IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2019 002367

FINDING INTO DEATH WITHOUT INQUEST

Form 37 Rule 63(1)

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

*Amended pursuant to section 76 of the Coroners Act 2008 (Vic) on 9 April 2024 by order of the State Coroner, Judge Cain.

Inquest into the Death of Irene Mary Donne

Delivered on:	Judge John Cain, State Coroner
Delivered at:	Coroners Court of Victoria 65 Kavanagh Street Southbank
Hearing Dates:	2 November 2023
Findings of:	Judge John Cain, State Coroner
Counsel Assisting:	Ms Abigail Smith, Senior Coroner's Solicitor to the State Coroner
Keywords:	Uncharged homicide; dementia; resident on resident death; the birches; aged care;

*Paragraph 33 has been amended to correct the spelling of Mr Lindsay Ford.

INTRODUCTION

1. On 3 May 2020, Iren Mary Donne (**Mrs Donne**) was 85 years old when she died at The Birches Aged Care Hostel (**The Birches**) in Hamilton, Victoria. Mrs Donne had resided at The Birches since late 2018.

2. Mrs Donne married Mr Ronald Donne in 1953 who sadly died in 1981. She is survived by their four children Anna, Stephen, Loretta, and Megan.

3. After her husband's death, Mrs Donne began working as a secretary at Monivae College in Hamilton and continued there until retirement. She later worked as a volunteer at St Vincent's DePaul in Hamilton. She initially volunteered in the Opportunity Shop but later became President and an Area Manager for StVincent's DePaul.

4. At the time of her death, Mrs Donne was suffering from dementia. Although she was frail, she was still mobile and capable of making her own way around The Birches unassisted. Mrs Donne regularly participated in the activities conducted in and around the Birches. Her daughter, Loretta stated that Mrs Donne really enjoyed the social side of the Birches.

5. On 23 April 2020, Mrs Donne was involved in an altercation with another resident at The Birches, Mr Lindsay Ford. As a result of that incident, she suffered injuries and her health continued to deteriorate over the subsequent days. She remained at The Birches until her passing on 3 May 2020.

THE PURPOSE OF A CORONIAL INVESTIGATION

6. Mrs Donne's death constitutes a '*reportable death*' under the *Coroners Act 2008* (Vic) (**the Act**), as Mrs Donne ordinarily resided in Victoria[1] and the death appears to have been unexpected and violent.[2]

7. Pursuant to section 52(2) of the Act, it is mandatory for the coroner to hold an inquest if the death occurred in Victoria and the coroner suspects the death was as a result of a homicide and no person or persons have been charged and convicted with an indictable offence in respect of the death.

[1] *Coroners Act 2008* (Vic) s 4.
[2] *Coroners Act 2008* (Vic) s 4(2)(a).

8. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[3] The Act provides for a system whereby reportable deaths are independently investigated to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which the death occurred.[4]

9. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[5] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation,[6] or to determine disciplinary matters.

10. The expression "*cause of death*" refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

11. For coronial purposes, the phrase "*circumstances in which death occurred*",[7] refers to the context or background and surrounding circumstances of the death. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the death, it is confined to those circumstances which are sufficiently proximate and causally relevant to the death.

12. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners. This is generally referred to as the Court's "*prevention*" role.

13. Coroners are empowered:

    a) to report to the Attorney-General on the death;[8]

    b) to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice;[9] and

[3] *Coroners Act 2008* (Vic) s 89(4).
[4] *Coroners Act 2008* (Vic) preamble and s 67.
[5] *Keown v Khan (1999)* 1 VR 69.
[6] *Coroners Act 2008* (Vic) s 89(4).
[7] *Coroners Act 2008* (Vic) s 89(4).
[8] *Coroners Act 2008* (Vic) s 72(1).
[9] *Coroners Act 2008* (Vic) s 67(3).

c) to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety of the administration of justice.[10]

14. These powers are the vehicles by which the prevention role may be advanced.

15. This finding draws on the totality of the material obtained in the coronial investigation of Mrs Donne's death. That is, the court file, the coronial brief prepared by Detective Sergeant Mark James and further material obtained by the Court.

16. In writing this finding, I do not purport to summarise all the material evidence but refer to it only in such detail as appears warranted by its forensic significance and the interests of narrative clarity. It should not be inferred from the absence of reference to any aspect of the evidence that it has not been considered.

17. All coronial findings must be based on proof of relevant facts on the balance of probabilities.[11] In determining these matters, I am guided by the principles enunciated in *Briginshaw v Briginshaw*.[12] 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 that they caused or contributed to the death.

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

Identity of the deceased, pursuant to section 67(1)(a) of the Act

18. On 3 May 2020, Irene Mary Donne, born 3 August 1938, was visually identified by her daughter Lorretta Kearney.[13]

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

[10] *Coroners Act 2008* (Vic) s 72(2).
[11] *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152.
[12] 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.
[13] Statement of Identification at CB, p 45.

Medical cause of death, pursuant to section 67(1)(b) of the Act

20. On 4 May 2020, Specialist Forensic Pathologist Dr Sarah Parsons from the Victorian Institute of Forensic Medicine, conducted an autopsy and provided a written report of her findings dated 28 September 2020.[14]

21. In her autopsy report, Dr Parsons stated:

    a) The cause of death in this 85-year-old lady is complications following a fall.

    b) At autopsy, there was evidence of a skull fracture with underlying extradural haemorrhage, multiple posterior rib fractures associated with pneumonia.

    c) Lung swabs did not culture any bacteria or viruses and it is likely that the pneumonia is secondary to lung trauma and difficulty in breathing in Mrs Donne.

    d) Mrs Donne was pushed over by another resident, the injuries sustained in this fall are directly related to her death.

    e) This case has been reviewed in its entirety by a second pathologist.[15]

22. Dr Parsons provided an opinion that the medical cause of death was:

    (1)(a) Complications following a fall

23. I accept Dr Parson's opinion as to the cause of death.

Circumstances in which the death occurred, pursuant to section 67(1)(c) of the Act

24. At approximately 5.50pm on 23 April 2020, a disagreement occurred between Mrs Donne and Mr Lindsay Ford. There is no evidence as to the cause of the disagreement. There was another resident John O'Flaherty nearby, but it is unclear whether he was involved in the disagreement or not. All three residents were standing in the passageway outside the sunroom at The Birches.

25. Ms Vera Oswald who is employed as a service assistant at the Birches heard the argument and immediately approached the three residents to investigate and attempt to resolve the disagreement. As she walked towards the residents, she observed Mr Ford push Mrs Donne

[14] Specialist Forensic Pathologist Dr Linda Iles on 6 May 2020 conducted a separate examination of the Mrs Donne Brain and provided a written report dated 9 September 2020 the conclusions were incorporated into Dr Parsons report
[15] Autopsy report Dr Sarah Parsons CB p

with his open hands (both hands) to her shoulders. Ms Oswald described the push as quite forceful.

26. As a result of the push, Mrs Donne fell backwards striking her head on the wall and then fell to the ground. Ms Oswald immediately rendered assistance to Mrs Donne and called for assistance. She was quickly joined by other staff who responded to the call for assistance.

27. Nurse Sally Anne Byrne was working at the charge desk and heard yelling and immediately went to investigate. She discovered Mrs Donne on the ground being assisted by Ms Oswald. She described Mrs Donne as distressed and upset. Although there were no obvious signs of injury, Mrs Donne did complain of a sore head.

28. Nurse Byrne completed a 'head to toe' assessment of Mrs Donne and observed redness on her back and a haematoma on the back of her head. She arranged for Mrs Donne to be placed in a wheelchair and taken to her bed with instructions to staff that observations should be taken each half hour for the subsequent four hours. Mrs Donne was treated with analgesic medication to ease her pain and observed by The Birches staff. Over the next three to four hours, Mrs Donne complained of pain in her legs and was favouring one leg when walking. She was also complaining of headaches.

29. In the late morning on 24 April 2020, Mrs Donne was assessed by the on-call doctor, Dr Robertson who prescribed tramadol and ordered an Xray to ascertain the source of her hip/leg pain. The Xray showed that Mrs Donne had a fractured left pubic ramus. The treatment plan was to continue with analgesic (tramadol) and review the following day. The staff at The Birches observed that Mrs Donne was comfortable while resting.

30. Over the next day, Mrs Donne was having difficulty taking her oral medication and was distressed. Fentanyl patches were prescribed as an alternative to oral medication together with Endone and Clonazepam to be administered as required. Mrs Donne's family were consulted and the decision was made to keep her as comfortable as possible but further treatment or hospitalisation was not to be undertaken.

31. Over the coming days, Mrs Donne continued to be treated with pain relief medication and was kept as comfortable as possible. This continued until her condition further deteriorated and she passed away in the early hours of 3 May 2020.

HOMICIDE INVESTIGATION BY VICTORIA POLICE

32. Following Mrs Donne's death, police commenced an investigation into the circumstances which led to the altercation with Mr Ford and Mrs Donne's subsequent death.

33. As part of the investigation, a medical report from Psychiatrist Mark Ives was obtained in relation to Mr Ford's medical condition. Dr Ives stated that Mr Ford has a diagnosis of advanced dementia and a recent CT scan showed significant cerebral atrophy and chronic ischaemic changes.[16] He also stated that it was known that Mr Lindsay could become agitated at times and there were situations where he had been aggressive towards other residents.

34. The criminal investigation was not progressed as Mr Ford's medical condition meant that it was not appropriate to attempt to interview him in relation to the events of 23 April 2020 at the Birches. Mr Ford passed away on 20 October 2021 from natural causes prior to Victoria Police concluding their investigation.[17] The Office of Public Prosecution had not been consulted in relation to the matter and no charges were ever brought against Mr Ford.

THE BIRCHES

35. As part of my investigation, I requested copies of all relevant policies and procedures relevant to the management of high risk residents that were in place at The Birches at the time of disagreement between Mrs Donne and Mr Ford. I also requested a statement addressing questions relevant to the management and care of Mrs Donne whilst she was a resident at The Birches. These questions included, the steps taken by The Birches to manage the risk of aggressive residents, details of any tools or guidelines used by staff to assist in managing residents and finally whether changes had been made to policies and procedures since the date of this incident.

36. Dr Dale Ford the Chief Medical Officer at Western District Health Service provided a detailed statement addressing these issues. Dr Dale Ford provided an overview of all the relevant policies and procedures and the risk management arrangements. The Birches is operated by Western District Health Service and provides permanent and respite accommodation to the frail, elderly and disabled. The Birches also has a secure unit within the facility that provides care for people living with dementia.[18]

[16] Letter from Psychiatrist, Mark Ives dated 16 June 2020 at CB, p 33.
[17] Statement of Detective Sergeant Mark James, dated 6 January 2023 at CB, p 36.
[18] Statement of Mr Dale Ford dated 6 July 2022 at CB, p 25.

37. I have carefully reviewed his statement and the various policies and procedures, and I am satisfied that the arrangements in place for managing residents were reasonable and appropriate. I am also satisfied that the employees at The Birches reacted quickly and appropriately to the incident on 23 April 2020 in separating both parties, rendering assistance to Mrs Donne, and arranging medical assistance as required.

38. Being mindful of section 7 of the Act which makes clear that a coroner should 'avoid unnecessary duplication of inquiries and investigations' and having reviewed the available evidence in detail, I am satisfied that no further investigation of the circumstances surrounding the death of Mrs Donne is required.

FINDINGS AND CONCLUSION

39. Having investigated the death of Irene Mary Donne and having held an inquest in relation to her death on 2 November 2023 at Melbourne, I make the following findings, pursuant to section 67(1) of the Act, I make the following findings:

    a) the identity of the deceased was Irene Mary Donne, born 3 August 1938;

    b) the death occurred on 3 May 2020 at The Birches Aged Care Hostel Tyers Road Hamilton from *complications following a fall*.

    c) the death occurred in the circumstances described above.

40. Having considered all available evidence, I am satisfied that the actions of Mr Ford on 23 April 2020 in pushing Mrs Donne caused or contributed to her death.

41. Further, I consider that the events of 23 April 2020 which were the catalyst for Mrs Donne's death could not have been reasonably foreseen or prevented by The Birches.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

42. While I have not identified any particular concerns arising from The Birches response to the incident on 23 April 2023, I consider that it is critical that residential aged care providers continue work to improve their processes for preventing and responding to resident-to-resident aggression, including in circumstances where both parties have been diagnosed with dementia.

43. In this case, Victoria Police commenced a criminal investigation which did not progress as they were unable to interview Mr Ford prior to him passing away due to his advanced dementia. A criminal charge in resident-to-resident aggression in the vast majority of cases is not an appropriate response because in most cases there is no public interest served by pursuing a criminal charge.

44. Unfortunately, resident-to-resident aggression will continue to pose a significant challenge for residential aged care providers due to a combination of factors, including an increasing ageing population, an increase in the number of vulnerable people entering care and the difficulties of administering care to a large group of residents with varying levels of needs and cognitive impairment. Proactive approaches by care providers to regularly monitor, reassess and manage resident risks are vital.

45. It is apparent that further research is required to determine best practice in addressing, managing, and preventing resident-to-resident aggression. The Royal Commission into Aged Care Quality and Safety was set up in 2018 to consider issues related to the quality of residential and in-home aged care. The Royal Commission's final report, '*Care, Dignity and Respect*' was tabled in the Australian Parliament on 1 March 2021. This report included 148 wide-ranging recommendations for fundamental reform of the aged care system. The Royal Commission identified four areas in need of immediate attention: food and nutrition; care and support for people living with dementia; elimination and reduction of restrictive practices; and palliative care. A number of recommendations were targeted at improving care arrangements for those suffering with dementia.

46. In response to the recommendations of the Royal Commission the Australian Government, in consultation with state and territory governments, is currently developing a new National Dementia Action Plan (the **Plan**). A consultation paper has been published with feedback now submitted with work continuing on the development of the Plan. The Plan will span over 10-years and include specific actions that promote a collaborative national approach to drive improvements for people living with dementia, their carers and families throughout Australia.[19]

47. The Australian Government has recognised the critical need to improve care and support for residents of aged care with complex needs and I am hopeful that these initiatives may reduce the risk of deaths occurring in similar circumstances.

[19] https://www.health.gov.au/our-work/national-dementia-action-plan

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

Pursuant to section 73(1B) 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:

Loretta Kearney, Senior Next of Kin

Dr Dale Ford, Chief Medical Officer, Western District Health Service

Detective Sergeant Mark James, Coroner's Investigator

Signature:

JUDGE JOHN CAIN
STATE CORONER
Date:11 April 2024

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.