells staff to go away and refuses to open her eyes'*. When Cornelia refused her midday medication she is recorded to have said: *'I just don't want to take them now please leave me alone'*. The RN recorded, *'Wishes respected'*.

45. Ms Primmer stated that at around 2:00pm, when staff attended to Cornelia's hygiene – and which was clearly a painful experience for her[8] – Cornelia was *'offered a transfer to hospital to investigate the causes of her pain and swelling but is documented to have declined three times'*. Instead, she was *'documented for close monitoring'*.

46. At around 4:45pm, staff again offered for Cornelia to be transferred to hospital which despite initially refusing, she eventually accepted. The ambulance was booked to arrive at 8pm and I

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[7] The parietal region/lobe is at the upper sides of the brain/skull.

[8] The pain was documented in Cornelia's pain management chart. This was the first entry of her reporting pain on 6 April 2024.

note it is unclear whether the call to book the ambulance was made directly after Cornelia's consent. By this time, Wallace Lodge staff noted she was *'unwell'*.

Communication between Wallace Lodge and Cornelia's family

47. John was not called at the time Wallace Lodge staff found Cornelia at around 1:55am on 6 April 2025. According to Ms Primmer, in the hours immediately after Cornelia's fall, John was documented in Cornelia's records as *'to be informed'*.

48. Ms Primmer explained the reason that John was not contacted:

> *'It is understood this is because it was the middle of the night and at that stage there was no indication of serious injury and the locum GP had yet to visit'.*

49. In a nursing entry made at 12:23pm, it states, *'Son John came to visit this morning and notified of incident'*. John was scheduled to pick up Cornelia at 9am to go shopping however, neither the records nor Ms Primmer's statement explicitly state the time that he was contacted.

STANDARDS FOR POST-FALL PATIENT MANAGEMENT

50. Given the extended period of time between Cornelia's fall (2am) and her being transported to hospital (8:15pm) - approximately 18 hours - I turned to consider whether Wallace Lodge appropriately managed her condition and complied with relevant standards and procedures.

Victorian Government Standardised Care Process

51. In 2018, the then-Department of Health and Human Services of the Victorian Government,[9] released its Standardised Care Process relating to falls (**the Falls SCP**)[10] which was developed to *'promote evidence-based practice'* for falls prevention and management in residential aged care settings.[11]

52. The Falls SCP addresses aspects including comprehensive physical assessments and environmental reviews to address a resident's falls risk. It also outlines a recommended post-fall assessment routine including monitoring vital signs and screening for injuries. It states that *'Vital signs should be repeated every hour for four hours then reviewed. They should be*

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[9] Now the Department of Health.

[10] Falls Standardised Care Process, Department of Health and Human Services, March 2018 and accessible at https://www.health.vic.gov.au/sites/default/files/migrated/files/collections/factsheets/s/scp-falls-pdf.pdf.

[11] The Falls SCP was developed for public sector residential aged care services (PSRACS) by the Australian Centre for Evidence Based Care (ACEBAC) at La Trobe University through the Department of Health and Human Services Strengthening Care Outcomes for Residents with Evidence (SCORE) initiatives.

continued four-hourly until 24 hours of observation have been completed'. If the patient sustained a head injury or the fall was unwitnessed, the Falls SCP states that neurological observations (measuring GCS) should be commenced and repeated *'every 30 minutes until GCS is within normal limits, then continue hourly for the next four hours, then two-hourly until 24 hours of observation has been reached'*.

53. Regarding escalation of treatment, the Falls SCP states that *'the healthcare team should consider further investigation (cranial computed topography) or transfer to hospital in accordance with the clinical evidence, the resident's wishes, the resident's advance care plan or the wishes of the resident's authorised representative'*.

Barwon Health Functional Mobility and Falls Minimisation and Management

54. Barwon Health's policy entitled *'Functional Mobility and Falls Minimisation and Management'* applies to its residential aged care sector and similarly addresses post-fall assessment (**the Barwon Health Falls Policy**).

55. The Barwon Health Falls Policy states that following the fall, several actions should be taken and recorded in the patient's progress notes. These include:

    a) Details of the fall and possible contributing factors,

    b) Any observed indicators of head injury or other injury,

    c) Vital observations including neurological observations,

    d) Notification of medical officer and actions implemented; and,

    e) Notification and discussion with resident and/or Medical Treatment Decision Maker.

56. For an unwitnessed fall, or a fall with a witnessed head strike,[12] staff are to perform vital signs and neurological observations half hourly for four hours, hourly for four hours, four hourly for 24 hours and daily for 7 days.[13]

57. The Barwon Health Falls Policy states that *'Neurological observations are to be recorded in [electronic resident management system] on the Weight/Vital Signs and staff to ensure all relevant fields are completed'*.

[12] Or for an anticoagulated resident.

[13] Appendix 1 to the Barwon Health Falls Policy provides a flowchart for staff to follow in the event of a fall.

58. It continues that, *'Where vital signs or neurological observations cannot be completed (e.g. resident refusal)'* staff are to complete an ongoing visual assessment which is recorded in the patient's electronic record. This assessment is to canvass alertness, mobility, participation in usual activities breathing, oral intake, output (urine/bowel), general appearance (flushed, pallor, sweating etc.).

59. The Barwon Health Falls Policy does not specify what method of neurological observations should be adopted; however, it references the GCS as a means to identify a resident's deterioration when attending to neurological observations.

60. Staff are to monitor for indicators a head injury, liaise with the resident's GP and/or locum clinicians *'for review and inform of any deterioration including indicators of head injury'* and to *'follow instructions regarding further neurological investigations e.g. CT scan'*. Indicators of a head injury include abnormal vital observations, alerted behaviour/mental state/irritability, bruising around both eyes, altered conscious state, severe headache, and continuing nausea/vomiting.

61. The Barwon Health Falls Policy also outlines that staff are to contact the resident's Medical Treatment Decision Maker, complete an incident report, review the resident's Falls/Safety Assessment and Care Plan. If radiological imagining is indicated, it provides instruction for escalation occurring inside and out of business hours, and states: *'Outside business hours will require transfer to University Hospital Geelong (UHG) or resident's hospital of choice via the Emergency Department (ED)'*.

62. The Barwon Health Falls Policy does not specify when a resident may need to be transferred to hospital or referred for imaging in the absence of a clinician's advice, resident compliance and/or direction from the family.

ADEQUACY OF NEUROLOGICAL OBSERVATIONS PERFORMED ON 6 APRIL 2025

63. Both the Falls SCP and the Barwon Health Falls Policy make clear that neurological observations (and vital signs) were to be attended at designated intervals following Cornelia's fall.

64. At the outset I note that neurological observations can be performed[14] using a variety of methods – the GCS is one such method. The purpose of neurological observations is to collect

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[14] I note that in the nursing context, the language adopted is that observations are '*attended*'.

data on an individual's neurological status and in the context of an unwitnessed fall and/or headstrike and they can assist to determine whether there is a brain injury which requires urgent medical attention. Methods of performing neurological observations are designed to assess level of consciousness, pupillary reaction, motor function, sensory function and vital signs. In addition to the GCS, other methods include mental status, cranial nerve, motor exam, gait and deep tendon reflexes.[15]

65. Applying the Barwon Health Falls Policy, nursing staff were required to perform neurological observations 14 times between 2am and 8pm when the ambulance arrived, as follows:

    a) Half-hourly between 2 and 6am,

    b) Hourly between 6 and 10am; and,

    c) Four-hourly between 10am and 8pm.[16]

66. In a chart entitled, *'Weight and Vital Signs: Selected Resident Glasgow coma scale'* (**GCS Chart**), Cornelia's GCS score was documented half-hourly between 2 and 5am and was *'14'* on each occasion. The GCS Chart is separate from resident progress notes and the first entry to Cornelia's progress notes occurred at 6:20am.

67. Her GCS was next documented in the CGS Chart at 7:07am and was entered as *'8'*. The corresponding *'notes'* section contained the entry, *'post fall'*. A note made to Cornelia's progress notes at 7:32 reads, *'0700hrs Appeared drowsy but arousable, answering questions then falling asleep. Obs NAD* [observations no abnormalities detected]*'*.

68. An entry to the GCS Chart at 8am documented her GCS had increased to *'13'*.

69. There are two entries to the record at 10am. According to one entry, Cornelia's GCS was *'13'* while the other documented it was *'10'* but contained the note that Cornelia *'refused to open her eyes, stating "I don't want to"'*. Her progress notes read, *'neuro obs* [neurological observations] *have been a challenge to attend as she tells staff to go away and refuses to open her eyes'*. This entry was made at 12:23pm, and it is unclear whether this is a specific reference to either of the 10am entries to the GCS Chart.

[15] Mahsa Shahrohki and Ria Asuncion 'Neurologic Exam' StatePearls Publishing 2025 and accessible at: https://www.ncbi.nlm.nih.gov/books/NBK557589/.

[16] That is; at 2am, 2:30am, 3am, 3:30am, 4am, 4:30am, 5am, 5:30am and 6am; 7am, 8am, 9am and 10am; 4pm and 8pm.

70. Cornelia's GCS was next recorded at 11:55am, when it was *'14'* and at 2:21pm when it was *'10'*. During the latter, Cornelia *'complained of pain during movement post falls OBs'*. There were no entries to the GCS Chart after 2:21pm.

71. An entry to Cornelia's progress notes at 3:14pm documented that she had *'refused food and fluids'* but that post fall observations were *'WNR'*, meaning *'within normal range'*. Another entry 10 minutes later, at 3:24pm documented, *'frequent checks done, eyes open occasionally but shuts them on staff approach and refused to have neuro obs checked a few times.'*

72. It is unclear whether *'checks'* refers to neurological observations, vital signs or both. It is also unclear at what time(s) Cornelia refused to comply with neurological observations.

73. The next entry to her progress notes occurred at 6:27pm, Cornelia's blood pressure and temperature were recorded, and it was noted that *'all other OBS unremarkable'*.

74. Not every attendance to Cornelia's neurological observations was accompanied by an entry to her progress notes. It is apparent that entries to her progress notes were not made contemporaneously. For example, the first entry on 6 April 2024 was made at 6:20am and covered events which had occurred in the past 4 hours and 20 minutes. It appears there was a delay of up to several hours before events were recorded in her progress notes. This has made it difficult to effectively and comprehensively track and monitor Cornelia's progress during the relevant 18 hours.

75. For completeness I note that Cornelia's vital signs were records (in another separate chart), at 2am, 2:30am, 3am, 3:30am, 4am, 4:30am, 5am, 6am, 7:06am, 8:00am, 9am, 10am, 2:28pm, 5:30pm, 6pm and 7:13pm. Her vital signs (pulse, blood pressure, temperature, respiratory rate and oxygen saturation) appeared normal at these times.

76. On occasions when Cornelia did not allow for staff to perform neurological observations[17] – by *'refus[ing] to open her eyes'* – there is no evidence that staff attempted to perform the alternative assessment as set out in the Barwon Health Falls Policy.

CHANGES IN CORNELIA'S CONDITION ON 6 APRIL 2025

[17] The specific times when Cornelia refused to engage with neurological observations is unknown.

77. Under the Barwon Health Falls Policy, Wallace Lodge staff were expected to *'monitor for signs of head injury'*. It sets out a list of factors which staff ought to monitor, and which includes *'altered behaviour/mental state/irritability'* and bruising around the eyes.

Monitoring Cornelia's facial and head injuries

78. When staff found Cornelia on her bedroom floor, she had bruising to her left cheek and eye and a small lump to her parietal region which was red and slightly tender.

79. At around 6am, separate *'Wound / Skin Management Plan and Evaluation'* reports were created for each wound. A photograph of each area was included in the document. I note however that the photographs were captured approximately 4 hours after the injuries were sustained and first observed.

80. The wound to Cornelia's left eye area was described as a *'bruise'* resulting from *'friction'* and which measures 5 x 2.5cm. This is consistent with the entry to her progress notes made at 6:20am which documented the wounds were likely *'?from carpet'*.

81. The wound to her left cheek was similarly described as a *'bruise'* resulting from *'friction'* and measured 6 x 2.5cm. The parietal wound was described as a *'small lump with bruising'* resulting from *'trauma'* and measures 2 x 1.5cm.

82. In all three wound reports, Cornelia's pain was rated as a *'0'* of out of 10 and the plan was made to *'monitor daily'*.

83. There is no further mention of these injuries in Cornelia's progress notes, in any of the wound charts nor in Ms Primmer's statement and there is no evidence that they were monitored throughout the day.

84. It is reasonable to expect that for staff to adequately *'monitor for signs of head injury',* they conduct ongoing visualisation, assessment and recording of the bruise to Cornelia's eye area and parietal lump. Without these assessments, I am unable to determine whether the injuries increased, decreased or remained unchanged nor whether any change(s) – particularly to the eye bruise and parietal lump - may have indicated for earlier escalation of treatment.

Cornelia's fatigue and irritability

85. Drowsiness, lethargy and a reduction in consciousness/alertness are recognised symptoms of intracranial haemorrhage.[18] Personality and demeanour changes such as increased aggression or irritability can also be seen,[19] and were recognised by the Barwon Health Falls Policy as a potential indicator of head injury.

86. Progress notes show that Cornelia was first recorded as *'drowsy'* at 7:32am, but she was still rousable. In an entry made at 12:23pm, she was noted as *'very tired but rousable'*. Further entries document that she did not open her eyes but was noted as *'alert'* at the same time. She also refused to comply with attempts to perform neurological observations and this was documented in her progress notes and GCS Chart.

87. In the absence of fulsome documentation relating to each attendance upon Cornelia, it is difficult to determine whether her fatigue and irritability were indicators of an escalating head injury. Given that the fall happened during the early morning and she was recorded to have slept only between 4am and 7am, it is possible that her tiredness was due to a disturbed night. Similarly, it is possible that her reluctance to engage with Wallace Lodge staff and refusal to open her eyes could be attributed to the difficult behaviours which she demonstrated prior to 6 April 2024.

88. That is to say, while these features of Cornelia's presentation could have a clinically insignificant cause, they were nonetheless, symptoms that *may* have been indicative of her escalating head injury. Due to the paucity of contemporaneous records, I am unable to effectively monitor changes in her presentation nor am I able to determine their significance in relation to her clinical course.

A drop in Cornelia's GCS

89. Between 2 and 5am, Cornelia's GCS was consistently recorded at 14 in the GCS Chart. At 7:07am, it dropped to 8. There is no reference in Cornelia's progress notes to the sudden drop in consciousness. As previously identified, an entry made at 7:32am stated, *'0700hrs*

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[18] *See for example* British Medical Journal website at https://bestpractice.bmj.com/topics/en-gb/416; Health Direct Australia website at https://www.healthdirect.gov.au/subdural-haematoma; and, Louisdon Pierre, Noah Kondamudi, Subdural Hematoma, StatPearls Publishing accessible at https://www.ncbi.nlm.nih.gov/books/NBK532970/.

[19] *See for example* National Health Service UK website at https://www.nhs.uk/conditions/subdural-haematoma/#:~:text=Symptoms%20of%20a%20subdural%20haematoma&text=a%20bad%20headache%20that%20does,such%20as%20being%20unusually%20aggressive; Louisdon Pierre, Noah Kondamudi, Subdural Hematoma, StatPearls Publishing accessible at https://www.ncbi.nlm.nih.gov/books/NBK532970/.

Appeared drowsy but arousable, answering questions then falling asleep'. It does not reference her reduced GCS nor whether any actions were taken in response.

90. Medical literature indicates that a GCS of 8 can indicate a *'severe'* brain injury and *'can reflect vegetative state, minimally conscious state, or posttraumatic confusional state'*.[20] Some data also suggests that individuals with such a reduced GCS should be intubated. I also note that some studies advised of the *'risk of dichotomising the GCS'*.[21]

91. Turning to the Barwon Health Falls Policy, it states that a GCS less than 15 or a GCS at least 2 points lower that the resident's baseline is an indicator of head injury and that staff are required to *'notify the resident's GP/In Reach/Locum or Telehealth for review'*. Cornelia's GCS of 8 fell into this category.

92. There is no evidence that Cornelia's significantly reduced GCS caused concern among Wallace Lodge staff or that it prompted them to consider whether she needed urgent medical attention. There is no indication that it was escalated to senior staff on shift, that her GP was advised or a more urgent locum appointment was sought. Rather, the progress note entry at 7:32am documented the plan for *'staff to closely monitor'*.

93. Low GCS readings of 10 at 10am and 2:21pm also ought to have raised concerns among Wallace Lodge staff given it is less than 15 and more than two points below Cornelia's baseline GCS.[22] I further note that her GCS was not recorded between 2:21pm and 8pm when she left the facility (approximately 5.5 hours). This is not in accordance with the application of the Barwon Health Falls Policy which required neurological observations be performed every four hours between 10am and 8pm. Cornelia's low GCS at 2:21pm (score 10) added further impetus that neurological observations continue to be performed.

94. I acknowledge that after 7am, Cornelia's GCS increased – it was 13 at 8am. However, on the basis of the information available to Wallace Lodge staff at the time of Cornelia's drop in GCS, they could not have known that it would increase and ought to have escalated her condition.

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[20] Shobit Jain et al 'Glasgow Coma Scale' StatPearls Publishing 2025 accessible at: https://www.ncbi.nlm.nih.gov/books/NBK513298/.

[21] *See for example* Mark Fitzgerald et al 'An initial Glasgow Coma Scale score of 8 or less does not define severe brain injury' *Emergency Medicine Australasia* 2022 34(3) accessible at: https://onlinelibrary.wiley.com/doi/10.1111/1742-6723.13937; Justin Hatchimonji et al. 'Questioning dogma: does a GCS of 8 require intubation?' *European Journal of Trauma and Emergency Surgery'* 2020 47(6) accessible at: https://pmc.ncbi.nlm.nih.gov/articles/PMC7223660/.

[22] I consider that Cornelia's baseline is a GCS of 15, as indicated by previous days' recording.

LACK OF CLINICIAN ASSESSMENT

95. Cornelia's declining condition (in terms of irritability, increased pain, and sudden drop in GCS) was compounded by the lack of clinician oversight. The progress note made at 6:20am documented, *'e-mail sent to GP'*. However, this record was not made contemporaneously, and it is unclear at what time the GP was informed of Cornelia's fall and head injury. The contents of the e-mail are also unclear, as is whether the GP responded and provided any instruction as to post-fall management.

96. According to the records, the GP was not contacted nor updated until that evening when an ambulance was booked. The record reads, *'[called] GP and inform resident condition. GP is okay to send to hospital for further investigation'*.

97. Wallace Lodge staff also attempted to secure a locum to attend the facility and assess Cornelia. At 6:20am, an RN entered to Cornelia's progress notes, *'Locum booked due to headstrike'* and at 7:32am, the same RN wrote, *'staff to closely monitor and rebook locum this am [morning]'*. However, the reason for the rebooking is not documented.[23] At 12:23pm, a note was made that read *'LOCUM booking confirmed, awaiting review'*. By 3:24pm, approximately 13.5 hours after the fall, Cornelia was *'still awaiting locum review'*.

98. After 3:24pm, there is no further entry to Cornelia's progress notes which references the locum. Indeed, the locum had not attended by the time Cornelia was transported to hospital. The reason for the locum's non-attendance is not clear.

99. In totality, Cornelia did not receive an assessment or review by a clinician until she was assessed at the Emergency Department around midnight, some 22 hours after her fall.

ESCALATION OF MEDICAL TREATMENT

100. It was approximately 18 hours after Cornelia fell that the ambulance arrived and she was transported to hospital. The first offer for Cornelia to be transported to hospital occurred around 2pm, according to Ms Primmer, when she reported hip and leg pain. However, the entry to Cornelia's progress notes which corresponds to this discussion was made at 3:24pm. This is unlikely a contemporaneous entry.

101. There is no indication that Wallace Lodge staff considered that Cornelia ought to be transferred to hospital sooner, despite her drowsiness/irritability, sudden drop in GCS and

[23] For example, whether the locum cancelled the appointment or a change to Cornelia's condition indicated rebooking.

their inability to consistently perform neurological observations nor secure a locum GP review.

Victorian Virtual Emergency Department

102. I acknowledge that Wallace Lodge staff have varying degrees of training – ranging from personal care assistants to RNs – and that they cannot be expected to exercise clinical judgment in lieu of medical practitioners. That being said, there are resources which were accessible to Wallace Lodge staff on 6 April 2024 when it became apparent that securing a locum appointment was proving difficult.

103. The Victorian Virtual Emergency Department (**VVED**) is a statewide, free Telehealth service which connects hospitals, ambulance services and aged care facilities by enabling access to emergency services 24/7.[24]

104. The VVED is staff by emergency doctors and nurse practitioners and provides clinical assessments and early treatment. It is a useful service that can assist residential aged care staff in determining whether a resident requires urgent medical treatment and escalation to a dedicated health service provider, or whether their symptom(s) and condition(s) can be managed without transfer.

Communication with Cornelia's Medical Treatment Decision Maker

105. Commencing at around 2pm, Wallace Lodge staff offered to organise an ambulance transfer to hospital for Cornelia. Cornelia consistently refused the offers.

106. I acknowledge that in aged care settings, respecting and upholding patient wishes is important, including when their decision is to refuse medical treatment. However, given the lack of detail regarding each of these conversations, I am unable to determine whether Cornelia made a fully informed decision and was adequately advised of the risk of refusing treatment. It does not appear that staff impressed upon her the seriousness of her condition and risk of life threatening brain injury following her fall – indeed, it is not apparent that they appreciated it themselves. I also note that Cornelia had demonstrated a drop in consciousness (even if her

[24] *See* https://www.latrobe.edu.au/industry-and-community/la-trobe-industry/case-studies/an-emergency-department-like-no-other#:~:text=The%20Victorian%20Virtual%20Emergency%20Department%20(VVED)%20is%20a%20pioneering%20telehealth,in%20Victoria%2C%2024%2F7..

GCS had increased afterward) which also raises doubts as to her capacity to have make such decisions.

107. John was appointed as Cornelia's Medical Treatment Decision Maker (**MTDM**) – this was known by Wallace Lodge staff. The Barwon Health Falls Policy states that *'any decision regarding further investigations and ongoing management should be made in consultation with the resident and or their representative/MTDM, the Advance Care Plan and Goals of Care and Deterioration Management form'*.

108. In his correspondence with the Court, John stated that *'[he] was not informed that she'd had a fall'* when he visited her on the morning of 6 April 2025. Rather, it was hours later when nursing staff told him that *'she was experiencing severe pain due to a heavy fall taken in the early hours of Sunday morning'*. In response to this information, John *'promptly gave'* his authority, as MTDM, to initiate a hospital transfer. Evidence indicates this conversation occurred around 4:45pm (according to Ms Primmer) or 6:30pm (according to the progress notes).

109. While Ms Primmer said that: *'It is documented [John] did attend as planned at around 0900 hours. He was told of the fall and his mother's condition at that time, and he visited his mother'*. In the entry made at 12:23pm, an RN wrote: *'Son John came to visit this morning and notified of incident'*.

110. There is no evidence that Wallace Lodge staff told John of his mother's declining condition – specifically of her risk of head injury, drop in GCS and refusal to comply with neurological observations. There is no evidence that they sought his direction, as Cornelia's MTDM, regarding her medical treatment/monitoring such as whether she should be transferred to hospital sooner, or whether to continue waiting indefinitely for the locum to attend. This is not consistent with the Barwon Health Falls Policy which required that decisions relating to *'ongoing management*' should be made in consultation with the MTDM.

THE PREVENATIBILITY OF CORNELIA'S DEATH

111. I turned to consider whether Cornelia's death could have been prevented had she been transported to hospital sooner.

112. I am conscious that Cornelia was of an advanced age, she had a BMI of 15 kg/m^2 which placed her in the *'Underweight'* category and had multiple conditions including Parkinson's disease

and haemochromatosis.[25] As a result of the fall, she sustained both head injuries and a fractured hip – either of which may have been fatal on their own.

113. The paucity of detail in Cornelia's progress notes has made it difficult to adequately track her clinical deterioration throughout 6 April 2025. Her prognosis was likely complicated by the presence of two major injuries, poor *body habitus* and ongoing medical conditions. That is to say, she may have been ineligible for surgical intervention even if she had received medical treatment earlier.

FINDINGS AND CONCLUSION

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

a) the identity of the deceased was Cornelia Groot, born 30 June 1937;

b) the death occurred on 11 April 2025 at Barwon Health Bellerine Street Geelong Victoria 3220, from 1(a) *Complications of head injuries and left proximal femur fracture sustained in a fall*; and

c) the death occurred in the circumstances described above.

115. Wallace Lodge responded appropriately to Cornelia's fall in the immediate aftermath of her fall by conducting a head to toe injury assessment, performing a neurological exam and contacting clinicians for further assessment.

116. However, Wallace Lodge's management of Cornelia throughout the day of 6 April 2024 was suboptimal. Neurological observations were periodically performed however not at the frequency required by the relevant Barwon Health Falls Policy and her head injuries were not re-checked despite being an indicator of head injury listed in the same policy.

117. There is no evidence that staff turned their mind to the totality of Cornelia's presentation was indicative of a potentially life threatening brain injury. This compounding effect of (i) a sudden drop in GCS, (ii) increasing pain, (iii) Cornelia's refusal to engage with neurological observations and (iv) inability to secure a locum review, was such that Cornelia did not receive appropriate medical attention until some 22 hours after the fall.

[25] A condition which causes excessive iron absorption and dangerous accumulation in organs such as the liver, heart and pancreas.

118. It is unclear why the locum clinician was unable to attend Cornelia on the day of her fall. However, despite their inability to secure an assessment by a clinician and Cornelia's poor compliance with neurological observations, there is no evidence that Wallace Lodge staff turned their mind to whether a hospital transfer should be arranged to ensure timely assessment of her condition.

119. I accept that Cornelia was a difficult patient to manage and that she was often non-compliant (both before and on 6 April 2025), however there were avenues open to Wallace Lodge staff to obtain advice and direction regarding her clinical management. One such avenue was for staff to seek direction from Cornelia's son and Medical Treatment Decision Maker as was required by the relevant policy. Despite this, there is an insufficient cogency of evidence before me to support a conclusive finding that Cornelia's death could have been prevented had she been transported to hospital sooner. While I cannot determine, with any level of certainty, that her death could have been prevented, had she received medical treatment earlier she would have, at the least, been provided more comfortable care.

120. I emphasise that my investigation and the findings which I am able (or unable) to make, has been complicated by the poor documentation and record keeping practices of Wallace Lodge and that this has had the consequence of obfuscating Cornelia's deterioration and the events which led to her tragic death.

COMMENTS

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

121. During the final phases of my investigation, I wrote to Barwon Health and provided it with a draft copy of the findings which I intended to make and comments which it may consider were adverse to its interests. I provided the health service with an opportunity to respond to those comments and make submissions in support of its position. The draft provided to Barwon Health also contained two proposed recommendations that I intended to hand down.

122. The Court received a response from Barwon Health's legal representatives that the medical records it had previously provided to the Court had been an incomplete copy and provided with Court with some 100 additional files.

123. It explained that its aged care patient records – such as for a Wallace Lodge resident – and health service patient records are stored on different computer software programs and that when health service records are downloaded, they do not automatically include aged care records. It also explained that residential aged care records cannot be downloaded *en masse* and observations charts and notes must be individually exported, creating an onerous task for administrative staff.

124. It is the Court's understanding that Barwon Health is currently in the process of updating its file management system(s) to avoid the recurrence of this issue.

125. Having reviewed the additional records provided, the Court again wrote to Barwon Health to advise them of slight amendments to my draft findings but that the substance of my conclusions remained unchanged. The correspondence again contained the two draft recommendations that I intended to hand down. Those were that Barwon Health:

    a) *provide education to all its aged care staff on the importance of conducting comprehensive neurological observations as a part of resident post-fall management. This education ought to provide clear instruction on what to do when residents demonstrate a sudden drop in GCS* <u>*and*</u> *alternative procedures when residents refuse to engage with neurological observations;* and,

    b) *amend its policy and develop a procedure on resident post-fall management when a GP and/or locum clinician assessment cannot be secured to ensure that residents receive medical treatment without delay.*

126. Approximately four weeks later, Barwon Health confirmed (through its legal representative) that it did not have any submissions regarding the comments I was intending to make. It did, however, articulate that it had implemented changes corresponding to the recommendations which I proposed to make and submitted that this obviated the need for those recommendations to be made. Those changes were:

    a) Updates to its education modules regarding what to do when a resident has a change in status including a drop in GCS, and when a resident refuses to comply with observations. Education on *'Recognising and Responding to Deteriorations in Older person'* was made mandatory; and,

b) The relevant policy was updated to *'include a pathway for escalation if the resident's GP is unavailable'*. The changes include direction to contact the Residential In-Reach team who will triage the call and organise a phone or face-to-face assessment within an appropriate timeframe. Residential aged care staff are otherwise directed to contact the Barwon Health Virtual ED or VVED for further assistance as necessary.

127. I note that prior to receipt of my draft findings and the recommendations contained therein, Barwon Health had not informed the Court of any changes which it was intending to make. In considering the changes which had been implemented by Barwon Health, I am satisfied that to hand down the recommendations would be unnecessarily duplicative. However, I have included them in this comment for transparency's sake and to provide greater clarity to the Victorian public and in particular, to the Groot family regarding to the coronial process and its outcome.

I convey my sincere condolences to Cornelia's family for their 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 fining be provided to the following:

Mr John Groot, Senior Next of Kin

Barwon Health, c/- Ms Abby Neylon, Meridian Lawyers

Aged Care Quality and Safety Commission

Senior Constable Amber Kessler, Reporting member, Victoria Police

Signature:

Coroner Leveasque Peterson

Date: 06 May 2026

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.