

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2019 3861

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

Section 67 of the Coroners Act 2008

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| Findings of: | Audrey Jamieson, Coroner |
| Deceased: | Joyce Drummond |
| Date of birth: | 6 August 1939 |
| Date of death: | 11 August 2019 |
| Cause of death: | 1(a) Complications of chronic lymphocytic lymphoma in the setting of multiple medical comorbidities |
| Place of death: | Peninsula Health- Golf Links Road Rehabilitation Centre, 125 Golf Links Road, Frankston Victoria 3199 |

INTRODUCTION

1. On 11 August 2019, Joyce Drummond was approximately 80 years old when she died at Peninsula Health- Golf Links Road Rehabilitation Centre located at 125 Golf Links Road, Frankston Victoria 3199. Prior to her deterioration, Ms Drummond was a long time resident at the shared accommodation residence, Olsen House in Frankston, Victoria 3199.
2. Olsen House is currently run by the disability service provider, Kindilan Society- **focus** Individualised Support Services (**Kindilan Society**).
3. Ms Drummond was not a National Disability Insurance Scheme recipient and was not the recipient of funding through the Victorian Department of Health and Human Services. Ms Drummond's funding came through the Commonwealth Continuity of Support Program.
4. Detailed in the body of this finding are the issues pertaining to the registration of Ms Drummond's birth and subsequent ambiguity surrounding her date of birth. For the purpose of this finding and corresponding records, I have used the date of birth listed by Ms Drummond's longest standing care provider, Kindilan Society.

THE CORONIAL INVESTIGATION

5. Ms Drummond'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. The death of a person in care or custody is a mandatory report to the Coroner, even if the death appears to have been from natural causes.
6. 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.
7. 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.

8. The Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Ms Drummond's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.
9. This finding draws on the totality of the coronial investigation into the death of Ms Drummond, 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.¹

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

Circumstances in which the death occurred

10. On 18 July 2019, Ms Drummond was transferred from The Mornington Centre to the Palliative Care Unit at Golf Links Road Rehabilitation Centre. She was diagnosed with recurrent febrile episodes in the background of pancytopenia secondary to chronic lymphocytic lymphoma. The aim of her transfer was “to assess her ongoing functional needs, provide supportive care and provide the end of life when clinically indicated”.

The decision for palliation was based on a progressive functional decline and recurrent febrile neutropenic episode despite [sic] of multiple treatments under the acute and slow stream rehabilitation units of Peninsula Health.

...

A clinically well-considered decision to provide palliative and supportive care was made by multi-disciplinary and multiple teams based on their respective input over the preceding months.

11. Upon her admission, Ms Drummond was noted as being anxious, intermittently confused and refusing meals. She required full nursing assistance and was assessed by a speech pathologist, dietician, social worker, as well as clinical staff.
12. Ms Drummond's condition continued to worsen and on 11 August 2019 at approximately 4.03pm, she died as a result of her ailing health.

¹ Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

Identity of the deceased

13. On 11 August 2019, Joyce Drummond, born 6 August 1939, was visually identified by chief operating officer of Kindilan Society, Toni Stewart.
14. Identity is not in dispute and requires no further investigation.

Medical cause of death

15. Forensic Pathologist Dr Victoria Francis from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an external examination on 12 August 2019 and reviewed the Victoria Police Report of Death to the Coroner (Form 83), E-Medical Deposition form, medical records from Langwarrin Medical Clinic and the post mortem computed tomography (CT) scan. Dr Francis provided a written report of her findings dated 29 August 2019.
16. The post-mortem examination revealed a frail elderly woman with no external evidence of trauma. The post mortem CT scan showed peripheral vascular disease, splenomegaly and increased right lower lobe markings.
17. Dr Francis noted that Ms Drummond had a history of chronic lymphocytic lymphoma with pancytopenia, as well as osteoarthritis, osteoporosis, low grade B cell non-Hodgkin lymphoma (chronic lymphocytic lymphoma) and hypertension.
18. Dr Francis provided an opinion that Ms Drummond died from natural causes. The medical cause of death being '1(a) Complications of chronic lymphocytic lymphoma in the setting of multiple medical comorbidities'.

FURTHER INVESTIGATIONS

19. Ms Drummond's general practitioner, Dr Stephen Vaughan of the Langwarrin Medical Clinic, detailed that Ms Drummond had an intellectual disability. Dr Vaughan further detailed that Ms Drummond had an extensive medical history that included but was not limited to breast cancer, osteoporosis, progression of low-grade B cell lymphoma and febrile neutropenia.
20. Following Ms Drummonds death, investigations unearthed inaccuracies pertaining to her particulars. Specifically, that she had been in care here entire life, had no known relatives or next of kin and that several services involved in her care throughout her life had conflicting information as to her date of birth.

21. Chief operating officer for the disability service provider at Kindilan Society², Toni Setwart, provided that Kindilan Society records had Ms Drummond's date of birth listed as 6 August 1939. State Trustees³, however, provided a contradictory date of 19 September 1936.
22. A public notice was published in the Herald Sun seeking a potential next of kin. This process did not reveal a next of kin nor did it clarify Mr Drummond's date of birth.
23. Further investigation by Ms Stewart into archived material relating to Ms Drummond revealed a letter dated 3 May 1988⁴ to a Sister Francis McFaull (family research representative of the Covent of the Good Shephard) from Sylvia Atkinson (administrator/ secretary to the Committee of Management of Peninsula Retarded Citizen's Welfare Association). The letter details that Ms Drummond was seeking a birth certificate and confirmation of her birth date for an upcoming hospital admission. Ms Atkinson detailed that the Peninsula Retarded Citizen's Welfare Association records detail her date of birth as being 6 August 1939 and that she was placed under their care in 1977 with no previous history supplied, including no details of a next of kin.

Joyce's memory of her past is somewhat hazy but during a number of conversations we have ascertained that her earliest recollections are of being in an orphanage in Bendigo.

24. In a letter dated 13 May 1988, Sister McFaull replies to Ms Atkinson. The letter details Ms Drummond's date of birth as being 19 September 1936 and further details Ms Drummond's place of birth as being "Broadmeadows (Royal Park)". Under her name in brackets, the surname "Wong" is listed.
25. On 20 May 1988, Ms Atkinson wrote to the Registry of Births, Deaths and Marriages in Melbourne and requested birth certificates for the names Joyce Drummond, date of birth 6 August 1939 and Joyce Wong, date of birth 19 September 1936. No records were found for either name.
26. Ms Stewart detailed in her statement to the Court that Kindilan Society were aware Ms Drummond's date of birth was approximate because she had always maintained that "she had been abandoned by her mother and was left on the door steps of a church in Bendigo".
27. A letter dated 30 June 1988 from Carolyn Bates (social worker at St Joseph's Babies Home) to Ms Atkinson details that according to their records, Ms Drummond was born on 19

² Now trading as *focus Individualised Support Services*: <https://www.focuslife.com.au/>

³ Ms Drummond's Victorian Civil and Administrative Tribunal appointed financial administrators.

⁴ Date has faded, appears to read 3 May 1988.

September 1936 and “admitted” to St Joseph’s Babies Home⁵ on 19 May 1937. The letter details that she remained there until 4 April 1940, when she was “discharged” to St Anthony’s Home in Kew⁶.

28. In a subsequent letter from Ms Bates dated 27 July 1988 to Ms Atkinson, Ms Bates advises that the birth certificate search for “Joyce Wong” did not return a result. Ms Bates raises the possibility of the birth having been registered in another state due to an estimated time lapse of eight months between Ms Drummond’s birth and her placement at St Joseph’s Babies Home. Ms Bates further writes that St Anthony’s Children’s Home have a record of “Joyce Wong” being born on 19 September 1936.
29. Both Ms Bates and Ms Atkinson conducted follow up investigations, including contacting Community Services Victoria for a record search and applying for additional search options for birth certificates. All avenues failed to return results.
30. At some time in 1977, the Mental Health Authority moved Ms Drummond into a group home, known as Olsen House⁷. There are no records detailing where she was residing between 1974 and 1977. Olsen House was managed by Peninsula Retarded Citizens Welfare Association⁸.
31. The Mental Health Authority provided documentation to Woorinyan stating that Ms Drummond’s date of birth was 6 August 1939.
32. At some time in 1998, Kindilan Society took over management of Olsen House. Based on a date of birth of 6 August 1939, Ms Drummond was approximately 59 years of age at this time.
33. In 2009, Kindilan Society purchased the site of Olsen House and built a five bedroom house. Ms Drummond and other resident’s from the previous dwelling moved into the new build and this is where Ms Drummond remained until her deterioration.

Ms Drummond’s deterioration

34. On 30 April 2019, Ms Drummond was “unsteady on her feet, dizzy and very confused”. Staff at Olsen House called Ambulance Victoria and Ms Drummond was transported to Frankston Hospital.

⁵ Previously known as the St Joseph’s Foundling Hospital.

⁶ Ms Drummond was later moved to St Aidan’s Orphanage (also known as The Convent of the Good Shephard).

⁷ Located at 15 McAlister Street, Frankston Victoria 3199.

⁸ Also known as Woorinyan before changing to Connecting 2 Australia.

35. On 1 and 3 May 2019, Ms Drummond underwent tests that showed her cancer had progressed. Ms Drummond subsequently refused further testing.
36. On 6 May 2019, the Office of the Public Advocate (**OPA**) was contacted to have a medical power of attorney appointed.
37. On 7 May 2019, Sonja Gardner of the OPA advised that she had been appointed as medical power of attorney. Ms Gardner was asked to consent to a biopsy and MRI, to which she agreed.
38. On 8 May 2019, the Oncology Team at Frankston Hospital advised they would take over care of Ms Drummond at the consent of Ms Gardner.
39. On 11 May 2019, Frankston Hospital transferred Ms Drummond to Peninsula Health-The Mornington Centre (**The Mornington Centre**) for outpatient treatment. The decision was made that she would not return to Olsen House due to staff not having the skills and resources to meet Ms Drummond's new care requirements.
40. On 24 May 2019, a meeting was held between Kindilan Society and The Mornington Centre to discuss Ms Drummond's ongoing care requirements. Long term care arrangements were determined to be beyond Olsen House's resources. Subsequently, it was determined that an Aged Care Assessment would be conducted so alternative housing could be considered.
41. On 17 June 2019, The Mornington Centre completed the Aged Care Assessment.
42. On 24 June 2019, Mr Drummond was transferred back to Frankston Hospital for treatment of an infection.
43. On 25 June 2019, discussions between treating clinicians and Ms Gardiner culminated in the decision to "withdraw active treatment based on medical futility".
44. On 9 July 2019, Ms Drummond signed paperwork consenting to The Mornington Centre finding her alternative accommodation. Kindilan Society were informed of the consent and subsequently prepared documentation advising the Commonwealth Continuity of Support Program that Ms Drummond was no longer their client.
45. On 18 July 2019, Ms Drummond was transferred from The Mornington Centre to the Palliative Care Unit at Golf Links Road Rehabilitation Centre.

46. On 29 July 2019, Kindilan Society were advised that Ms Drummond was moved to palliative care at the Golf Links Road Rehabilitation Centre.
47. On 11 August 2019, Ms Drummond passed away.

FINDINGS

48. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:
- (a) the identity of the deceased was Joyce Drummond, born 6 August 1939;
 - (b) the death occurred on 11 August 2019 at Peninsula Health-Golf Links Road Rehabilitation Centre located at 125 Golf Links Road, Frankston Victoria 3199;
 - (c) I accept and adopt the medical cause of death formulated by Dr Victoria Francis, and I find that Joyce Drummond died from natural causes: ‘1a complications of chronic lymphocytic lymphoma in the setting of multiple medical comorbidities’, and
 - (d) the death occurred in the circumstances described above.
49. I find that Joyce Drummond lived in circumstances analogous to the definition of ‘in care’ defined in section 4 of the Act. Accordingly, I have invoked s 52(3A) of the Act to finalise the investigation into her death.
50. I find that there is no evidence of any causal connection between Joyce Drummond’s death and her dependence on the care of others.

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.

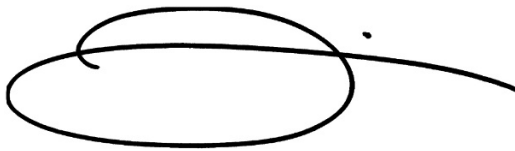
I direct that a copy of this finding be provided to the following:

Marita Gill, State Trustees

Amber Salter, Peninsula Health

Leading Senior Constable Emma Rainey, Coroner's Investigator

Signature:



Audrey Jamieson

CORONER

Date: 9 February 2021



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.
