IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 006831

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Simon McGregor
Deceased:	Evelyn June Wiseman
Date of birth:	26 August 1931
Date of death:	8 December 2023
Cause of death:	1a : PNEUMONIA COMPLICATING INJURIES SUSTAINED IN A FALL AND SARS COV-2 INFECTION 2 : DEMENTIA
Place of death:	Andrews House 40-42 School Road Trafalgar Victoria 3824
Keywords:	Falls; Aged Care

INTRODUCTION

1. On 8 December 2023, Evelyn June Wiseman was 92 years old when she passed away from injuries sustained during a fall on 26 October 2023. At the time of her death, Evelyn lived at Andrews House, 40-42 School Road, Trafalgar, Victoria 3824.

2. Evelyn married her late husband Ivo Wiseman in 1953 and the couple had four children together, Raymond, John, Darren and Tricia. Ivo passed away in 1994 and Evelyn continued living on her own with support from her children until January 2023 when she moved into Andrews House, a supported aged care facility.

3. Evelyn's last treating General Practitioner, Dr Michael Kunze, confirmed that she had been diagnosed with type 2 diabetes mellitus, atrial fibrillation, shingles, hearing impairment, metatarsal fracture, thrombocytopaenia, depression, anxiety, falls risk and limited mobility requiring a walking aid and.[1] Dr Kunze also noted that Evelyn had declining cognitive function that was consistent with dementia.[2]

THE CORONIAL INVESTIGATION

4. Evelyn'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. Victoria Police assigned Sergeant Glenn Redenbach to be the Coronial Investigator for the investigation of Evelyn's death. The Coronial Investigator conducted inquiries on my behalf,

[1] *Coronial Brief*, Statement of Dr Michael Kunze.
[2] Ibid.

including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

8. This finding draws on the totality of the coronial investigation into the death of Evelyn June Wiseman including evidence contained in the coronial brief. 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.[3]

9. In considering the issues associated with this finding, I have been mindful of Evelyn's human rights to dignity and wellbeing, as espoused in the *Charter of Human Rights and Responsibilities Act 2006*, in particular sections 8, 9 and 10.

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

Circumstances in which the death occurred

10. On 26 October 2023, Evelyn requested to go for a walk on her own outside the facility. Andrews House staff attempted to persuade Evelyn against leaving the premises, but subsequently she left the facility without the staff's knowledge.[4]

11. At around 10:00 am, members of the public found Evelyn lying on a concrete pad approximately 300 metres from Andrews House.[5] Emergency services were contacted and Evelyn was taken to Latrobe Regional Hospital for treatment for injuries to her right humerus fracture, left clavicle fracture, and head strike to the right-side of her face.[6]

12. On 2 November 2023, Evelyn was discharged and returned to Andrews House.[7] Andrews House staff noted that Evelyn's health was declining during the following weeks and on 30 November 2023 she was admitted to West Gippsland Hospital and diagnosed with COVID-19 and Pneumonia.[8]

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[3] 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.
[4] *Coronial Brief*, Statement of Shannon Phelan.
[5] *Coronial Brief*, Statement of Hadyn Draper.
[6] *Coronial Brief*, Statement of Dr Michael Kunze.
[7] Ibid.
[8] Ibid.

13. Evelyn was stabilised and discharged back to Andrews House on 8 December 2023 for palliative care and Andrews House staff confirmed that she passed away on 8 December 2023 at around 4:42 pm with her family present.[9]

Identity of the deceased

14. On 8 December 2023, Evelyn June Wiseman, born 26 August 1931, was visually identified by their daughter, Tricia McWaters.

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

Medical cause of death

16. Forensic Pathologist Dr Michael Duffy from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on 12 December 2023 and provided a written report of his findings dated 19 December 2023.

17. Post-mortem CT scans revealed evidence of degenerative cervical spine changes, bilateral lower lobe pneumonia, coronary artery calcifications and aortic valve calcifications. There was also evidence of left shoulder replacement, right humerus fracture and left clavicle fracture. Dr Duffy noted that there were no acute injuries identified that would have caused or contributed to death.

18. Dr Duffy provided an opinion that the medical cause of death was 1(a) PNEUMONIA COMPLICATING INJURIES SUSTAINED IN A FALL AND SARS COV-2 INFECTION, 2 DEMENTIA and I accept his opinion.

FAMILY CONCERNS

19. In their email communications to the Court on 9 December 2023, Evelyn's son, Raymond Wiseman, expressed significant concern about the following:

    a) Concerns about not being notified that Evelyn left the Andrews House facility on 26 October 2023 and that she had sustained a fall and required hospital treatment; and

    b) That she was able to leave the facility on 26 October 2023 without staff preventing her from leaving.

[9] *Coronial Brief*, Statement of Shannon Phelan.

20. I have considered the above concerns noted by Evelyn's family in my investigation and acknowledge that they required further investigation by the Court.

FURTHER INVESTIGATIONS - CPU REVIEW

21. As a result of receiving the family's concerns relating to medical care and management of Evelyn's falls risk, I referred her case to the independent practitioners in the Health and Medical Investigation Team of the Coroners Prevention Unit (**CPU**)[10] to review the circumstances of Evelyn's fall on 26 October 2023 and the medical care she received at Latrobe Regional Hospital and West Gippsland Hospital.

22. Following a careful review of the available evidence, CPU noted the following concerns:

    a. There were no keypad locks on the facilities external door to restrict Evelyn's passage outside;

    b. Andrews House rationalised this position, as the 'avoidance of restrictive practices' instead of providing a secure area to prevent harm for a vulnerable resident;

    c. Andrews House did not contact Evelyn's next of kin when she was agitated and trying to leave and when the fall occurred;

    d. Andrews House did not have a behaviour care plan detailed person-centred care or investigation as to why Evelyn was trying to leave the facility; and

    e. Andrews House did not offer Evelyn's family the option of restrictive practices to keep her from leaving the facility unaccompanied prior to her fall.

23. The CPU also commented that unexplained absences from aged care are reportable incidents to the Aged Care Quality and Safety Commission and especially since Evelyn was seriously injured on this occasion. The code of conduct for aged care providers includes keeping people receiving aged care safe from harm and must be considered a priority when caring for vulnerable residents.[11]

[10] 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.

[11] Available online at: https://www.agedcarequality.gov.au/for-providers/code-conduct#provider-responsibilities

24. To gain a fuller picture of Evelyn's clinical course, I directed that further information be obtained from the Aged Care Quality and Safety Commission (**ACQSC**) and Andrews House.

25. As a result of receiving the family's concerns, the ACQSC conducted an extensive investigation into the care and services provided to Evelyn by Andrews House, including an extensive review of information and evidential material provided by Andrews House as part of its internal investigation into care provided to Evelyn. The ACQSC is the national regulator of aged care services and is responsible for resolving complaints about services, monitoring and assessing providers' compliance with the Aged Care Quality Standards.

26. In response to the ACQSC investigation and Andrews House's own internal investigations, the following remedial actions were undertaken by Andrews House:[12]

    a) Meetings were scheduled with the Facilities department to discuss door opening/locking options. The options included auto locking or timed locking. This has been actioned regarding some internal courtyard doors, meaning that no code/lock is required to go outside. There has been no change to the main external door;

    b) Consideration of the practicality of moving the exit button further up the wall to make it harder for residents to reach or placing a cover over the exit button. This needs to be balanced with ensuring that there is no restriction to resident egress;

    c) A decision was reached that due to the balance of ensuring that other resident's movement, and not preventing egress, as well as ensuring that the facility is not inadvertently environmentally restraining residents, this was not a viable solution. It is also impractical for the physically disabled;

    d) A review was undertaken of documentation for consumers with a known cognitive impairment;

    e) A review of admission process was undertaken to better identify consumers with a cognitive impairment and their wishes or suitability to leave the facility unsupervised. This is currently in progress at Andrews House;

    f) Review is being undertaken into environmental restraint documentation and processes for identifying and implementing appropriate strategies.

[12] Statement of Leah Adams (West Gippsland Health Group Quality and Safety Manager).

FINDINGS AND CONCLUSION

27. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the *Briginshaw* gloss or explications.[13] Adverse findings or comments against individuals in their professional capacity, or against institutions, are not to be made with the benefit of hindsight but only on the basis of what was known or should reasonably have been known or done at the time, and only where the evidence supports a finding that they departed materially from the standards of their profession and, in so doing, caused or contributed to the death under investigation.

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

    a) the identity of the deceased was Evelyn June Wiseman, born 26 August 1931;

    b) the death occurred on 8 December 2023 at Andrews House, 40-42 School Road, Trafalgar, Victoria, 3824, from 1(a) PNEUMONIA COMPLICATING INJURIES SUSTAINED IN A FALL AND SARS COV-2 INFECTION, 2 DEMENTIA; and

    c) the death occurred in the circumstances described above.

29. Having considered all of the evidence, I am satisfied that in the lead up to the fatal incident, Andrews House failed to recognise their responsibilities to keep Evelyn in a safe and secure environment which enabled her to be seriously injured. The injuries sustained in the fall would have increased Evelyn's fragility which significantly increased her risk of contracting a covid infection and pneumonia.

30. After careful consideration of the evidence in this matter, I am satisfied that the shortcomings of the care that Evelyn received have been addressed so far as possible by Andrews House in the time since her passing.

I convey my sincere condolences to Evelyn's family for their loss.

[13] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 362-363: 'The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences…'.

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

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

Raymond Wiseman, Senior Next of Kin

Nathan Yohan, Latrobe Regional Health

Aged Care Quality and Safety Commission

Leah Adams, West Gippsland Healthcare Group - Andrew House

Sergeant Glenn Redenbach, Coronial Investigator

Signature:





Coroner Simon McGregor

Date: 29 October 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.