CORONERS COURT OF SOUTH AUSTRALIA

INQUEST INTO THE DEATH OF HANS BIERMANN

[2026] SACC 34

Inquest Findings of his Honour State Coroner Whittle

21 August 2026

CORONIAL INQUEST

Examination of the cause and circumstances of the death of a man following a fall whilst detained within a residential aged care facility pursuant to section 32 of the *Guardianship and Administration Act 1993*.

Held:

1. Hans Biermann, aged 92 years of Davoren Park, died at Davoren Park on 1 March 2023 as a result of respiratory failure secondary to bilateral pleural effusions on a background of rib fractures and Alzheimer's dementia.

2. Circumstances of death as set out in these findings.

No recommendations made.

Counsel Assisting: MS R SCHELL
Hearing Date/s: 13/03/2026
Inquest No: 09/2026 **File No/s: 0601/2023**

INQUEST INTO THE DEATH OF HANS BIERMANN [2026] SACC 34

Introduction

1 The Court heard a mandatory inquest on the papers into the death of a man who, at the time, was subject to a Guardianship Order with a power of detention.

Hans Biermann

2 Mr Biermann was born in Germany on 9 October 1930. He emigrated to Australia in the 1950s. He met and married his wife Nina in the 1960s and they resided together in their home in Para Hills until Nina died on 3 March 2022. The couple had no children. Following the death of his wife Mr Biermann remained living at Para Hills.

3 In 2022, Mr Biermann was diagnosed with Alzheimer's dementia.

4 Mr Biermann's medical history included hypertension, atrial fibrillation, obstructive sleep apnoea, hypercholesterolaemia, osteoarthritis and heart failure with preserved ejection fraction.

5 In December 2022 Mr Biermann was hospitalised after a fall at home. After a brief discharge back to his home, he was readmitted and remained in hospital until 21 February 2023 when he was transferred to the Regis Playford aged care facility. There he had a further fall with a head strike on 23 February 2023. He was admitted to hospital, deteriorated and was returned to his care facility on 27 February 2023 for end-of-life care. He died on 1 March 2023 at the age of 92 years.

Cause of death

6 A pathology review was conducted at Forensic Science SA by Dr Alexandra Yuill, in consultation with senior consultant forensic pathologist, Associate Professor Neil Langlois. I accept Dr Yuill's opinion as to the cause of death, which I find to have been respiratory failure secondary to bilateral pleural effusions on a background of rib fractures and Alzheimer's dementia.

Healthcare provided to Mr Biermann

7 Following his fall at home on 22 December 2022, Mr Biermann was reviewed at the Modbury Hospital, where a CT of the brain revealed no acute pathology. He was discharged home.

8 Following this he experienced right upper arm weakness, expressive dysphasia and a speech disorder. He was admitted to the Lyell McEwin Hospital on 27 December 2022. Although he denied falling again since the previous discharge, a CT brain showed a subdural haematoma with localised mass effect.

9 The CT was repeated on 9 January 2023 and showed stability.

10 Mr Biermann remained at the Lyell McEwin Hospital until 21 February 2023. He developed delirium during this time. He was referred to a speech pathologist due to poor oral intake. A soft diet and thin fluids were recommended.

11 He was identified as a very high falls risk and had further falls, following which the hospital's unwitnessed falls protocol was followed, and he was reviewed by a medical officer. A CT brain indicated that a new brain haemorrhage was clinically very unlikely. A chest X-ray revealed no fractures.

12 A discharge plan for care facility placement was prepared. Mr Biermann was discharged to Regis Playford on 21 February 2023.

13 He was assessed on the first day by a physiotherapist and was provided with a four-wheeled walker, as he had previously been using one. His care plan identified that he was a 'very high falls risk' and demonstrated 'impulsive risk-taking behaviour'. A floor sensor mat and crash mats were ordered. From this assessment it is clear that Mr Biermann was still mobile, notwithstanding his falls and injuries to date.

14 On 23 February 2023 at approximately 1:55 pm Mr Biermann suffered an unwitnessed fall with a head strike while he was in the dining room. The on-duty registered nurses found Mr Biermann was lying on the floor on his right side and face down. There was a moderate amount of blood from his forehead. His right eye also appeared inflamed. Mr Biermann was assessed for pain, his vital signs were obtained, and he was not moved but made comfortable. The SA Ambulance Service was called at 1:58 pm as a priority 3 and arrived at 2:50 pm.

15 Mr Biermann was taken to the Lyell McEwin Hospital where he was reviewed. He was found to have sustained multiple rib fractures and a small pneumothorax, along with a right orbital roof fracture. Chronic pleural effusions were noted to have slightly increased in size.

16 A CT brain revealed the previous subdural haematoma, which was stable, but he also had a small new right-sided subdural haematoma and subarachnoid blood near the right frontal lobe.

17 Neurosurgical intervention could not be offered. Mr Biermann received oral and intravenous pain relief medication. His haemoglobin dropped. He was at risk of respiratory infection due to his rib fractures.

18 He was reviewed by a speech pathologist and assessed as safe to eat pureed foods and thickened fluids.

19 Mr Biermann had an episode of aggression and non-compliance with medical interventions on 25 February 2023.

20 On 26 February 2023 Mr Biermann experienced low oxygen saturations. A chest X-ray revealed worsening of the pleural effusions. He did not tolerate oxygen therapy. It was considered unlikely that a chest drain would be tolerated.

21 Following extensive discussions regarding his management, all oral medications were ceased.

22 Mr Biermann was discharged to Regis Playford on 27 February 2023 for end-of-life care and passed away on 1 March 2023.

Assessment of care provided to Mr Biermann

23 Regis Playford conducted an internal investigation in relation to the incident. The fall was unwitnessed as care staff were attending to another resident and heard Mr Biermann fall. They immediately called the registered nurse on duty. Care was escalated with ambulance transfer to the Lyell McEwin Hospital.

24 Mr Biermann was a very high falls risk. He had a lack of insight into his own safety. Regis Playford was aware of this and his history of falls, including the fall which resulted in his admission to the home. Likewise, the Lyell McEwin Hospital identified Mr Biermann as a very high falls risk patient and implemented strategies, including sensor mats. Following any falls, all appropriate investigations were undertaken by these facilities.

25 Mr Biermann's mobility was appropriately assessed upon admission to Regis Playford, and his care plan reflected his very high falls risk. He was provided with a walker as he arrived at the care facility without one. Arising out of his physiotherapy assessment, sensor mats were recommended and requested. There was a turnaround time of just under 48 hours between assessment and his fall, and it appears that every effort was made to establish Mr Biermann in the home as quickly and safely as possible.

26 The care facility had an up-to-date Falls Management and Prevention Policy in place.

27 It appears that Mr Biermann was not using his four-wheeled walker at the time and this contributed to his fall.

28 Mr Biermann presented as a person at very high risk of falls who had lived independently at home until very soon before his death. He suffered a decline following his first documented fall requiring hospital admission in late December 2022. He had further falls in the hospital setting. He was admitted to his care facility with complications of his previous falls injuries. Regis Playford made efforts to implement processes to reflect his risk.

29 Notwithstanding his many serious falls over a short period of time, Mr Biermann remained somewhat mobile and determined to move about independently, until his final fall on 23 February 2023. He had a right to freely move around his care facility without restraint. Case notes suggest that for much of his first day at Regis Playford he remained in bed, with the fall occurring on the afternoon of his second day. Short of physically restraining him, his risk of falls would remain significant and ongoing. The Charter of Aged Care Rights stipulates that residents of an aged care facility have a right to independence. Mr Biermann had a right to explore his new environment. His aged care provider attempted to implement appropriate risk mitigation in the short time that he was a resident. The care provided to Mr Biermann was appropriate.

Guardianship Order

30 At the time of his death Mr Biermann was subject to an order of the South Australian Civil and Administrative Tribunal (SACAT) made on 3 February 2023 after a full hearing, which appointed the Public Advocate as Mr Biermann's full guardian and granted his guardian the power to direct where Mr Biermann should reside and authorised his detention at his place of residence. The Public Trustee was also appointed full administrator of Mr Biermann's estate.

31 It is not necessary for present purposes for me to refer to the reasons of the Tribunal in granting these orders. All of the documents to which SACAT had had regard in making the order are contained within Exhibit C3, a statement of the Deputy Registrar of SACAT. That statement also contains a transcript of the hearing, the Tribunal's Statement of Reasons and a copy of the Orders.

32 It is clear, and I find, that at the time of making the orders, as well as interim orders which were made prior to 3 February 2023, that Mr Biermann was a person who was suffering a mental incapacity within the meaning of s 3 of the *Guardianship and Administration Act 1993*. The orders for his guardianship and administration of his estate were valid orders and, having regard to the power of detention granted to his guardian, Mr Biermann was a person lawfully in custody at the time of his death.

33 I further find that the care and treatment afforded to Mr Biermann at the Lyell McEwin Hospital and at Regis Playford was entirely appropriate.

34 I make no recommendations in this matter.

Keywords: *Death in Custody; Falls; Section 32 Powers*