CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Robert Driver
Hearing dates:	28 January 2025
Date of Findings:	28 January 2025
Place of Findings:	Coroner's Court of New South Wales, Lidcombe
Findings of:	Magistrate Derek Lee, Deputy State Coroner
Catchwords:	CORONIAL LAW – cause and manner of death, homicide, resident of aged care facility, challenging behaviour of resident, clinical management, indication for transfer to hospital, post-fall management, escalation of care
File number:	2020/248307
Representation:	Mr T O'Donnell, Coronial Advocate Assisting the Coroner
Findings:	Robert Driver died on 25 August 2020 at Bolton Point NSW 2283. The cause of Mr Driver's death was cervical spine trauma. Mr Driver sustained this injury after being struck a number of times by another resident of the aged care facility where Mr Driver resided, resulting in him falling to the ground. The manner of Mr Driver's death is therefore homicide.

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1. Introduction

1.1 On the evening of 20 August 2020, Robert Driver, an 89 year old resident of an aged care facility was struck a number of times in the face by another resident, who was 78 years old and suffered from dementia. The incident occurred suddenly and without warning. As a result of the strikes, Mr Driver's head impacted with a wall and he fell to the ground.

1.2 Mr Driver was assessed and observed overnight. He was later transferred to hospital on the morning of 21 August 2020 where investigations revealed a high cervical spine fracture. Due to his poor prognosis, Mr Driver was later returned back to his residence for palliative care. Mr Driver was tragically pronounced life extinct on 25 August 2020.

2. Why was an inquest held?

2.1 Under the *Coroners Act 2009* (**the Act**) a Coroner has the responsibility to investigate all reportable deaths. This investigation is conducted primarily so that a Coroner can answer questions that are required to be answered pursuant to the Act, namely: the identity of the person who died, when and where they died, and what was the cause and the manner of that person's death.

2.2 Section 27(1)(a) of the Act makes an inquest mandatory where it appears to a Coroner that a person died or might have died as a result of homicide. At the outset it should be explained that a finding that the manner of person's death is homicide is not to suggest that any person has committed a criminal offence. Indeed, section 81(3) of the Act expressly provides that any finding made about the identify, date, place, cause and manner of a person's death must not indicate or in any way suggest that an offence has been committed by any person.

2.3 In Mr Driver's case, the available evidence indicates that Mr Driver died as a result of an intentional act performed by another person towards Mr Driver which caused his death. The manner of Mr Driver's death is therefore homicide. Again, there is no suggestion that any person has committed a criminal offence in relation to Mr Driver. In fact, the New South Wales Police Force (**NSWPF**) have declined to commence criminal proceedings against any person in relation to Mr Driver's death.

2.4 Separate from the above, it should also be recognised that the operation of the Act, and the coronial process in general, represents an intrusion by the State into what is usually one of the most traumatic events in the lives of family members who have lost a loved one. At such times, it is reasonably expected that families will want to grieve and attempt to cope with their enormous loss in private. That grieving and loss does not diminish significantly over time. Therefore, it should be acknowledged that the coronial process and an inquest by their very nature unfortunately compels a family to re-live distressing memories several years after the trauma experienced as a result of a death, and to do so in a public forum. This is an entirely uncommon, and usually foreign, experience for families who have lost a loved one.

3. Mr Driver's life

3.1 Inquests and the coronial process are as much about life as they are about death. A coronial system exists because we, as a community, recognise the fragility of human life and value enormously the preciousness of it. Understanding the impact that the death of a person has had on those closest to that person only comes from knowing something of that person's life. Therefore, it is important to recognise and acknowledge the life of that person in a brief, but hopefully meaningful, way.

3.2 Mr Driver was born in 1931. He married twice and had five children. As a child, Mr Driver had dreams of becoming an architect. However, he later joined the Army and then the Royal Australian Air Force (**RAAF**) when he was 18 years old. Mr Driver achieved the rank of Lieutenant by the time that he left the RAAF. He later joined his father in the family tiling business.

3.3 Mr Driver developed dementia in later life. In around November 2010, Mr Driver moved into a low care section of RSL Care (now known as Bolton Clarke) as a self-care client. In around 2018, Mr Driver moved into the dementia ward, known as the Long Tan Unit, of Macquarie View Retirement Village at Bolton Point. Although Mr Driver used a 4-wheel walker to assist with mobility, he remained in good physical condition for his age.

3.4 Mr Driver's daughter describes him as a gentleman who was a very proud person, polite, considerate, and someone who did not want to be a bother to anyone.

4. Mr Driver's medical history

4.1 Mr Driver had a history of advanced dementia with confusion, previous falls, chronic back pain, hypertension, depression, peripheral vascular disease and recurrent urinary tract infections. He also had previous injuries in the form of fractured scapula and fractured lumbar vertebrae.

5. What happened on 20 August 2020?

5.1 At around 7:20pm on 20 August 2020, Mr Driver had just finished dinner with other residents of the Long Tan unit. He and the other residents were returning to their rooms. Mr Driver was having difficulty returning to his room and was being assisted by a care worker. They were standing in the corridor between the lounge room and dining room when another resident, who also suffers from dementia, pushed past the care worker from behind, and slapped Mr Driver twice in the face. Mr Driver placed his hands out to protect himself and the care worker told the other resident to stop and attempted to separate him and Mr Driver. However, the other resident proceeded to punch Mr Driver twice in the face. This caused Mr Driver to strike his head on the corridor wall and fall to the floor. Mr Driver also sustained a mouth injury, with blood visible on his upper lip and front teeth, and an abrasion to the back of his head.

5.2 The care worker called for assistance. Registered Nurse (**RN**) Toderai Bondeezi, the nurse-in-charge, responded and conducted a neurological assessment of Mr Driver and found that he had full range of motion in his limbs with no loss of strength, was verbally responsive, alert and orientated within his usual capacity, able to obey commands and had no other visible injuries. With the assistance of

staff, Mr Driver was placed in a wheelchair and taken to his room where another set of neurological observations was taken.

5.3 As Mr Driver had no other apparent injuries, he was later settled in his bed. RN Bondeezi sent messages to both Mr Driver's general practitioner (**GP**), Dr David Holford, and Joanne Teerman, the Residential Manager of Macquarie View, containing details of the incident and photos of Mr Driver's injuries. Dr Holford called RN Bondeezi and it was agreed that Mr Driver would be transferred to hospital if his condition deteriorated. Dr Holford also advised that a dose of risperidone should be administered to the resident who had struck Mr Driver in order to minimise his aggression and that he should be transferred to hospital for further management. RN Bondeezi called Mr Driver's son, Lance, to notify him of the incident and to explain her assessment of Mr Driver, and her discussions with Dr Holford regarding Mr Driver's management.

5.4 Mr Driver was later observed at around 10:16pm and showed no signs of pain or discomfort. At around 12:51am on 21 August 2021, Mr Driver complained of neck pain and was given paracetamol. Further paracetamol was given at around 2:13am when Mr Driver again complained of pain the back of his neck when sitting up. Staff contacted the Aged Care Emergency team which advised that, unless his pain became more severe, Mr Driver should be reviewed by a general practitioner (**GP**) in the morning.

5.5 Later that morning, Mr Driver complained of severe pain and was again given Panadol at around 6:41am. Dr Holford was notified at around 8:30am but unable to attend. An ambulance was called and attending paramedics noted that Mr Driver reported tenderness in his upper cervical neck region, and that he had a small abrasion to the right temporal region of his scalp and a small laceration with bleeding to his upper lip. Mr Driver was also noted to be combative when attempts were made to take his vital signs, and paramedics were unable to place a cervical collar on Mr Driver who became distressed and attempt to remove it.

5.6 Mr Driver was taken to the Emergency Department at John Hunter Hospital, arriving at around 10:27am. Imaging investigations revealed an undisplaced type 3 fracture through the base of the odontoid peg involving the left foramen traversarium, and no other acute pathology.

5.7 Following assessment by a neurosurgical registrar, Dr Adamson Barnes, and consultation with the on-call neurosurgeon, advice was given for non-operative management and for Mr Driver to instead be managed with an Aspen collar, but that if Mr Driver did not tolerate this, he could be managed without one. Dr Barnes confirmed with Lance that Mr Driver was not suitable for surgical intervention, that the Aspen collar may cause Mr Driver discomfort and anxiety, and that consideration could be given to no collar being used.

5.8 Dr Jeremy Smillie, the Senior Career Medical Officer in emergency medicine, also spoke with Lance and Dr Holford to explain that the most appropriate level of care for Mr Driver was an Aspen collar with pain relief. However, Dr Smillie explained that it was very likely that Mr Driver would not tolerate the collar and that if this was the case then the approach should be for compassionate, comfort-based care without the collar, and to start any medication on an as needed basis via a subcutaneous line. Mr Driver was later transferred back to the Long Tan unit with a plan for analgesia and transition to a palliative care pathway.

5.9 Mr Driver's condition continued to deteriorate and he was provided with appropriate comfort care. Mr Driver was later pronounced life extinct on 25 August 2020.

6. The post-mortem examination

6.1 Mr Driver was subsequently taken to the Department of Forensic Medicine where a post-mortem examination was performed by Dr Allan Cala, forensic pathologist, on 28 August 2020. This examination identified bruising and abrasion to the right side of the upper lip, but no other evidence externally of any significant trauma to the head region. Dr Cala noted that the antemortem radiology studies showed a fracture through the base of the odontoid peg involving the left foramen transversarium, but no evidence of intracranial injury or skull fracture.

6.2 Dr Cala also noted that even though there appeared to be a radiologically stable high cervical spine C2 fracture, these can be very serious as they can interfere with normal spinal cord function. This in turn can cause death especially in older persons who have significant comorbidities.

6.3 In the autopsy report dated 20 October 2020, Dr Cala recommended that the cause of Mr Driver's death be recorded as cervical spine trauma.

7. Outcome of the coronial investigation

7.1 The coronial investigation focused on a number of issues relating to factors which contributed to the interaction between Mr Driver and the other resident, Mr Driver's management following the incident both at Macquarie View and at hospital, and any changes and improvements have been made since August 2020.

Post-incident clinical management

7.2 Associate Professor Sally McCarthy AO, a senior specialist emergency physician from Prince of Wales Hospital, was briefed to review the circumstances surrounding the incident and to provide an independent expert opinion regarding Mr Driver's management. Professor McCarthy expressed the following views:

(a) Following the incident, Mr Driver was assessed as having soft tissue injuries and worsening neck pain. The pre-hospital interventions were "*graded and responsive to his worsening pain*" and his management was "*adequate and appropriate*";

(b) There were no high-risk features (such as loss of consciousness, change in level of functioning, other apparent injury) which provided a clinical indication for transferring Mr Driver to hospital at the time of the incident. The indication was not met until the morning of 21 August 2020 when it was decided to call an ambulance as Dr Holford was not available to review Mr Driver;

(c) Whilst Mr Driver's cervical spine fracture provided the indication for use of the Aspen collar for Driver, the evidence base for use of cervical spine immobilisation in elderly patients is poor and prolonged immobilisation is associated with morbidity such as development of pressure sores, raised intracranial pressure, dysphagia, breathing difficulties and delirium. However, "*trial of*

the Aspen collar was a reasonable option despite Mr Driver's age, frailty and cognitive impairment";

(d) The indication for removal of an Aspen collar prior to fracture healing is intolerance when wearing the collar causes more pain, distress and morbidity than it prevents. In Mr Driver's case, "*removal of the collar made no difference to [his] prospects for recovery and did not adversely affect Mr Driver's management*"; and

(e) There was a lack of clarity about the Medical Orders for Life Sustaining Treatment (**MOLST**) that had previously been prepared for Mr Driver. This resulted in Mr Driver being transferred to hospital for active intervention when he could have been managed conservatively, not removing the Aspen collar earlier, and not commencing palliative care measures earlier. However, both Associate Professor McCarthy and Dr Smillie acknowledged that preparation of MOLST is a complex issue, and that it is common for there to be inconsistencies within the terms of a MOLST as occurred in Mr Driver's case.

Aged Care Quality and Safety Commission

7.3 The Aged Care Quality and Safety Commission (**ACQSC**) assessed a complaint made by Mr Driver's daughter. As part of its assessment, a Quality Assessor conducted an unannounced visit to Macquarie View on 25 September 2020 to collect information relevant to compliance with the Aged Care Quality Standards. The outcome of the ACQSC assessment can be summarised as follows:

(a) All potential residents are assessed by an Aged Care Assessment Team, and this assessment is reviewed by the Clinical Manager and Residential Manager to assist in determining whether the potential resident's care needs can be met, including gauging the level of risk associated with any high impact elements of their care. Whilst this process was followed prior to the admission of the other resident involved in the interaction with Mr Driver, there would have been benefit in escalating the proposed admission, as per the *Resident Selection Guidelines*, "*as this would have allowed discussion with Dementia Behaviour Specialists internally prior to the decision to admit being made*";

(b) Regular reviews were being undertaken to inform care planning, and external supports had been engaged to assist the residence;

(c) Bolton Clarke had engaged an independent Nurse Advisor to provide support in reviewing the incident and identifying additional training for staff and other improvements. The Nurse Advisor was engaged to provide further support one day per week for the following two months; and

(d) Bolton Clarke prepared a Quality Improvement Action Plan which identified gaps in staff knowledge, and included details of education and processes that have been put in place, and ongoing reviews.

Changes and improvements made by Bolton Clarke

7.4 Katherine Platt, General Manager – Clinical and Service Governance at Bolton Clarke, provided a letter to the Court which set out the following matters:

(a) Since August 2020, the *Resident Selection Guideline* (which, amongst other things, is used to gauge the level of risk associated with any high impact elements in a resident's care, such as challenging behaviour) has been reviewed to ensure it is fit for purpose, and to ensure new residents are selected in consideration of the nature of their cognitive impairments and their behavioural and psychological symptoms of dementia. This is done with a view to minimise a newly admitted resident being triggered by an existing resident, or vice versa;

(b) Also since August 2020, the Clinical Governance Team implemented a system (including monitoring) where monthly self-assessments are undertaken and a clinical oversight report is provided of incidents of elevated risk, including where a resident or staff member has required medical attention as a result of challenging behaviours from a resident;

(c) The Clinical Governance Team oversees all instances of aggression and all forms of elder abuse, which are reported monthly to a Clinical Quality and Safety Committee. In addition, a Senior Nurse Clinical Advisor – Dementia receives alerts for every incident of resident aggression, which is reviewed including, if required, a review of the resident;

(d) A new *Falls Management Guideline* was released following a major review in July 2020. This revised Guideline was updated to include a detailed post falls management flowcharts and provided a more thorough process for all clinical and nonclinical workers to follow. New elements that had not been included in previous versions of the Guideline include: detailed process for nursing staff regarding what assessments to conduct, and a regime of regular observations, monitoring and documentation, arrangements for medical assessment in line with advance care planning, and notification to family members and incident reporting, including review of the Falls Risk Assessment Tool and updating management plans;

(e) The *Clinical Deterioration Guideline* was updated in April 2021 to ensure that consideration of advance care planning is made in the event of deterioration; and

(f) Education and training was provided to staff including, relevantly, admission processes for new Residential Managers, and managing challenging behaviours, including understanding dementia, for all staff.

Conclusion

7.5 Having regard to the evidence gathered as part of the coronial investigation and the outcome of the assessment conducted by the ACQSC, it is considered that the response by Bolton Clarke has been appropriate. Further, the changes and improvements made by Bolton Clarke have addressed particular factors relevant to the circumstances of Mr Driver's death. Accordingly, it is neither necessary or desirable for any recommendation to be made pursuant to section 82(1) of the Act.

8. Findings

8.1 Before turning to the findings that I am required to make, I would like to acknowledge, and express my gratitude to Mr Tim O'Donnell, Coronial Advocate, for his excellent assistance during the coronial investigation and the inquest itself. I am most appreciative of the thoroughness of his work, and the sensitivity and empathy that he has shown to Mr Driver's family, in keeping them updated with the progress of the coronial investigation.

8.2 I also thank Senior Constable Ian Pearson and Detective Senior Constable Daniel Mason, the NSWPF Officers-in-Charge, for their roles in compiling the initial brief of evidence.

8.3 The findings I make under section 81(1) of the Act are:

Identity

The person who died was Robert Driver.

Date of death

Mr Driver died on 25 August 2020.

Place of death

Mr Driver died at Bolton Point NSW 2283.

Cause of death

The cause of Mr Driver's death was cervical spine trauma.

Manner of death

Mr Driver sustained this injury after being struck a number of times by another resident of the aged care facility where Mr Driver resided, resulting in him falling to the ground. The manner of Mr Driver's death is therefore homicide.

8.4 On behalf of the Coroners Court of New South Wales, I offer my sincere and respectful condolences, to Mr Driver's family, and in particular, Mr Driver's children, Lance, Julie-Anne, Philip, Anthony and Michelle, for their most tragic loss.

8.5 I close this inquest.

Magistrate Derek Lee
Deputy State Coroner
28 January 2025
Coroners Court of New South Wales