



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2020 005310

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

Section 67 of the Coroners Act 2008

INQUEST INTO THE DEATH OF ROSA BONAVENTURA

Findings of:	Coroner David Ryan
Delivered on:	20 October 2026
Delivered at:	Coroners Court of Victoria 65 Kavanagh Street, Southbank, Victoria
Inquest hearing dates:	6 and 7 October 2026
Counsel Assisting the Coroner:	Daniel McCredden of counsel Instructed by Dominique Cuschieri Coroners Court of Victoria
Fred Bonaventura:	Dr Ian Freckelton KC Instructed by Petterlin Legal
Mercy Health:	Naomi Hodgson of counsel Instructed by Gilchrist Connell
Keywords:	Aged care – standing machine – sling hoist – communication - training

INTRODUCTION

1. On 25 September 2020, Rosa Bonaventura was 97 years old when she passed away at the aged care facility where she resided in Abbotsford. The facility is managed by Mercy Aged & Community Care (**Mercy**). Rosa was born on 11 July 1923, and she had lived at Mercy since 2014. She is warmly remembered and deeply mourned by her family.

BACKGROUND

2. Rosa's medical history included dementia, Alzheimer's disease, ischaemic heart disease, hypertension, osteoporosis, arthritis, and type 2 diabetes. In 2019, she had a stroke after which she lost her sight. She required significant assistance with activities of daily living and mobilising. Her prescribed medication included aspirin.¹
3. Mercy had recorded that Rosa required support in both sitting and standing and lacked understanding of personal safety and spoken instructions. Rosa was assessed as a high falls risk and her Care Plan² at Mercy recorded that she required two staff for transfers with the use of a sling hoist.³
4. On 10 September 2020, Rosa sustained an injury to her head. Staff at Mercy reported that the injury had occurred while Rosa was being transferred from her bed with the use of a standing machine (the Sara 3000).⁴ In Mercy progress notes recorded later that day, it was noted by staff that *"Rosa was sitting on the bed with the standing machine in front of her when suddenly she bumped her head on the right side of the standing machine and sustained a skin tear...X2 staff assisted Rosa back to her bed, re positioned, applied pressure on the wound"*.⁵

¹ Antiplatelet medication.

² Rosa's latest Care Plan and Mobility and Transfers Assessment was dated 3 July 2020; CB13-52; CB13-63.

³ A sling hoist is a frame coupled with a sling that is used to transfer a patient who is totally reliant on other persons to perform the transfer due to poor balance, coordination or frailty and unable to assist themselves to a sitting position during a bed or other transfer; See CB11-14.

⁴ A standing machine is a type of hoist that is used to mobilise a patient from a seated position to a standing position, and then typically into a chair. It is designed to be used with a patient who is able to assist in the transfer process; CB11-19.

⁵ CB13-192.

5. Rosa was assessed by a clinician from St Vincent's Residential In Reach who recorded that she had "*received a head strike from arm of lifting machine when being transferred to a shower chair this morning*".⁶ She was transported to St Vincent's Hospital by Ambulance Victoria where a computed tomography (CT) scan revealed that she had suffered a subdural haematoma.⁷ It was recorded by paramedics that she had fallen to the right while she had been sitting up on the side of the bed, striking the right side of her forehead on the arm of a standing machine.⁸ Rosa subsequently returned to Mercy and received comfort care, passing away on 25 September 2020.

THE CORONIAL INVESTIGATION

Original investigation

6. Rosa'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.
7. 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.
8. A coroner must not include in a finding or comment any statement that a person is, or may be, guilty of an offence.
9. 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.

⁶ CB14-3.

⁷ The medical records at St Vincent's Hospital did not note that there had been any abrasive injury.

⁸ It was recorded by St Vincent's Hospital staff that Rosa "*slipped in standing machine hoist today while being lifted to stand. Hit R forehead against frame and R shoulder also*"; CB13-71.

10. Forensic Pathologist Dr Linda Iles from the Victorian Institute of Forensic Medicine conducted an examination on 28 September 2020 which included the review of a post-mortem CT scan. She provided a written report of her findings dated 13 October 2020.
11. The post-mortem examination revealed bruising and a sutured laceration to the right side of the head as well as minor bruising to the leg.
12. Dr Iles provided an opinion that the medical cause of death was *I (a) Acute on chronic subdural haematoma sustained in a fall in a woman with dementia.*
13. Rosa's death was originally investigated by Coroner Hawkins. To assist the investigation, the Court obtained a statement dated from Gurpreet Kaur dated 21 January 2021. Ms Kaur was the Acting Service Manager at the aged care facility where Rosa had resided. Her Honour also considered correspondence submitted by Rosa's sons, John and Fred Bonaventura.
14. In her statement, Ms Kaur stated that the incident had been reported to have occurred in the following circumstances:

"I have been advised by the staff member involved in the incident that immediately prior to the incident, Rosa was sitting at the end of her bed facing the standing machine (a Sara 3000). The staff member put the lifting sling around Rosa and attached the sling to hooks on the right side of the standing machine (the left-side hooks were not yet attached). In this position, the resident to be lifted is positioned between the supports of the lifting machine to which the sling is attached..."

The staff member advised me that she was required to bend down to uncross Rosa's legs so they could be positioned in the leg supports of the machine.

While the staff member was bending down, Rosa suddenly moved forward and to her right side, with her head bumping against the sling attachment. The staff member has advised me that Rosa's movement was unexpected and sudden, with the staff member commenting that she thought Rosa may have briefly 'blacked out'. I have only become aware of this information in the course of preparing this statement, and the information was not relayed to nursing or medical staff at the time, nor was this information included in the incident report.

The staff member looked up and saw Rosa had suffered a skin tear to her forehead. The staff member immediately ceased the attempt at moving Rosa and called for help."

15. On 27 July 2021, Coroner Hawkins delivered a finding into Rosa's death without inquest. She found that the cause of death was an acute on chronic subdural haematoma sustained in a fall in a woman with dementia. Coroner Hawkins found that Rosa struck her head on the standing machine while she was being positioned for transfer from her bed. Further, she found that the manual handling requirements for the use of the standing machine were not complied with as Rosa should have been assisted in the transfer by two staff members, not one.
16. WorkSafe conducted an investigation into the incident and determined not to commence any criminal proceedings against Mercy in relation to the incident. They did however find that Mercy had failed to notify them of the incident as required by section 37 of the *Occupational Health and Safety Act 2004*.

Re-opened investigation

17. On 9 December 2025, Rosa's son, Fred Bonaventura, submitted an application under section 77 of the Act seeking to set aside Coroner Hawkins findings and re-open the investigation. He also requested that an inquest be held into his mother's death. Mr Bonaventura relied upon evidence that he obtained which was not considered by Coroner Hawkins as part of her investigation. The new material included expert evidence from two forensic pathologists, Professor Johan Duflou and Dr Byron Collins, which suggested that the mechanism of injury Rosa sustained was not consistent with the account provided by Mercy, and expert evidence from an engineer and ergonomist, Bill Contoyannis, who expressed the opinion that the standing machine was not a suitable means for transferring Rosa. Also relied upon was Rosa's Care Plan contained in her Mercy records which included a recent assessment from her physiotherapist confirming that transfers were required to be conducted with two staff using a sling hoist.
18. Mr Bonaventura's application was referred to me for determination by State Coroner Judge Sanger.

19. On 6 February 2026, I determined that it was appropriate to set aside the finding regarding the circumstances of Rosa's death and re-open the investigation. I was satisfied that there was relevant evidence that had not been considered by Coroner Hawkins during the investigation which warranted further scrutiny and inquiry. In particular, the expert evidence obtained by Mr Bonaventura cast doubt upon the circumstances in which his mother was found to have sustained the injury to her head, and whether the standing machine used for her transfer was suitable given her cognitive and physical capacities and limitations.
20. After the re-opening of the investigation, the Court obtained further evidence, including the following:
 - a) Two witness statements from Karin Pearse, a Personal Care Attendant employed at Mercy at the time of Rosa's death;
 - b) Two supplementary witness statements from Ms Kaur;
 - c) Witness statement from Lorylynn Balanga, a Registered Nurse employed at Mercy at the time of Rosa's death;
 - d) Witness statement from Anthony Bidmead, an Enrolled Nurse employed at Mercy at the time of Rosa's death;
 - e) Witness statement from Recka Singh, a Personal Care Attendant employed at Mercy at the time of Rosa's death; and
 - f) A supplementary report from Dr Iles.
21. Further expert reports were also provided to the Court by Mr Bonaventura, from Occupational Therapist Melissa Andreotti, Physiotherapist Sharon Reneaux and a further report from Dr Collins.
22. The holding of an inquest into Rosa's death was not mandatory under the Act. However, at a mention hearing on 19 June 2026, I determined that it was appropriate to hold an inquest in the exercise of my discretion under section 52(1) of the Act in order to fully

explore a number of uncertainties in the evidence relating to the circumstances of Rosa's death, in particular, the mechanism of her injury. A coronial brief of evidence was compiled by the Court and circulated to the interested parties. The inquest was held on 6 and 7 October 2026.

23. This finding draws on the totality of the coronial investigation into Rosa's death, including the evidence given at the inquest, material in the coronial brief and the submissions of counsel assisting and the interested parties. While I have considered 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.⁹
24. A number of factual disputes arose on the evidence at the inquest, and there was also an exploration of potential prevention opportunities. Some of these disputes and opportunities were exposed and debated through the questioning and submissions of counsel for the interested parties in the reasonable pursuit of their clients' interests. However, it has not been necessary to resolve all of those disputes in order to make the findings necessary under section 67 of the Act and only those prevention opportunities which directly arise from the making of those findings have been subject to recommendations.

NEW EVIDENCE

Ms Pearse

25. The Court obtained statements from Ms Pearse dated 9 April and 12 August 2026. She was the staff member who was involved in Rosa's transfer using the standing machine on 10 September 2020.
26. Ms Pearse stated that she prepared to assist Rosa to transfer to a chair using a standing machine at around 10.25am. She noted that such transfers were typically undertaken with the assistance of two staff members. She stated that, in accordance with her usual practice,

⁹ 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.

it had been her intention to seek the assistance of a second staff member once Rosa had been prepared for transfer. She further stated that she had routinely used the standing machine for transfers involving Rosa in the five years before the incident, and Rosa was familiar with the process. She did not consider that a sling hoist was required and stated that her Care Plan required that it was only necessary for use if Rosa had a fall to the floor. She stated that she would be expected to be notified by nursing staff if there had been a change to Rosa's Care Plan requiring the use of a sling hoist for transfers.

27. Ms Pearse stated that:

"I assisted Mrs Bonaventura to place her feet on the platform of the standing machine. I positioned the sling around Rosa's back, placing it under her arms and attached the left and right clips to the front of the machine on both sides. I then secured the strap around her waist.

I bent down to assist Mrs Bonaventura adjust her feet on the platform, ensuring they were parallel and in the correct position for the transfer. While I was doing this, Mrs Bonaventura suddenly fell forward, and her head struck the sling attachment on the right-hand side of the machine. Mrs Bonaventura sat back up. I observed that there was a cut on her forehead, although it was not bleeding.

When I saw the cut, I immediately unclipped the front of the machine, assisted Mrs Bonaventura to lie back on the bed, and called for the nurse.

...As I understand it, the correct positioning is for both arms to be outside the sling, and both feet to be on the foot plate, with both hands on the handle bars, which is how Mrs Bonaventura was positioned, when I was assisting her."

28. Prior to the incident, Ms Pearse recalled that Rosa had been sitting up "independently and comfortably" and that had she "seemed unsteady or was swaying at all", she would have stopped preparing for the transfer. Further, even if another staff member had been present, she considered it would have been unlikely that one of them would have been holding her upper body, and that her sudden fall forward would not have been able to be prevented.

29. Ms Pearse had worked with Rosa for a number of years and recalled that they had been involved in hundreds of transfers together using the standing machine without incident. Having reflected on the incident, Ms Pearse has acknowledged that she had misunderstood the Mercy policy and she should have waited for another staff member to be available before she commenced preparation for Rosa's transfer using the standing machine on 10 September 2020. She now understands that the policy requires two staff to be involved in preparation and transfer when using the standing machine to transfer residents.

Mr Bidmead

30. Mr Bidmead worked at Mercy in the morning on 10 September 2020. He recalled Ms Pearse calling out for assistance at around 10.30am. He stated that when he came into Rosa's room, she had been sitting unsteadily on the side of the bed with a cut on her head. He helped Ms Pearse put Rosa back into bed.
31. Given his understanding of Rosa's care needs, Mr Bidmead did not consider it unusual that a standing machine was being used for her transfer. However, he did understand that Mercy policy required that two staff were to be involved in preparation and transfer when using a standing machine and that the training received by staff was clear on this issue.

Ms Balanga

32. Ms Balanga worked at Mercy in the morning on 10 September 2020. She recalled responding to the incident at around 10.30am after being alerted by another staff member. She entered Rosa's room after she had been put back into bed. She recalled that Ms Pearse had told her that Rosa had "*suddenly and unexpectedly fallen forward and hit her head on the standing machine*" as she had been preparing for her transfer. Ms Balanga stated that she was not aware of any other staff member not adhering to the policy that two staff members are required when using a standing machine for both preparation and transfer and that she thought that the training was very clear on this issue.
33. Ms Balanga stated that a standing machine was suitable for transfers involving Rosa. She recalled that it was consistently used for Rosa's transfers and that she had no concern that it was being used. Ms Balanga also stated that, on the assumption that Rosa fell forward

“suddenly and unexpectedly”, “it is difficult to see how a second staff member assisting would have avoided this” as the second staff member is unlikely to have been holding her upper body steady or been in a position to stop her suddenly falling forward from the waist.

Ms Singh

34. Ms Singh worked at Mercy in the morning on 10 September 2020. She had been assigned as Ms Pearce’s “buddy” that day to assist her with duties such as transfers requiring two people. She was not involved in the incident but stated that she had been aware when using a standing machine that Mercy policy required two staff to be involved in the preparation of a resident for transfer and the transfer itself. She recalled that the training provided to her had been clear and consistent on this issue.

Ms Kaur

35. Ms Kaur stated that staff had been trained at Mercy about the policy requiring two staff to be involved when using a standing machine for the preparation and transfer of residents. She stated that the requirement was communicated during annual manual handling training and was reflected in resident care plans. She confirmed that following the incident, on 14 October 2020, manual handling training was arranged for staff at Mercy to reinforce the policy.

Professor Duflou

36. Mr Bonaventura obtained expert reports from Professor Johan Duflou dated 23 November 2022 and 18 December 2024. He agreed with Dr Iles that the cause of death can reasonably attributed to a subdural haematoma sustained in a fall. He stated in his opinion that it was entirely possible that Rosa sustained the subdural haematoma as a result of impact against a part of the standing machine as a result of a fall of some type.
37. Professor Duflou reviewed photographs taken on 12 September 2020 of Rosa’s facial injuries and stated that they appeared to disclose punctate bruising or abrasion which more likely occurred from impact against a relatively rough surface, rather than impact with the standing machine as described by Mercy.

38. Further, Professor Duflou stated that the subdural haematoma sustained by Rosa was more likely to have occurred from a fall to the ground in some way rather than from impact with the standing machine as described by Mercy.

Dr Collins

39. Mr Bonaventura obtained expert reports from Dr Byron Collins dated 25 October 2025 and 14 September 2026. Dr Collins stated his opinion that the mechanism of Rosa's head injury is inconsistent with the version of events provided by Mercy and is more likely to have resulted from her head striking the prominent, curvilinear area of the standing machine's foot support, following an unsupported fall from the bed to the floor.

Dr Iles

40. Pursuant to my request, and after having considered the relevant new evidence, Dr Iles prepared a supplementary report dated 28 April 2026. Dr Iles expressed the opinion that, although Rosa's injuries could have been sustained in other ways, the version of events described by Ms Pearse and Mercy could account for them. She noted that it is well recognised that elderly people in the setting of significant cerebral atrophy, and with the use of antiplatelet agents, can develop subdural haemorrhage following minimal, or no identifiable head trauma.
41. Dr Iles did not agree with the opinion of Dr Collins that Rosa's head injury is more likely to have resulted from her head striking the prominent, curvilinear area of the standing machine's foot support, following an unsupported fall from the bed to the floor. She stated that there is no evidence to favour one mechanism of injury over another.
42. Dr Iles did not agree with Professor Duflou that the photograph of taken on 12 September 2020 appeared to disclose an abraded injury. Further, she stated that the presence of punctate bruising does not preclude the mechanism of injury described by Ms Pearse and Mercy.

Mr Contoyannis

43. Mr Bonaventura obtained an expert report from ergonomist, Bill Contoyannis dated 31 January 2025. He expressed the opinion that the Sara 3000 standing machine was not an appropriate means for transferring Rosa given her frailty, poor balance and lack of coordination. He considered that a suitable means of transferring Rosa would have been with the use of a sling hoist, as specified in her Care Plan, with the use of two trained assistants.

Ms Andreotti

44. Mr Bonaventura obtained an expert report from Occupational Therapist, Melissa Andreotti dated 18 June 2026. She expressed the opinion that the Sara 3000 standing machine was not an appropriate means for transferring Rosa given her frailty, poor balance and inability to understand and follow instructions. She also considered that a suitable means of transferring Rosa would have been with the use of a sling hoist, as specified in her Care Plan.

Ms Reneaux

45. Mr Bonaventura also obtained an expert report from Physiotherapist, Sharon Reneaux dated 11 September 2026. She expressed the opinion that the Sara 3000 was not the most appropriate transfer aid for Ms Bonaventura in September 2020. She noted that the instruction manual for the Sara 3000 identified that it should only be used for people with the ability to partially bear weight through at least one leg and to demonstrate some trunk stability. While Mercy had documented that Rosa retained some capacity to weight bear, Ms Reneaux stated that there were “*significant limitations on her ability to consistently maintain postural stability and participation required for use of a standing transfer aid*”.¹⁰
46. Although staff had been able to successfully use the Sara 3000 in regular transfers for Rosa in the past, Ms Reneaux considered that “*her documented functional decline, requirement*

¹⁰ CB21-4

*for support in sitting and standing, variable cooperation and impaired cognition affected her ability to safely and consistently participate in a standing transfer”.*¹¹

47. Ms Reneaux stated that the *“principal risk associated with use of the Sara 3000 was that Mrs Bonaventura could lose her position or stability during preparation or transfer, resulting in her slipping or falling from the supported position and sustaining injury”.*¹²
48. Ms Reneaux expressed the opinion that, as documented in her Care Plan, a sling hoist used with two staff members (during preparation and transfer) was the more suitable alternative to the Sara 3000.
49. Mercy conceded that two staff should have been involved in the transfer of Rosa when using the standing machine at all stages of the process (including preparation). They also conceded that a sling hoist should have been used for the transfer. These concessions were reasonable and appropriate and reflected a constructive engagement by Mercy in the coronial process. Appropriate concessions made by interested parties are welcome and are in the public interest. They promote a more efficient process leading to reduced hearing time in an inquest by limiting the number of disputes that need to be resolved on the evidence.

INQUEST

50. Evidence was given at the inquest by the following witnesses:

- a) Ms Pearse;
- b) Professor Duflou;
- c) Dr Collins; and
- d) Dr Iles.

51. The evidence of Professor Duflou, Dr Collins and Dr Iles was given concurrently.

¹¹ CB21-5.

¹² CB21-5.

Ms Pearse

52. Ms Pearse stated in evidence that she had worked with Rosa for many years and had used the standing machine to transfer her on multiple occasions every shift. She said that Rosa was familiar with the process although she acknowledged that Rosa's ability to communicate was limited. She had never used a sling hoist to transfer Rosa and it was her understanding that her Car Plan provided for a standing machine to be used.¹³
53. Ms Pearse's evidence was generally consistent with the account provided in her statements. She maintained that she positioned the sling around Rosa's back, placing it under her arms and attached the left and right clips to the front of the machine on both sides. She did not have a specific recollection of attaching the clips on both sides, but she said that it was her practice to do so before positioning the feet on the foot plate.¹⁴ She denied that she would have only attached the clips on one side of the machine before adjusting Rosa's feet.
54. Ms Pearse stated that she heard, but did not see, Rosa hit her head while she was bending down to the foot of the standing machine to uncross Rosa's legs. She said that she did not simply ask Rosa to uncross her legs because "*she probably wouldn't be able to do that*".¹⁵ When she heard Rosa hit her head, Ms Pearse looked up and saw that Rosa had sat back up and she had an injury to her head. She surmised that Rosa had hit her head on the sling attachment on the right side of the machine.
55. Ms Pearse stated that Rosa had remained sitting on the edge of the bed when she hit her head. She emphatically denied that Rosa had fallen from the bed towards the floor and hit her head on the base of the standing machine.¹⁶
56. Ms Pearse stated that she then lay Rosa back down in bed before leaving the room to get assistance from Mr Bidmead. She did not agree with Mr Bidmead's recollection that he

¹³ T52

¹⁴ T36; T60.

¹⁵ T37.

¹⁶ T53.

entered the room after hearing her call for help from within, and then assisted her to put Rosa back in bed.¹⁷ Later that day, she gave Ms Kaur an account of the incident.

57. Ms Pearse acknowledged that the policy at Mercy required two staff to be present during the transfer of a resident using the standing machine, including during the preparation phase. However, she stated that she would occasionally prepare a resident for a transfer by herself before seeking the assistance of a second staff member for the transfer itself.¹⁸ It appeared from her evidence that it was not clear to Ms Pearse that the requirement for two staff included during the preparation phase.¹⁹
58. Ms Pearse stated that in her role as a Personal Care Attendant, she was not required to review the Care Plans of residents. Relevant information, including the required mode for transfers, was communicated to her in an oral handover with nursing staff at the commencement of her shift at 7.00am. She would also occasionally receive a one-page “Summary Care Plan” with that information.²⁰
59. Ms Pearse stated that she was never told that a sling hoist was required to transfer Rosa. It was always her understanding that a standing machine was the appropriate transfer aid.²¹
60. Since Rosa’s death, Ms Pearse stated that Summary Care Plans containing relevant information for residents are now provided to Personal Care Attendants.²²
61. Ms Pearse considered that it was unlikely Rosa’s fall would have been avoided if two staff had been involved in the preparation of the transfer. She stated that an extra staff member would have been standing either behind Rosa or behind the standing machine, and therefore would not have been in a position to prevent the sudden movement forward. However, on further questioning by counsel assisting and Dr Freckelton, Ms Pearse acknowledged it

¹⁷ T42;T62.

¹⁸ T43.

¹⁹ T46

²⁰ T50

²¹ T52.

²² T51.

was possible that a second staff member may have noticed Rosa falling in time to prevent her injury.²³

The expert panel

62. All of the experts agreed that a person with Rosa's comorbidities could sustain a head injury with minimal force.²⁴

Dr Iles

63. In her evidence given at the inquest, Dr Iles confirmed her opinion that Rosa's injuries could have occurred in the way described by staff at Mercy. She could not identify a patterned injury which would provide an indication of the specific blunt object that Rosa may have impacted. She noted the photograph of the standing machine and observed the composition of the side arm which included metal, a plastic buckle, webbing and strapping material. She considered that Rosa's injuries were not specific to the mechanism of impact with the arm of the standing machine, "*but they can be accounted for by that mechanism*".²⁵ Dr Iles stated that it was not the only mechanism which could account for the injuries, but she found the account given by Mercy staff to be "*an acceptable explanation*".²⁶
64. Dr Iles confirmed her opinion that the bruising around Rosa's eye identified in the photographs taken 12 September 2020 was unlikely to represent an abraded injury. She did not consider that the photographs were of sufficient quality to make that determination and she also noted that there was no reference to abrasions in the medical records of St Vincent's Hospital.²⁷ If it were an abrasion or punctate bruising, Dr Iles considered it would

²³ T48;T75

²⁴ T93-T96.

²⁵ T101.

²⁶ T104.

²⁷ A photograph of Rosa's head injury was taken by Mercy staff on 10 September 20220 and was forwarded to St Vincent's Residential In Reach that day. However, a copy of this photograph was not able to be located and provided to the Court by either Mercy or St Vincent's Hospital.

be an “*intradermal type bruising*” and that “*falling forwards or downwards might produce that spectrum of injury*”.²⁸

Professor Duflou

65. Professor Duflou agreed that Rosa’s injury was not a patterned injury. He considered that the laceration and the bruising were “*all part of one injury*”.²⁹ Further, he considered that the areas of punctate bruising appeared to be an abrasion, although he was not “*wedded*” to that view and he accepted that “*the photographs are not perfect at all for that type of assessment*”.³⁰ If the bruising were an abrasion then he considered that “*it would mean contact with another surface as well*” which would likely be an irregular surface such as “*flooring of some type, including carpeting*”.³¹
66. If the bruising injury were not an abrasion, then Professor Duflou agreed that Rosa’s injuries could have occurred in the way described by Mercy staff.³²

Dr Collins

67. Dr Collins agreed that there was no patterned injury to assist in establishing the most likely mechanism of causation. However, he maintained that a fall to the floor and onto the base of the standing machine to be “*a more reasonable explanation*”.³³
68. Dr Collins stated in evidence that he could not exclude that Rosa’s fall occurred in the way described by Mercy staff but he considered it a less likely mechanism of causation.³⁴ He considered this was a less likely mechanism due to the reduced force associated with the relatively short distance that Rosa’s head would have travelled from a seated position to falling forward and hitting the clip attachment on the arm of the standing machine; and the

²⁸ T110.

²⁹ T107.

³⁰ T107; T109

³¹ T108-T109.

³² T113.

³³ T115.

³⁴ T115.

“ill-defined edges of the clip attachment” being less likely to produce Rosa’s specific injury.³⁵

69. Dr Collins also stated that the areas of what he observed to be punctate bruising on Rosa’s cheek were caused by *“gravitational spread”* and have no relationship with the blunt force injury.³⁶ He did not consider that there were any abrasions on Rosa’s cheek.³⁷
70. Dr Collins stated that if the coroner were to accept the description of events as described by Mercy staff, then his assessment would be *“entirely wrong”*.³⁸

CIRCUMSTANCES IN WHICH DEATH OCCURRED

71. I am satisfied that at around 10.25am on 10 September 2020, Ms Pearse sat Rosa up on the side of her bed and positioned the standing machine in front of her in preparation for a transfer to a chair. In the process of preparing for the transfer, Ms Pearse bent down to the base of the machine to uncross Rosa’s legs. At that point, Rosa has fallen forward and struck her head on the right arm of the machine which also includes the sling attachment.
72. Ms Pearse did not see Rosa hit her head but she heard it and observed that she had sustained an injury to her head. She placed Rosa back in bed and also sought assistance from other staff.
73. It follows that I broadly accept Ms Pearse’s account in relation to how Rosa sustained her injury. I carefully considered her evidence given at the inquest and I am satisfied that she was an honest and credible witness who gave evidence faithful to her recollections. There is no documentary or witness evidence to challenge Ms Pearse’s account which is broadly consistent with the accounts of other Mercy staff and the contemporaneous records of Mercy, Ambulance Victoria and St Vincent’s Hospital. It is understandable and unsurprising that some of her recollections of the events given the passage of time may be unreliable. The recollections of witnesses of the same events may reasonably differ and it

³⁵ T119.

³⁶ T119.

³⁷ T98.

³⁸ T121.

does not necessarily lead to the conclusion that one version or another is untruthful evidence.

74. I am not able to be satisfied that Ms Pearse had fastened both clips to the sling attachment on either side of the standing machine before she bent down to adjust Rosa's feet. She has given evidence that it is her usual practice to fasten both clips before adjusting a resident's feet. However, Ms Kaur's account of Ms Pearse's description of events, provided to her shortly after the incident, suggests that only the right sling attachment had been fastened. Notwithstanding, even if only the right clip had been fastened before Ms Pearse bent down to adjust Rosa's feet, I am satisfied that she fell forward and likely hit her head on some part of the right arm configuration which included the sling attachment and that she did not fall off the bed and hit her head on the base of the machine or otherwise fall to the floor. I am satisfied that the standing machine had been positioned directly in front of Rosa as she sat on the side of the bed, which was unlikely to provide sufficient room to enable Rosa to fall between it and the bed and down towards the floor.
75. I am unable to be satisfied as to whether Ms Pearse left Rosa's room to get assistance from other staff, or whether Mr Bidmead came into the room before Ms Pearse left, after hearing a commotion. Either way, I am satisfied that he arrived very soon after the incident and observed that Rosa was on the bed. Further, if Rosa had fallen off the bed, it is unlikely that Ms Pearse would have had the time to physically carry her back to the bed before Mr Bidmead's arrival. Also, I am satisfied from Ms Pearse's evidence that she was a dedicated and diligent carer who would have complied with appropriate practice to move Rosa with a sling hoist had she fallen off the bed to the floor.
76. The weight of the expert evidence supports a finding that Rosa's injuries are consistent with having occurred in the way described by Ms Pearse in her evidence. They could have occurred in other ways, but they can be accounted for in the way described by Ms Pearse. This position reflects Dr Iles's unequivocal evidence, which I accept. It also reflects Professor Duflou's evidence if it is accepted that the bruising on Rosa's cheek does not represent an abraded injury. I prefer the evidence of Dr Iles and Dr Collins on this issue, and am satisfied that there were no abrasions. I accept that the quality of the photographs

do not enable this type of injury to be reasonably identified in the circumstances and I also consider that the existence of abrasions would likely have been referred to in the contemporaneous medical records.

77. I do not accept the evidence of Dr Collins that Rosa more likely sustained her injury by falling off the bed towards the floor and striking her head on the base of the standing machine. I do not consider that Dr Collins has given sufficient weight, if any, when forming his opinion, to the broadly uncontested evidence of Ms Pearse. In my view, his opinion is also inconsistent with his acknowledgement that an elderly person with Rosa's comorbidities is capable of sustaining a head injury with minimal force.

FINDINGS AND CONCLUSION

78. I am satisfied that, in accordance with Mercy policy and training, two staff ought to have been involved in Rosa's transfer when using the standing machine on 10 September 2020 (including the preparation phase). This has been conceded by Mercy and is consistent with the Care Plan and the unchallenged evidence of Mr Contoyannis, Ms Andreotti and Ms Reneaux.
79. Although her evidence was that she would usually prepare residents for transfer with a standing machine using two people, Ms Pearse appears to have misunderstood the training that had been provided by Mercy and considered that it was acceptable to have only one staff member involved in the preparation phase. The evidence provided by other Mercy staff is that it was clear from the manual handling training delivered that two staff were required at all stages of the transfer process when using a standing machine.
80. I am satisfied that, given Rosa's cognitive and physical limitations, a sling hoist should have been used in her transfer on 10 September 2020. This has been conceded by Mercy and is consistent with the Care Plan and the unchallenged evidence of Mr Contoyannis, Ms Andreotti and Ms Reneaux.
81. It had not been communicated to Ms Pearse by her supervisors that a sling hoist should be used when transferring Rosa. There was a failure by Mercy to have a system in place which ensured that the requirements of Rosa's Care Plan in relation to her mode of transfer were

effectively communicated to staff. None of the Mercy staff who have provided evidence to the Court (including nurses) have stated that they were aware that Rosa's Care Plan required her to be transferred with a sling hoist. A statement from the Clinical Manager at Mercy who was responsible (together with the physiotherapist) for operational decisions regarding individual residents was not provided to the Court by Mercy.

82. I am not satisfied that the manual handling training delivered to staff by Mercy provides sufficient clarity in relation to the suitability of residents for transfer using a standing machine or a sling hoist, with consideration of their particular physical and cognitive capacities and limitations. The Mercy nursing staff who provided evidence to the Court stated that they considered a standing machine to be an appropriate means to transfer Rosa, notwithstanding the requirements of her Care Plan and her well-documented frailty, cognitive decline, lack of balance, eyesight limitations and communication challenges. I am not satisfied that Mercy's initiative since Rosa's death to consistently provide Care Plan Summaries for each resident sufficiently addresses this issue.
83. It is *possible* that the incident may have been prevented if two staff had been involved at all times during Rosa's transfer (including the preparation) with the standing machine on 10 September 2020. However, I am unable to determine that Rosa's fall forward *would* have been prevented, even if two staff had been involved. In my view, it is possible that a second staff member may have been alerted to signs of instability in Rosa which would not have been visible to Ms Pearse while she was bending down to position her legs. This may have provided an opportunity for intervention by the second staff member to prevent her fall forward.
84. I am satisfied that the incident would have been prevented, and Rosa would not have sustained her injuries in the way that she did, had a sling hoist been used for her transfer on 10 September 2020.

85. I confirm the following findings made on 27 July 2021 pursuant to section 67(1) of the Act:

- a) the identity of the deceased was Rosa Bonaventura, born 11 July 1923;³⁹ and
- b) the death occurred on 25 September 2020 at Mercy Place Aged Care Services, 2 Clarke Street, Abbotsford, Victoria, from acute on chronic subdural haematoma sustained in a fall in a woman with dementia.

86. Further, I find that Rosa's death occurred in the circumstances described above.

RECOMMENDATIONS

Pursuant to section 72(2) of the Act, I make the following recommendations:

1. Mercy Health review its processes in aged care facilities managed by them to ensure that transfer requirements of residents recorded in their Care Plans are effectively communicated to staff.
2. Mercy Health ensure that staff employed at aged care facilities managed by them receive training to provide an effective understanding of the capabilities, limitations and safe use of different transfer aids, including standing machines and sling hoists, with consideration of the physical and cognitive abilities and limitations of residents.

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

Pursuant to section 73(1) 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:

Fred Bonaventura

Mercy Health

Senior Constable Bradley Cable, Coronial Investigator

³⁹ Rosa's date of birth was clarified during the course of the inquest. She was born on 11 July 1923, not 27 June 1923 as had been recorded in Coroner Hawkins' findings.

Signature:



Coroner David Ryan
Date: 20 October 2026



NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an inquest. 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.
