

CORONERS COURT OF SOUTH AUSTRALIA

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INQUEST INTO THE DEATH OF PEGGY EDWARDS

[2026] SACC 47

Inquest Findings of her Honour Deputy State Coroner Kereru

21 October 2026

CORONIAL INQUEST

Examination of the cause and circumstances of the death of a woman with chronic health conditions who fell from her bed in the night while residing at an aged care facility. The Inquest explored the circumstances that led to staff not conducting routine rounds during the night.

Held:

1. Peggy Edwards, aged 61 years of Coober Pedy, died at Umoona Aged Care on 16 July 2022 as a result of chronic obstructive pulmonary disease and myocardial fibrosis, in the setting of chronic alcoholic liver disease with cirrhosis.
2. Circumstances of death as set out in these findings.

No recommendations made.

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Family: MS C EDWARDS

Counsel: MS E BOWERING WITH MS P JONES - Solicitor: ABORIGINAL LEGAL RIGHTS MOVEMENT

Interested Party: UMOONA AGED CARE ABORIGINAL CORPORATION

Counsel: MR C KUMMEROW - Solicitor: COWELL CLARK COMMERCIAL LAWYERS

Witness: MS L HARRIS & MR C WRIGHT

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Witness: MR G SINGH

Counsel: MR S MENDS - Solicitor: EQUITABLE LAW

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Inquest No: 29/2025

File No/s: 1717/2022

Aboriginal and Torres Strait Islander readers are advised that this judgment may contain sensitive or distressing information pertaining to Aboriginal individuals, families and communities, and cultural business.

Where an Aboriginal or Torres Strait Islander person who has passed away is referred to by given name in this judgment, this has occurred with the consent of the family. Otherwise, bereavement terms or other aliases will be used.

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**INQUEST INTO THE DEATH OF
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Introduction

- 1 Peggy Edwards was a 61-year-old Aboriginal woman who lived in Coober Pedy under the care of the Umoona Aged Care Aboriginal Corporation. She was found deceased in her room on the morning of 16 July 2022, which brought about an investigation that revealed an unusual staffing arrangement that resulted in no care being provided to Ms Edwards on the night of her death. This included a nurse conducting a double shift in which she was permitted to sleep when not required for active duties.
- 2 At the request of Ms Edwards' family, I will refer to her as Peggy throughout these Findings.

Scope of Inquest

- 3 Following a difficult life, Peggy expressed how happy she was to be at Umoona and how pleased she was with their care. In fact, on one occasion she declined the opportunity to return home when it was raised as a possibility.¹
- 4 Upon review of the materials gathered during the coronial investigation, I was satisfied that Peggy's health situation and the care provided to her in a general sense were clear on the papers and of a generally good standard. For that reason, I did not require the oral examination of witnesses in relation to the general care provided and I instead conducted an Inquest of focused scope.
- 5 The Inquest was limited to an examination of the circumstances that led to the nursing arrangement put in place on the night of Peggy's death. To assist me to explore that issue, I heard evidence from the two nurses on shift that night; Mr Gurjant Singh and Ms Lara Harris, as well as the Executive Officer at the time, Ms Sonia Mazzone. I then heard evidence from an independent expert geriatrician, Professor Craig Whitehead.
- 6 There were two additional witnesses that would have assisted me, but who did not give evidence. The first was a resident, Ms Susie Prince. Ms Prince provided an affidavit in relation to her observations on the night of Peggy's death. I received information that in the time since Peggy's death, Ms Prince's dementia had advanced to a state where she was unable to give evidence. I excused her from attendance for oral examination and instead received her affirmed affidavit into evidence.²
- 7 The second witness who did not give evidence was Ms Simone Blakeman. Ms Blakeman was an agency nurse who put in place the arrangement for Ms Harris to work a double shift. I received evidence that Ms Blakeman died on 17 February 2025.³

¹ Exhibit C10, 118

² Exhibit C7

³ Exhibit C14

Peggy

- 8 Peggy Edwards was born on 5 October 1960. She was married and then widowed. She had one daughter.
- 9 Peggy had many health issues. Primarily, she suffered from cirrhosis, portal hypertension, anaemia, recurrent urinary tract infections, splenic vein thrombosis, hypothyroidism, chronic obstructive pulmonary disease, dementia, intellectual disability, gastroesophageal reflux disease and severe hearing loss.⁴
- 10 Peggy was placed under a Guardianship Order granted by SACAT on 16 September 2020. The Order contained special powers, including a power that Peggy be directed to reside wherever her guardians thought fit.
- 11 On 6 April 2021, Peggy was recovering from an episode of sepsis and was transferred from the Royal Adelaide Hospital to the Coober Pedy Hospital to complete her course of intravenous antibiotics.⁵ She was subsequently transferred to the Umoona Aged Care residential facility to convalesce. On 14 May 2021, she was directed to reside there by her legal guardians.⁶ After living there for some time, she told staff that she felt safe in their care and that her late husband would have been happy to know that she was safe.⁷
- 12 Peggy was independent in terms of her personal care and did not require assistance for mobility but otherwise received all of the services provided by the facility.⁸ Throughout her time there, she had appointments with specialists in speech pathology, audiology, occupational therapy, podiatry, dietetics, psychiatry, dentistry and optometry as well as visits from a general practitioner.⁹
- 13 Peggy experienced frequent nosebleeds that were found to be self-inflicted. She had a limited understanding that her own actions were contributing to their occurrence.¹⁰ Peggy was recommended for iron level monitoring which occurred.¹¹ She was booked for an iron infusion on 1 June 2022.
- 14 A general decline was noted over the course of Peggy's time at Umoona.¹² In February 2022, Peggy's doctor, Dr Dirk Hoffman, wrote a report where he summarised her health condition at that time. He noted that Peggy's liver cirrhosis had reached Child-Pugh Class C which carries a low 1-year survival rate. Dr Hoffman concluded by saying 'Her life expectancy is guarded'.¹³

⁴ Exhibit C22 [23]; Exhibit C2a, 2

⁵ Exhibit C22 [15]

⁶ Exhibit C10, 184

⁷ Exhibit C22 [22]

⁸ Exhibit C22 [18]

⁹ Exhibit C22 [24]

¹⁰ Exhibit C22 [26]; for example, Exhibit C10, 14, 19–20, 29, 79, 81, 92, 95, 113–114, 121, 133, 139, 142, 148, 151, 156, 175, 178, 192–193

¹¹ For example, Exhibit C10, 113

¹² Exhibit C10, 133

¹³ Exhibit C11, 2

15-16 July 2022

- 15 In mid-July 2022, the Registered Nurse who usually managed the care provided by the Enrolled Nurses and Carers employed by the facility, Ms Tina Doulgeris, was away from work and her role was being filled by a Registered Nurse from an agency, Ms Simone Blakeman.
- 16 In the early evening of Friday, 15 July 2022, the then Executive Officer of the Umoona Aged Care Aboriginal Corporation, Sonia Mazzone, received a call from Ms Blakeman notifying her that the Enrolled Nurse who was rostered to commence at 7:30 pm had returned a positive COVID-19 test and that there would be a vacancy for the shift.¹⁴ There are usually two nurses during the night-shift.
- 17 Ms Blakeman advised Ms Mazzone that she had asked the Enrolled Nurse who was rostered for duties on the day shift, Ms Lara Harris, to stay back and complete the night-shift as well, effectively doing a double shift.¹⁵ Ms Mazzone said that she was concerned about the plan, in particular that Ms Harris would not have any rest. She was also concerned because Ms Harris was reasonably new to enrolled nursing and had not completed a night-shift at this location before. Ms Mazzone expressed these concerns and said that she would have to make the night-shift a *passive* shift for Ms Harris in order to manage the risks associated with working a double. Ms Harris had apparently said that she understood that there was no other person to do the shift and that she would work the double.¹⁶ Ms Mazzone phoned Ms Harris and explained the proposal to her.¹⁷
- 18 The other staff member rostered on that night was Mr Gurjant Singh, an Enrolled Nurse who qualified in 2013 and then registered with AHPRA in 2020¹⁸ following a period in which he was under working visa restrictions that prevented him from registering. He had prior experience working in aged care before joining Umoona.¹⁹
- 19 Ms Harris arrived at work and spoke to Ms Blakeman, but there was no discussion about how the double shift arrangement would work.²⁰ Ms Mazzone went to Umoona early in the evening. She said that she passed Ms Blakeman in her car as she entered and that Ms Blakeman did not stop for a discussion.²¹
- 20 Ms Mazzone then set up her office as an overnight room to give Ms Harris a chance to rest and manage the shift between resting.²² While she was doing this, she said she could see both night-shift nurses, Ms Harris and Mr Singh, working through the CCTV system. Ms Mazzone then left at 9:30 pm. During Ms Mazzone's time at Umoona that night, she gave evidence that Ms Harris and Mr Singh were busy dealing with residents and Ms Mazzone was not able to speak to them in person.²³ She was not able to wait as

¹⁴ Exhibit C22 [3]

¹⁵ Exhibit C22 [4]

¹⁶ Exhibit C22 [5]

¹⁷ T41, T69-70, T244-245

¹⁸ T122

¹⁹ T125

²⁰ T72

²¹ T246

²² Exhibit C22 [7]

²³ T246-247

she had personal commitments that night. Ms Harris gave evidence that she recalled a conversation where Ms Mazzone showed her to the bed that had been set up in the office and during that conversation she said words to the effect of 'If you need to do anything they'll come and grab you. Only get up when you are required to get up'²⁴ and 'You are to rest here ... if the other person needs you, he'll grab you'.²⁵ There were no conversations with Mr Singh present.²⁶

- 21 After leaving, she called the team leader's phone which was answered by Mr Singh. He took the phone to Ms Harris in the Women's Wing. Ms Mazzone then spoke to Ms Harris, reiterating to her the importance of resting to avoid fatigue.²⁷
- 22 Coincidentally, that day Peggy had a disagreement with one of her fellow residents, Ms Susie Prince, who then gave her space for the rest of the day. Later, however, at 11:05 pm, Ms Prince, checked on Peggy. She was laying in her bed. Ms Prince asked her whether she was alright and Peggy replied, 'Yeah I'm ok, I'm trying to sleep'. She then fell off the bed and called out to Ms Prince to help her. Ms Prince helped her back into bed.
- 23 Ms Prince then went to the office area but could not find anyone to alert about what had happened.²⁸ Ms Prince then went to bed.
- 24 Umoona operated a system whereby baby monitors were placed into each resident's room with the speaker component near the nurses' station. This allowed for residents to call out, or to be heard moving around, thereby alerting carers and nurses to a need for attendance.²⁹ At other times, routine rounds were conducted to check on residents. Peggy's care plan in particular required routine checks every 30-60 minutes.³⁰ Ms Harris gave evidence of a general expectation of routine rounds 'every hour or so'.³¹ On the topic of general expectations, Mr Singh gave the following evidence:

Q. Were there any general practices in the nursing home when you're checking on the clients when there wasn't any noises.

A. For Umoona or general?

Q. Practices for Umoona.

A. I can't remember, but usually the female carer, she was permanent there and she knows better than me, so she -

Q. Well, just generally, what about the males as well.

A. Yes, we check.

...

Q. When you didn't need to change and you just wanted to check, would you go into the rooms.

²⁴ T42

²⁵ T70-71

²⁶ T42

²⁷ Exhibit C22 [7]

²⁸ Exhibit C7 [5]

²⁹ T32, T320

³⁰ Exhibit C10, 4

³¹ T35

A. Males I used to go, yes.³²

- 25 I will return to analyse this difference of approach, and its consequences, later. With Ms Harris sleeping, and Mr Singh not routinely checking residents, no one entered Peggy's room throughout the night.
- 26 The following morning, a carer, Lyn De Castro, started work at 8:30 am.³³ At about 10 am, she attended Peggy's room which was dark. She could not find Peggy, finding only blankets half on, half off the bed.³⁴ Ms De Castro checked Peggy's bathroom and she was not in there. Ms De Castro then opened the curtains and turned the lights on. She noticed that there were leftovers from dinner the day before still in the room. She decided to strip the bed to change the sheets. As she did so, she found Peggy on the floor, face down, unresponsive.³⁵ Peggy had blood around her nostrils and there was a smear of dried blood on the floor.³⁶ Ms De Castro sought help which led to paramedics being called.
- 27 Once paramedics arrived, they made a declaration of life extinct at 10:21 am.³⁷
- 28 Ms Mazzone was notified of Peggy's death. She attended Umoona and spoke to paramedics who advised her that they thought Peggy had likely been laying on the floor for some hours.

Post-mortem examination

- 29 A post-mortem examination was conducted by forensic pathologist, Dr Cheryl Charlwood, supported by neuropathologist, Professor Blumbergs.³⁸ Dr Charlwood found no significant injuries that contributed to death, although there were recent small subcortical haemorrhages caused without injury and with no associated swelling; with the cerebral cortex having a normal appearance. These microscopic haemorrhages were Beta APP positive indicating they were not sustained at the time of death. There was no biochemical evidence of any significant renal failure, ketoacidosis or hyperglycaemia. There was evidence of Peggy's many chronic conditions. Assessing the physiological evidence, Dr Charlwood concluded that Peggy had died as a result of chronic obstructive pulmonary disease and myocardial fibrosis in the setting of chronic alcoholic liver disease with cirrhosis. I find that to have been Peggy's cause of death.
- 30 An independent expert geriatrician, Professor Craig Whitehead, assessed the question of the mechanism of death. Professor Whitehead said that, given the post-mortem findings, there are two plausible mechanisms of death. One is that Peggy developed a respiratory infection that progressed quickly due to her poor immunity and structurally compromised lungs. He states this led to delirium and a fall, but this was secondary to the respiratory illness. The second plausible mechanism is that Peggy fell from bed for a reason unrelated to her infection which caused head injuries that compromised her

³² T137-138

³³ Exhibit C5 [4]

³⁴ Exhibit C5 [5]

³⁵ Exhibit C5 [7]

³⁶ Exhibit C5 [9]; Exhibit C6 [19]

³⁷ Exhibit C6 [3], [6]

³⁸ Exhibit C2a

respiratory function leading to death. Given Dr Charlwood's opinion as to cause of death, she has made her view clear. The second scenario assumes head injuries which were not found at post-mortem. I will address this issue in more detail below.

Actions taken

- 31 On the day of Peggy's death, Ms Mazzone phoned and spoke to Mr Singh. Her evidence was that he told her that he had checked Peggy at 7 am and that he had otherwise done all of his rounds. Mr Singh gave evidence that he had been confused that morning and thought that Ms Mazzone was asking about a male patient, whom I infer was referred to as 'Paddy'.³⁹ I accept that Mr Singh may have been confused when he made this comment to Ms Mazzone. However, I do not consider that Mr Singh could have been confused when he said that he had done *all* of the routine rounds checks that night, particularly given his position now that it was not his responsibility to conduct any checks. I will address the content of Mr Singh's evidence in more detail below.
- 32 After Peggy's death, Ms Mazzone checked the CCTV footage from that night. She particularly focused on the camera that covers the corridor outside Peggy's room. Ms Mazzone identified that between 5:30 pm and 10 am, the only person who was seen on the footage at Peggy's room was Ms Prince just after 11 pm.⁴⁰ Ms Mazzone then contracted COVID and played no further part in the investigation.
- 33 Ms Mazzone's daughter, Ms Shannon Mazzone, who was also an employee of Umoona in the Business Services Team, lodged a Serious Incident Response Scheme Notice with the Aged Care Quality and Safety Commission on 20 July 2022.⁴¹ In this Notice an investigation was foreshadowed as well as a number of specific actions to prevent recurrence, four of which were:
 4. Procedures will be put in place to ensure all staff are aware of nightshift tasks
...
 6. Management will be putting a procedure in place to outline night-shift tasks
 7. Management is putting in place forms with tasks that are required to be completed and will be filled out on completion of each nightshift
 8. There will be more direction to complete all tasks required during their shift.⁴²

³⁹ T115, T155, T191

⁴⁰ Exhibit C22 [11]

⁴¹ Exhibit C13, 4

⁴² Exhibit C13, 12

- 34 I received into evidence a copy of a new form prepared by Umoona. Ms Harris gave evidence that it had been placed at the nurses' station when she returned to work for her next shift.⁴³ That form was as follows:

NIGHT SHIFT HOURLY CHECK FORM

DATE:				<u>THIS FORM IS TO BE INITIAL ON EACH HOUR OF YOUR CHECK ON EACH RESIDENT</u>
Male Carer:				<u>RESIDENT</u>
Female Carer:				
Supervisor:				<u>THIS FORM IS TO BE INITIAL ON HANDOVER BY BOTH STAFF MEMBERS INVOLVED</u>
Sleepover:				

(INITIAL BOXES)	Walk around	INITIAL	INITIAL
1ST HANDOVER:			

	20:00:00	21:00:00	22:00:00	23:00:00	00:00:00	01:00:00	02:00:00	03:00:00	04:00:00	05:00:00	06:00:00	07:00:00	08:00:00
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KW - Change MT-Turning PB - Change (Enter the time of assistance in clear box)

	20:00:00	21:00:00	22:00:00	23:00:00	00:00:00	01:00:00	02:00:00	03:00:00	04:00:00	05:00:00	06:00:00	07:00:00	08:00:00
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Comments:(any issues on shift)

(INITIAL BOXES)	Walk around	INITIAL	INITIAL
2ND HANDOVER:			

- 35 I observe that this form records the identity of the shift supervisor. It requires the initials of a person conducting and a person receiving a shift handover. It contains specific boxes to record initials of the person conducting hourly checks on each resident. I consider that, had this form been in place on the night of Peggy's death, it is less likely that the failures identified during this Inquest would have occurred. In particular, the requirement to initial a record of each hourly check would have clearly identified who was responsible for undertaking those checks and would have readily revealed if they had not been performed.
- 36 I consider this swift initial response to Peggy's death was appropriate and that this document alone largely addressed the safety issue that was revealed. While there were issues raised during the Inquest about the implementation, I consider that the document largely speaks for itself and little training in relation to it was called for.
- 37 For the purposes of the internal investigation, Ms Shannon Mazzone and Ms Krista Carbine, another staff member, reviewed all footage from the facility during the shift. They prepared a table summarising the work undertaken that night.⁴⁴ I was advised that the footage from the facility that night was no longer able to be retrieved at the time of

⁴³ T52-53, T90

⁴⁴ Ms Shannon Mazzone could not recall compiling the CCTV schedule, but I find that she did so

the Inquest, notwithstanding attempts at obtaining it. I therefore received a copy of the table into evidence as the best *available* evidence of the footage.

- 38 Had I been required to apply the rules of evidence strictly, I would have to consider the application of the best evidence rule more carefully and whether I ought to be permitted to rely on the CCTV schedule at all. However, in the coronial jurisdiction, the rules of evidence are not strictly applied, and I am instead required to focus on finding the facts as clearly as I can using the evidence that I consider is fair and reliable.
- 39 Here, an important aspect of the CCTV evidence is that it is adverse to Mr Singh. I therefore need to carefully consider whether it is of sufficient reliability in order to consider making an adverse finding against Mr Singh, partly on the basis of the CCTV schedule.
- 40 I observe that I am not faced here with a situation of a witness attesting the opposite and being unable to respond to what is shown in the schedule. Instead, I am faced with a witness who has no specific memory of his duties that night and when confronted with the CCTV schedule was able to give an explanation for why it would record him in the manner it did. That is, he tacitly accepted that the footage was accurate and provided an explanation for him not conducting any routine checks. The situation would be much more difficult and potentially produce an unfairness if, for example, Mr Singh's position was that he recalled performing routine checks and said that he was unable to explain the footage and that it must be incorrect. There was never any assertion that the table must be incorrect.
- 41 The table was reasonably detailed, and I am satisfied that it represents a diligent summary of what the cameras recorded that night. One portion of the footage, the camera outside Peggy's room, was seized by police shortly after her death. I received a copy of that footage into evidence, and it depicts the events recorded on the table which further satisfies me that the table is accurate and reliable.
- 42 Further, I consider it would be remarkable if the table had recorded specific care provided to male and female patients on specific occasions but was otherwise inaccurate. It clearly represents a careful assessment of what the cameras recorded that night, and I am prepared to accept it as accurate, notwithstanding that it inherently undermines some of Mr Singh's evidence.
- 43 Following an internal investigation into the incident conducted by the Board, Mr Singh's employment was terminated.⁴⁵

What happened during the night-shift?

- 44 As I have set out, the focus of the oral evidence during the Inquest was the manner in which the night-shift was arranged and carried out. This is where the oral examination of witnesses focused. The examinations provided me with sufficient evidence to be satisfied, on the balance of probabilities, as to what occurred on the night of Peggy's death.

⁴⁵ Exhibit C22 [13]

- 45 I was particularly impressed with the evidence of Ms Harris. I found Ms Harris to be a credible and reliable witness. She gave her evidence in a careful and considered manner and appeared to be a diligent and hardworking carer and administrator. In contrast, I found the evidence of Mr Singh, and to a lesser extent Ms Mazzone, to be less reliable. Mr Singh's memory was vague and at times this obstructed a proper understanding of the full circumstances of the events. His version of events was not wholly consistent. Ms Mazzone also struggled with her memory in respect of policy and procedure but had a solid recollection of the events of the night of 15 July 2022.
- 46 Ms Harris' evidence was that she slept through the shift except for a small number of occasions when Mr Singh came to wake her to assist with personal care of certain female residents.⁴⁶ This is consistent with the footage that depicts her doing just that. Mr Singh denied that he had woken Ms Harris up at any point.⁴⁷ However, that is not consistent with the CCTV footage which showed Ms Harris assisting particular residents with particular care issues. It is unclear to me how Ms Harris would have known that those residents needed assistance unless she was advised by someone. She could not hear the residents' monitors from the office. If it is suggested that Ms Harris coincidentally awoke at the right moment and went directly to the particular resident who needed assistance, then I reject that suggestion as implausible.
- 47 I accept that Ms Harris is a diligent worker and that if she had been aware that residents were not being routinely checked, she would have done so herself. Ms Harris said that, late in her shift, she woke up and did paperwork. Mr Singh inferred that Ms Harris had said much earlier that she could not sleep and got up.⁴⁸ This does not fit with the evidence of the footage where Ms Harris was not depicted working throughout the facility. I accept Ms Harris' evidence that, apart from specific instances, she did not wake up until near to the end of the shift. I accept Ms Harris' evidence that when she did get up through the night, that this was at the instigation of Mr Singh.
- 48 Mr Singh commenced his evidence with the position that he had performed all required duties and that he had checked on the male residents through the night and accompanied Ms Harris to the female quarters two or more times.⁴⁹ Upon review of the CCTV schedule, he accepted that he may not have visited any residents in a routine way,⁵⁰ but then reasserted that he understood that it was Ms Harris' responsibility to do that.
- 49 I consider Mr Singh's position to be illogical. Mr Singh acknowledged that it was part of his duties to care for the residents during the night and to check if they needed anything.⁵¹ He acknowledged that he knew that Ms Harris had a bed set up and would be resting through the night.⁵² He was never able to explain in a satisfactory way how he reconciled those two things. That is, if he knew that Ms Harris was resting and knew that residents needed to be routinely checked, how did he think that was happening? The combination of these two facts alone ought to have alerted Mr Singh that it was going to be his responsibility to conduct routine checks on all patients. Further, if

⁴⁶ T44, T47

⁴⁷ T152, T185

⁴⁸ T109, T184-186

⁴⁹ T110

⁵⁰ T158

⁵¹ T106

⁵² T108

Mr Singh's understanding was genuine, the fact that Ms Harris did not actually conduct any routine checks ought to have been observed by Mr Singh and ought to have led to a conversation with her about her lack of routine checks. That no such conversation occurred speaks against Mr Singh genuinely understanding that Ms Harris was required to check all the residents and he was not.

- 50 Mr Singh referred many times to working as a team, to the trust he had in Ms Harris to do her job and said that he expected that Ms Harris would have checked all the females on the occasions that she was providing care. She would then have also checked the males on the way back to the office to return to sleeping. He gave evidence that he did not discuss this expectation with Ms Harris.⁵³ It is unclear where he got this expectation from. I am unable to accept that Mr Singh genuinely believed that Ms Harris would do this without being asked. I base this finding primarily on the fact that there were numerous sequential hours throughout the night where Ms Harris did not arise at all. That is, even if Mr Singh thought that Ms Harris would check the female then male residents when she got up to provide specific care, this did not occur hourly and so would have left residents unchecked for many hours. I am also unable to accept that Mr Singh genuinely believed that Ms Harris, being on her second shift for the day, with a bed set up for sleeping, was the person intended to conduct hourly rounds. If that were the case, the sleeping arrangement would have been nearly pointless. Later in his evidence, Mr Singh refused to accept that Ms Harris was sleeping for even part of the shift.⁵⁴

- 51 Mr Singh raised that he had been trained that he was not permitted to check on the female residents, due to cultural reasons. While I accept that there would have been training to that effect, I do not consider it to have been as strict as Mr Singh claimed. His precise explanation of this concept during his evidence-in-chief was:

For example, if they needed something, they explain to me that you stay until the consent that you be there to help them.⁵⁵

This, in and of itself, supports the conclusion that Mr Singh's training about gender division of duties was limited to where active care was required, and that it was envisaged he would be in the presence of female residents awaiting consent to actively help them.

- 52 Mr Singh took his position to the extreme when he gave evidence that it was for female staff to make notes in the case note system about female patients⁵⁶ and that he was not permitted to 'go to the female side by myself'.⁵⁷ It was apparent during his evidence that Mr Singh was trying as best as he could to distance himself from any and all obligations in respect of female residents, including Peggy.
- 53 Both Ms Harris and Ms Mazzone said that there was no prohibition on male carers and nurses conducting a simple routine check on female residents.⁵⁸ The restriction was

⁵³ T188, T198

⁵⁴ T204

⁵⁵ T103

⁵⁶ T114

⁵⁷ T188

⁵⁸ T44, T240-241

limited to when specific acts of care were required for female residents.⁵⁹ In addition, Ms Mazzone gave evidence that where the person providing care was a qualified nurse, then the concern fell away.⁶⁰

- 54 The records tendered in relation to Peggy's care demonstrated instances of male staff performing acts of care in relation to Peggy.⁶¹ The fact that the Umoona organisation expected Mr Singh to have provided care to Peggy was also demonstrated when they terminated his employment due to a breach of his duty of care.
- 55 If Mr Singh formed the view that he was not permitted to conduct routine checks on female residents then that view was wrong. Even if he had, it does not explain his almost entire lack of care action on the night of Peggy's death.
- 56 Mr Singh was asked during the evidence that if he had formed the view that he was not permitted to check on the female residents through the night, what explanation could he have for not routinely checking on any of the male residents. He explained that his understanding of the gender issue was not strict in relation to females checking on males and that he expected Ms Harris to routinely check both females and males.⁶² I am unable to accept this explanation. It amounts to Mr Singh understanding that there was a strict gender division protocol, but only in his favour.
- 57 Ms Harris gave evidence that in the morning, in accordance with her usual practice, she believes she asked Mr Singh if Peggy had toileted during the night for the purpose of filling in a bowel chart.⁶³ Mr Singh could not remember this.⁶⁴ If Mr Singh believed that it was not his responsibility to check on the residents, one would expect this question to have raised, even at this very late stage, a response that he did not know and that Ms Harris ought to be aware of that, given it was her role to monitor the female residents. Even in his evidence, Mr Singh did not raise this in response to questions on this topic which further speaks against the genuineness of his asserted belief that he was not responsible for the female residents.
- 58 The final evidence which is particularly telling is that Mr Singh told a member of the Umoona Board, during an investigation after Peggy's death, that he had conducted rounds every two hours.⁶⁵ This clearly did not occur. When asked in his evidence whether he could have been confused about this, he said:
- A. No, actually, it could be meant by both staff member. I thought we were went - she went together with me to female resident and sometimes she went by herself and I thought that's what I believe at that time, and I wasn't told that it should be specific two hours or something.
- Q. Did you know that there was a period, for example, between 1 a.m. and 5 a.m. or midnight and 5 a.m. where nobody had conducted any checks on anyone, did you know that at the time.

⁵⁹ T243

⁶⁰ T240

⁶¹ For example, Exhibit C10, 148, 198

⁶² T167-168, T187-188

⁶³ T49, T75

⁶⁴ T190

⁶⁵ Exhibit C13, 3

A. No, I didn't know that.

Q. So, how were you able to tell them that there had been checks every two hours between you and Lara if you didn't know that that was the case.

A. As I mentioned before, I believed that was a normal shift and she knows better than me and because I was doing the other jobs and she probably went and checked the residents.⁶⁶

59 Extraordinarily during closing addresses, Mr Singh instructed his counsel to make a submission that he now accepts that the work he performed on the night of Peggy's death was not to the standard required and in particular the level of checking he conducted was insufficient. I find it difficult to understand how Mr Singh reconciles that position with his clear defiance to accepting that proposition during his oral evidence.

60 I have considered the principle enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. After considering the evidence carefully and with rigour, I am not only satisfied of my conclusions about Mr Singh's behaviour on the balance of probabilities, I am wholly satisfied of the conclusions I have reached, notwithstanding their significance to Mr Singh which is considerable.

61 Mr Singh gave evidence that he felt it was unfair that Ms Harris was permitted to sleep during the shift.⁶⁷ He said that his previous workplaces had a greater number of carers who performed care duties under his supervision.⁶⁸ I find that the combination of Ms Harris not being subordinate to Mr Singh, and a perceived sense of unfairness at the arrangement, led to Mr Singh choosing not to perform his routine care duties on that night. When asked what he had done during the 12-hour shift aside from two instances of specific care, he said:

It very lot of jobs to do at night over there, which I think I will let you know the main one I remembered. For example there was a very big area, as I mentioned before, in front of the nursing station lunch area. I have to take the tables away and clean the mess that they have done during the day; and sweep all the floor, including nursing station; and then mop it; and I wait until it's dry. And also the rooms next to the lunch area, and next to the kitchen as well. And also around in the morning, because it's very busy around in the morning, I prepared breakfast trays for them. And during night that I remember clean all the bathrooms. Not the resident private bathroom, but outside; and filling the toilet rolls on all - whatever was needed. And the rubbish to collect in all the bins; and cleaning the staff room as well.⁶⁹

...

I can't make it comments that I did 12 hours for the cleaning because I'm still a human being, I need to have a rest. Maybe if, for example, one of the lounge area we were talking about it, it's very large, I need to clean it, it takes time and it's not that I can move it and go away from there because it can be wet - I stay there until it's dry and I got to do other things to do as well. ...I think it's not about only cleaning, I think there are other things that we are missing that I couldn't remember. For example, filling the pads for the

⁶⁶ T202

⁶⁷ T196

⁶⁸ T164-165

⁶⁹ T105

resident and I can't remember that I did on that night, I can't remember because there are other things I need to perform which maybe I did or maybe I didn't. And maybe I could forgot a lot of things which I did on that night.⁷⁰

- 62 I am unable to accept that Mr Singh spent an entire 12-hour shift cleaning three bathrooms in the common area, mopping, doing laundry and performing other non-care-related duties to such an extent that he was unable to conduct a single routine round. I am unable to reach any specific conclusion about what he was doing. Given his knowledge that Ms Harris was to be sleeping, I am unable to accept his evidence that he was 'just following the lead of somebody else'.⁷¹
- 63 As I have said, Mr Singh belatedly accepted, through his counsel, that his work was inadequate. He explained that this was not due to choosing not to perform his duties but was instead due to what he suggested was a misunderstanding of the cultural concerns and that there was no explanation of who was to carry the bulk of the work on that shift. That is, by the time submissions were made on his behalf in closing, Mr Singh had not only accepted that his work was inadequate, but he had also accepted that his assertions about the cultural concerns were also wrong. He then asserted that his failure to properly understand the cultural concerns was due to a lack of proper training and that he misunderstood that he was required to conduct the routine care work of the night-shift. I am unable to accept Mr Singh's final shift in position. That is, I am satisfied that Mr Singh understood what his duties were. At the very least, he would have understood that when he saw that Ms Harris was not conducting routine rounds, he ought to do so or otherwise wake her up to do so if he genuinely felt that was more culturally appropriate.

Degree of difficulty

- 64 At the time of Peggy's death, Umoona was a facility that housed nine residents.⁷²
- 65 The operation of an aged care facility, even one as small as Umoona, is a complex and difficult task. There are many sides to the operation which all compete for the time of the administrators. Ms Mazzone spoke of the difficulty of the task generally and also of the compounding effect of COVID and new aged care standards.⁷³
- 66 Particularly in relation to COVID, Ms Mazzone spoke of the strategy put in place to deal with expected staff absences. She said that she reduced the staffing model down to two 12-hour shifts.⁷⁴ This meant that the operations could run with less staff. However, the result was that if a staff member rostered on became unwell at short notice, the facility was left without adequate staff for an entire 12-hour time period. This, combined with the effect of being situated in a rural area, meant that short-notice absences were extremely difficult to deal with and required novel approaches that were implemented swiftly and with great care.

⁷⁰ T197

⁷¹ T113

⁷² Exhibit C18, 25

⁷³ T221-222

⁷⁴ T222-223

- 67 Setting aside the difficulties with filling short-notice absences, Professor Whitehead gave evidence that a staffing model of one male and two female nurses or carers for the day shift and one female and one male nurse or carer for the night-shift was a very reasonable level of staffing for a facility housing nine residents.⁷⁵ I therefore have no concerns about the staffing model Umoona adopted during COVID.

The passive shift strategy

- 68 I consider that the approach of having Ms Harris attend work and assist where needed, but otherwise remain resting in a makeshift bed, was a reasonable plan to deal with what was a difficult situation. There simply was no alternative staffing arrangement given the remote location and the lead-time needed to engage agency staff. I consider that there was no issue with Ms Harris conducting her first night-shift in this manner, particularly where an Enrolled Nurse experienced in night-shift was to be available all night and would be able to guide her on any night-specific duties. In some respects, being able to rest throughout the night was an easier way to approach a first night-shift.
- 69 However, I consider that there was a failing in the implementation of what was otherwise an appropriate strategy. This primarily arose because there were no written protocols or procedures about passive night-shifts. Compounding that issue was the complete lack of direct discussions with Mr Singh and Ms Harris together where expectations were set. Had this occurred, it is more likely that Mr Singh would have conducted his routine rounds because this expectation would have been freshly set. It would have also raised the opportunity for him to query whether he was even permitted to check on the females and if he had a genuine misunderstanding of the protocol, it would have been corrected. The responsibility for convening this discussion was arguably for Ms Blakeman to arrange, but in the end, it was Ms Mazzone who proposed the passive shift and so I consider it was for her to ensure that she had this discussion and that her idea was implemented in a safe way. Ms Mazzone might have been relieved of this obligation had there been a formal written policy or procedure governing how a passive shift would work. Without such a written policy and without a specific discussion, it is unsurprising that the plan was not carried out as she had hoped.

The use of monitors

- 70 The Court heard evidence that monitors are used to broadcast each resident's room through speakers at the nurses' station. In that way, any events of significance can be heard and care provided in response. I was asked to make a finding that the monitors were likely not turned up to full volume on the night of Peggy's death. I am unable to do so. There was no clear evidence one way or the other. Both Ms Harris and Mr Singh had no memory of the status of the monitors.⁷⁶ However, the fact that specific acts of care were provided to specific residents throughout the night suggests to me that the monitors were working at an adequate volume.
- 71 There is another aspect to the use of the monitors. The Court heard that Peggy did not understand that there was a monitor in her room that could be heard by nurses.⁷⁷ The result is that, other than by detecting the natural calling out for help when a person is in

⁷⁵ T363

⁷⁶ T66

⁷⁷ T80

distress, the monitoring system was unlikely to be of particular assistance to Peggy because she would not have appreciated that she could have called out for help. For that reason, the status of the monitoring system takes on less significance. It was not suggested by anyone that it could replace the routine checks that were required.

The management of Peggy's falls risk

- 72 Peggy underwent several falls risk assessments while she was at Umoona. The first was on 7 July 2021. A shuffling gait was noted with night lights, a call bell and removal of clutter recommended as mechanisms to address any risk, together with physical checks while sleeping.⁷⁸ It was recommended that Peggy's bed be set at a height that allowed her to mobilise in and out herself. Peggy was said to have had falls in the past related to her alcohol use and unmet dependency issues during her time living independently.⁷⁹ It was recorded that placement in Umoona had brought about lifestyle changes which resulted in functional improvement and a considerably reduced risk of further falls. With no history of relevant falls, she was determined to be a low risk.
- 73 Later, in November 2021, a commode was placed near to Peggy's bed to help reduce her need to get up at night.⁸⁰ She was again assessed as having a low risk of falls in bed.⁸¹
- 74 The falls risk assessment was reconducted on 29 June 2022.⁸² This assessment was conducted by Enrolled Nurse, Lara Harris. Ms Harris recorded that Peggy had a recent incident where she was found sitting on the floor, but that it was unable to be determined whether Peggy had actually fallen. Peggy apparently reported that she had felt tired from walking long distances. The outcome was a recommendation that staff monitor Peggy while she is wandering and they placed chairs around the facility so that she can rest when she feels tired. A similar incident had occurred in November 2021, but with Peggy positively denying that she had fallen.⁸³
- 75 Professor Whitehead's evidence in relation to the falls risk assessment documents fluctuated at times. On the one hand he indicated that the assessments were reasonable and adequate, cautiously incorporating an incident where Peggy had been found sitting on the floor, reporting having been tired from walking around. Later, Professor Whitehead said that the incorporation of that incident ought to have resulted in an increase in the risk level assigned. Overall, Professor Whitehead explained that, on the reasonableness of the risk assessments conducted, his opinion had factored in that they were completed by an Enrolled Nurse. His position was that a more senior clinical person might have made more extensive assessments, including assessing the role of an antidepressant drug that Peggy was prescribed.
- 76 Professor Whitehead explained in evidence that since Peggy's death there was a wholesale shift in the industry's approach to falls risk management with the introduction of new Aged Care Standards. Professor Whitehead explained that rather

⁷⁸ Exhibit C10a, 13

⁷⁹ Exhibit C10a, 11

⁸⁰ Exhibit C10a, 7

⁸¹ Exhibit C10a, 3; Exhibit C10, 94

⁸² Exhibit C10a, 9

⁸³ Exhibit C10, 100

than assessing a resident and assigning a risk level, all residents in aged care facilities are assumed to be at high risk, which aligns with the overall risk that that population poses. This new approach should see the adoption of *universal* falls prevention strategies which are tailored to mechanisms of individual concern.

- 77 Professor Whitehead's opinion was therefore that proper falls procedures, as they existed at the time of Peggy's life, were followed, although they did inadvertently downplay her true risk. That is, the use of risk levels *at all* leads to complacency for a population that carries a high risk of falls.

Other issues arising during the Inquest

- 78 A number of other ancillary issues arose during the Inquest that I will briefly address.
- 79 The first was a suggestion on the papers that Ms Blakeman detected a pulse and breathing when Peggy was found close to 10 am. I observe that Peggy's body temperature at that time was 30.2°C. Aligning with the expert evidence of Professor Whitehead on the topic, I find that Ms Blakeman had not actually detected signs of life and was likely misguided by the stressful circumstances confronting her at the time.
- 80 The second issue was whether Peggy's death was contributed to by trauma sustained during her fall from bed. Professor Whitehead had proposed a scenario where Peggy had sustained a fall and then struggled to deal with the consequences of trauma from the fall. In his evidence, Professor Whitehead accepted that there was no pathological evidence which supported a fall. Consistent with the findings and opinion of Dr Charlwood, I find that there was no trauma. Subcortical haemorrhages responded positively to a Beta APP test, which indicates a period of recovery following their development. The haemorrhages were surrounded by no injuries and applied no force effect. There were no other injuries to Peggy's body. While Peggy did have blood around her face, this must be viewed in light of the chronic nosebleeds that she experienced throughout her time at Umoona. Given that there was no trauma, I find, on the balance of probabilities, that the trauma scenario posed as possible by Professor Whitehead did not occur.
- 81 Linked to that issue was the raising of aspiration as a potential cause of Peggy's death. When asked in evidence, Professor Whitehead said:

Q. And her being found in that position, and what you were describing before, that it seems less likely that she had some sort of head trauma, would you say it's more likely that she aspirated.

A. I think that's a significant risk.⁸⁴

- 82 Professor Whitehead's evidence, properly understood, is that there is more likely to have been an aspiration event than a head trauma event. Given that I have found that there was no evidence at all of any traumatic event, I accept this as a possibility. At its highest, Professor Whitehead spoke of a 'significant risk' which falls short of the level of certainty I would require to vary the cause of death proposed by Dr Charlwood after careful consideration. I am satisfied that Peggy suffered a medical event of some nature

⁸⁴ T367

which led her to succumb to her chronic conditions. There is no evidence of what that episode might have been. Professor Whitehead said himself that there is a degree of uncertainty about exactly what might have happened. If aspiration has contributed to death, it would be encompassed by and was an aspect of Peggy's chronic obstructive pulmonary disease. I consider that I am unable to find anything other than that Peggy's death was as a result of her chronic conditions, although aspiration could have been a part of that equation.

- 83 The next issue was whether Mr Singh had received a 'buddy shift'⁸⁵ prior to being required to work night-shifts. There is contemporaneous evidence that he did have a buddy shift, but ultimately, I consider that very little significance rests on whether this occurred or not. I am satisfied from his evidence that Mr Singh knew he was required to conduct routine rounds on the residents.
- 84 The next issue was whether Mr Singh had access to the computer system to make case notes about residents. Mr Singh produced two emails in which he had complained to Ms Mazzone that his email password was not working.⁸⁶ Ms Mazzone said she would have forwarded Mr Singh's emails to an IT consultant,⁸⁷ but Umoona has no record of her having done so.⁸⁸ There was evidence that the email system was separate to the case note system and that a lack of email password would not prevent using the case notes system. There was evidence that iPads in use did not require a password, however Ms Mazzone thought that they did, although it would not necessarily be the same username and password. In any event, whether Mr Singh could make notes in the computer system or not, that had no bearing on whether he ought to have provided care and routine checking on the residents the night of Peggy's death. That is, the inability to record digital notes does not relieve a nurse of their obligations to their patients. I therefore do not consider that I need to resolve this dispute.
- 85 I have referred in passing to the question of whether a walkaround occurred at the commencement and conclusion of the shift during which Peggy died. In my view, Peggy had died some hours before the conclusion of the shift and a walkaround was not likely to have materially changed anything. I therefore make no finding as to whether a walkaround occurred.
- 86 Queries were raised during the evidence as to whether the baby monitor speakers were turned up loudly in the nurses' station on the night of Peggy's death. As I have observed a number of times, Ms Harris was woken by Mr Singh on multiple occasions, and she attended to specific patients. This strongly suggests that the monitoring system was operating satisfactorily on the night.
- 87 The general structure of Umoona's corporate affairs and its clinical governance was raised during the Inquest. The evidence clearly established that Umoona had a poor policy framework with key aspects of clinical policy and procedure entirely unwritten. Ms Mazzone maintained that there was adequate written policy and procedure,⁸⁹

⁸⁵ Where he would have been rostered as a supernumerary to shadow and learn from a colleague

⁸⁶ Exhibit C20; T113

⁸⁷ T296

⁸⁸ Exhibit C21a

⁸⁹ T224-225

however she was unable to clearly articulate where such policies might have been stored at the time of Peggy's death, or even the title of such documents. It appears that Umoona largely ran on the goodwill of those who worked there, each apparently working diligently to look after the residents without formalised guidance. While I consider that Ms Mazzone's leadership was poor, as I have found that Peggy's death was as a result of her chronic conditions, I do not consider that better leadership would have materially changed the course of Peggy's death, although she may have been found earlier.

- 88 The final issue that arose briefly was the manner in which Mr Singh's employment was terminated. It is unclear how the news was specifically communicated to him, however it is very clear that he was suspended following Peggy's death, was formally interviewed and then by some mechanism advised of his termination. Mr Singh gave evidence that he returned to his home country due to the difficulties he faced working in Coober Pedy.⁹⁰ In September 2022, he wrote to Umoona seeking a letter of confirmation of his employment and duties performed. He received a response on 6 September 2022 which confirmed in writing that his employment had been terminated due to 'breach of duty of care'. While Mr Singh gave evidence that he had no idea why his employment had been terminated,⁹¹ I am unable to accept this. He had been informed of a death on his shift and suspended. He was formally interviewed and never permitted to return to the workplace. He received a letter confirming that he had breached his duty of care which would have made it obvious to any reasonable person that his termination was related to the events of his last shift. The only comment that is necessary for me to make is that the apparent lack of a properly documented termination process further reinforces concerns about the general management of the facility at the time.

Preventability

- 89 Given that I have found that the evidence comfortably establishes that Peggy's death was brought about by her chronic conditions, I do not consider that her death was preventable.
- 90 Submissions were made that Peggy's death being undetected for some hours denied the ability to prevent her death for long enough to allow her family the chance to attend to give their farewells. I accept the proposition that this potentially occurred. I am unable to be certain that Peggy's death could have been prevented, even in the order of hours. I do however accept that the aftermath of her death lacked the dignity that one would expect to be afforded in a supported care facility.
- 91 It was suggested to me that if hourly checks had been conducted, Peggy would have been found within an hour of her medical episode and that this would have allowed her death to have been prevented for a period, even briefly. This submission relies on an assumption that the medical event that led Peggy to fall out of her bed was causative of her death, or that the fall itself was causative. In other words, that, for example, an aspiration event occurred which caused her death that could have been rectified by sitting Peggy up. As I am not satisfied that an aspiration event occurred, I am unable to

⁹⁰ T195

⁹¹ T205

conclude that such an intervention within an hour would have prevented her death. To be clear, I find that Peggy should have been routinely checked by Mr Singh that night and I accept that she would likely have been found within an hour of falling from bed. I am unable to be certain that she would not have died by that time, even within an hour. It is entirely possible that she died as she fell from her bed.

- 92 What I can be sure about is that for Peggy to have remained on the floor for a period of time unattended, such that her body temperature was 30 degrees when SAAS arrived, is unacceptable and understandably very upsetting for her family. This should not have happened.

Recommendations

- 93 I was asked to make a general recommendation that aged care workers take into account that antidepressant drugs like the paroxetine that Peggy was taking can cause an increased risk of falls. While that topic briefly arose on the evidence, Professor Whitehead said that it is not something that he would expect care workers and nurses to be familiar with. I am reluctant to make a recommendation with the effect of subtly increasing the scope of practice of care workers and nurses without hearing evidence and submissions about the full scope of the impact such a recommendation might have. I also observe that the aged care sector is currently undergoing significant amounts of change with new aged care standards being introduced. I am hesitant to add to the burden of change being experienced in the sector purely to raise a general consideration that might be made. Given these considerations, I have determined not to make a recommendation on this topic.
- 94 I received a suite of policies and procedures that are now in place at Umoona,⁹² in particular a specific written policy mandating hourly checks of every resident.⁹³ I heard evidence about new aged care standards that introduced rigorous requirements for the operation of aged care facilities. I heard that a recent audit by the Aged Care Quality and Safety Commission found that Umoona satisfied all aged care standards.⁹⁴ In light of that, and my findings, I do not consider that there are any systemic safety issues to which I could direct a recommendation that would prevent a future occurrence of the same or similar circumstances. I therefore make no recommendations.

Condolences

- 95 It was clear that Peggy was loved and cared for by her close and extended family. I express my condolences to them.

Keywords: Aged Care; Staffing

⁹² Exhibit C21, Annexures CGW-1 to CGW-7

⁹³ Exhibit C21, Annexure CGW-2, 38

⁹⁴ Exhibit C21b [10.5]