IN THE CORONER'S COURT	)	
IN CANBERRA IN THE	)	CD 226 OF 2001
AUSTRALIAN CAPITAL TERRITORY	)	

INQUEST INTO THE MANNER AND CAUSE OF DEATH OF IVY PEARL GHOBRIAL

1. Ivy Pearl Ghobrial (Mrs Ghobrial) died at the Canberra Nursing Home on 17 September 2001. Mrs Ghobrial had been at the Nursing home since January 2001. Her General Practitioner Dr Sandra Hogg issued a certificate of death in respect of the deceased. The deceased's death was caused by bilateral acute bronchopneumonia. According to the report of Dr Jain who carried out the post mortem on Mrs Ghobrial the death was due to natural causes. Dr Jain in his report dated 28 December 2001 (Exhibit 2) made the following summary of the autopsy findings;

1. Chronic Cerebral Hypoxic damage.
2. Bilateral Bronchopneumonia.
3. Emaciated with feeding by PEG tube.

2. Mrs Ghobrial was admitted to the Canberra Nursing Home on 19 January 2001 having transferred from the Liverpool Brain Injury Rehabilitation Unit. The circumstances which led to the transfer of Mrs Ghobrial to the Australian Capital Territory were not strictly within the ambit of this inquest as the events which led to her hospitalisation and ultimate death occurred in New South Wales.

3. The events which led to her transfer need however to be briefly referred to as they are the initiating incident which ultimately, on the evidence before me, led to the death of Mrs Ghobrial. I will briefly refer to these events. The information relating to the events which I will now relate has been obtained from a report provided by Dr Vince Ponzio of the St George Hospital and Community Health Service dated 10 December 2001 and now marked Exhibit 13.

4. Dr Ponzio relates that Mrs Ghobrial presented at the Emergency Department of the St George Hospital on 12 March 2000. She complained of depressive symptoms and suicidal ideation. Mrs Ghobrial was assessed initially by a registered nurse and subsequently by the psychiatric registrar.

> *"She gave a four month history of depression relating to deterioration of her relationship with her husband. She described symptoms of depression and, in recent weeks, increasing suicidal ideation. She had a past history of a suicide attempt and she described episodes of abuse as a child. She described her*

mood as depressed and as having current suicidal ideation. She did not wish to return home. She accepted a voluntary admission to the St George Mental Health Unit with a diagnosis of depression and suicidal ideation. She denied any recent acts of self-harm. However, later that day she was noted to be confused and ataxic and she disclosed to nursing staff that night that she had, in fact, taken an overdose at about the time of admission. She was reviewed medically but found not to have sustained serious injury". (Exhibit 13).

5. The doctor reports that *"in view of her unpredictable behaviour she was changed from a voluntary to an involuntary status"* (Exhibit 13).

6. The doctor sets out in his report the procedures that were followed during the next 48 hours of her stay in the hospital and this included, amongst other things, 15 minute observations by nursing staff.

7. On the evening of 14 March 2000, Mrs Ghobrial attempted to cut her wrists with a knife but did not sustain any injury.

8. The report indicates that her husband Mr Michael Ghobrial expressed a wish to take his wife home. The report indicates that Mrs Ghobrial was at that time regarded as being at high risk of suicide and was formally detained under the Mental Health Act.

9. On 15 March 2000 Mrs Ghobrial engaged in an interview with a nursing sister when various matters were discussed. Following this interview she returned to her room and about ten minutes later was found with a curtain wrapped around her neck. She was unconscious. A cardio-pulmonary arrest was called, resuscitation was commenced and Mrs Ghobrial was transferred to the intensive care unit. She remained in this unit until 20 March 2000 when she was transferred to a medical ward of the St George Hospital. She was transferred to the Liverpool Brain Injury Rehabilitation Unit on 26 June 2000.

10. Mrs Ghobrial suffered a hypoxic brain injury as a result of her hanging on 15 March.

11. Mrs Ghobrial underwent intensive treatment and rehabilitation during her period at the Liverpool Brain Injury Rehabilitation Unit and remained at that place until her transfer to the Canberra Nursing Home on 19 January 2001. The various reports and statements indicate that some small progress was made in relation to the rehabilitation of Mrs Ghobrial during her time at the Liverpool Rehabilitation Unit.

12. Mrs Ghobrial was the subject of a Guardianship Order in New South Wales at the time of her transfer to the Territory and the precise circumstances of her transfer are somewhat difficult to gauge from the documentary evidence. It was not appropriate in the circumstances of this inquest to enquire in any detail into matters that occurred outside this jurisdiction but there are a number of documents that have been tendered during the inquest, which sets out in a general way the circumstances of the transfer. Some of the circumstances would seem to be in dispute particularly when one looks at the statement of Mrs Wojtkowski, the mother of Mrs Ghobrial, dated 27 September 2001. The dispute seems to be as to the precise basis upon which Mrs Ghobrial was transferred from Liverpool to Canberra. Mrs Wojtkowski says her daughter was "*ordered out*" from Liverpool. A statement from Dr Veerabangsa, who is described in his letter of 19 January 2001 (Exhibit 19) as a Specialist in Rehabilitation Medicine attached to the Brain Injury Rehabilitation Unit at Liverpool Hospital, indicates that

agreement was reached between the husband and the parents and that the Public Guardian had been consulted and had agreed to the transfer to the A.C.T. A report (Exhibit 8) provided by Ms Heather McGregor, the Community Advocate, who ultimately became involved with Mrs Ghobrial in January 2001, indicates that as far as Ms McGregor was concerned the NSW Public Advocate, who was the guardian at the relevant time in NSW of Mrs Ghobrial, had not consented to the transfer.

13. The evidence however is quite clear that the consent of various persons was required in order to affect the transfer and there is no dispute that the transfer occurred. I am in the circumstances prepared to accept that the transfer did occur with consent of the relevant parties, at least the husband and mother of Mrs Ghobrial.

14. Dr Veerabangsa in his letter, already referred to, indicates that the condition of Mrs Ghobrial as at her transfer to Canberra was as follows;

1. *"Due to the severe permanent brain injury she has suffered Mrs Ivy Ghobrial has severe global cognitive impairments. She is not able to express or indicate her wishes and is not able to make any decisions in regard to her treatment, care or accommodation.*

2. *Considering her care needs, i.e. totally dependant requiring 24 hour care, the only available option for her long term care at present is a nursing home and I consider this as appropriate under the circumstances."*

15. Dr Veerabangsa indicated that he had communicated with Dr Maureen McCluskey the General Practitioner in Canberra who would be responsible for the ongoing medical care of Mrs Ghobrial and had appraised her of Mrs Ghobrial's situation.

16. Mrs Ghobrial was transferred by air ambulance to the Canberra Nursing Home on 19 January 2001.

17. The existence of a Guardianship order in NSW and the circumstances of the transfer of Mrs Ghobrial, together with a number of other issues which had lead to conflict between Mr Ghobrial, Mrs Wojtkowski and others, lead to the ACT Community Advocate becoming involved almost immediately upon the arrival of Mrs Ghobrial in the Territory. Ms McGregor, the ACT Community Advocate, was appointed Emergency Guardian for Mrs Ghobrial on 22 January 2001. Ms McGregor in her statement of 30 October 2002 (Exhibit 8) indicates that she, as the guardian of Mrs Ghobrial, was of the view that the Canberra Nursing Home was not a suitable placement for Mrs Ghobrial and that strenuous attempts were made from January 2001 until the death of Mrs Ghobrial in September 2001 to find some other more suitable placement for Mrs Ghobrial. These attempts, it appears, were unsuccessful.

18. Some evidence has been given and some comments have been made during the hearing that would suggest that there is a lack of proper facilities, not only within the ACT but generally, to care for people in situations such as those confronting Mrs Ghobrial. It would seem to be accepted by many of those who have given evidence or provided statements that the care of people with acquired brain injury, particularly younger people, presents a very significant challenge and requires very substantial

and constant rehabilitation efforts. It appears that the facilities provided by and available at the Canberra Nursing Home were not of the type appropriate for this form of intensive rehabilitation.

19. Ms McGregor, as I have indicated, was appointed as an Emergency guardian on 22 January 2001. Ms McGregor arranged for Dr Maureen McCluskey to be Mrs Ghobrial's General Practitioner. On 26 February 2001 a hearing was held in the Guardianship Tribunal in the Territory, as a result of which Ms McGregor was appointed the Guardian of Mrs Ghobrial. Mrs Ghobrial's financial affairs continued to be administered by the Protective Commissioner in NSW.

20. The history of Mrs Ghobrial during her stay at the Canberra Nursing Home is well set out in the evidence before me and it is not necessary, in my view, to go in any detail into this history but I will refer shortly to a brief history provided in the statement of Ms McGregor, this history refers in some detail to the role of the Community Advocate in relation to Mrs Ghobrial. Suffice to say that the evidence indicates that Mrs Ghobrial remained seriously ill during the months at the nursing home and in particular her nourishment presented significant problems. There were a number of admissions to the Calvary Hospital to investigate problems arising from her feeding and there were a number of problems arising from the conflict that had already arisen in NSW involving Mr Ghobrial and Mrs Wojtkowski and on this occasion the Community Advocate. It is not necessary in my view in the circumstances of this inquest to go into any detail concerning this conflict but it is clear that the ongoing disputation between the various parties caused considerable problems, and indeed litigation, during the remaining months of the life of Mrs Ghobrial.

21. The legal representatives of Mrs Wojtkowski and Mr Ghobrial in person, raised a number of issues concerning the involvement of the Community Advocate. These issues seemed principally to arise from a difference of opinion between Mr Ghobrial and Mrs Wojtkowski and the Community Advocate together with the medical advisors of the Community Advocate as to the best treatment, which might be rendered to Mrs Ghobrial in order to assist her in her situation. Mr Ghobrial and Mrs Wojtkowski appear from their various statements and comments to have been of the view that there was hope of a recovery on the part of Mrs Ghobrial. All of the medical evidence from the very beginning of the treatment of Mrs Ghobrial, following her hanging in March 2000, suggest to the contrary. This disagreement as to medical treatment led to ongoing conflict, not only in NSW but also in the ACT.

22. The ongoing disagreement as to the medical treatment again became a significant issue during August and September 2001 and more particularly in the time immediately prior to the death of Mrs Ghobrial.

23. A history of the treatment of Mrs Ghobrial and the ongoing activities involving the relevant parties is, I believe, properly and fairly set out in the report of Ms McGregor, Exhibit 8. I intend to accept that history which is as follows;

> *"9. On 26 February 2001, the Guardianship Tribunal held a hearing to appoint a guardian for Pearl. The Applicant on that occasion was Ms Maria Fairweather, Director of Nursing at Canberra Nursing Home. The*

Community Advocate was appointed. Management of Pearl's financial affairs remained with the Protective Commissioner in NSW.

10. On 13 March 2001, Pearl was transferred from CNH to Calvary Hospital suffering persistent vomiting despite the PEG. One concern was that the PEG kept coming out. The cause of this remains unknown. She had lost weight, 1.5kg in 2 months, and was suffering from aspiration pneumonia. She was admitted under the care of Dr Khoo. She was discharged on 16 March 2001.

11. On 23 April 2001, Pearl was again admitted to Calvary hospital, requiring IV antibiotics for an infected pressure sore on her sacrum. She was discharged on 25 April 2001.

12. On 18 May 2001, Dr Maureen McCluskey withdrew her services as general practitioner. The OCA engaged the services of Dr Sandra Hogg as general practitioner.

13. On 2 July 2001, on an application by the OCA, the Guardianship Tribunal reviewed Pearl's guardianship and management orders. The Guardianship Tribunal appointed the Community Advocate as guardian and the ACT Public Trustee as manger.

14. The ACT orders were reviewed on 17 September 2001, to determine the fresh application for review by Dorothy and Peter Wojpkowski (sic). The NSW order appointing the Protective Commissioner remained in place.

15. On 2 July 2001, Pearl was admitted to Calvary Hospital at the instigation of the CNH and with my consent. She was suffering vomiting, dehydration and diarrhoea. She was discharged on 5 July 2001.

16. On 17 July 2001, Pearl was admitted to Calvary Hospital with pneumonia, again at the instigation of the CNH and with my consent. She was suffering repeated bouts of vomiting. During this admission issues concerning the removal of her PEG were discussed.

17. On 2 August 2001, while Pearl was in the care of staff at the Calvary Hospital, she fell off an x-ray table. OCA advised that Pearl was left lying quietly on an X-ray table for one minute and she fell, resulting in a broken neck of femur. I was advised by Dr Burke that Pearl faced substantial risks from a procedure involving anaesthetic, such that she may not survive its application. Therefore, I consented to treatment being limited to pain relief. As Pearl was not weight bearing, this response was considered appropriate by the medical team involved.

18. On 8 August 2001, a case conference was held at Calvary Hospital involving myself, Margaret Haas Social Worker, Margaret Read CNC, Marie Smith Dietician, Wendy Kinton OT, Drs Sharmala and Khoo. Following this conference Pearl was discharged on 9 August 2001.

19. During this admission to the Calvary Hospital Pearl underwent a series of medical reviews. She was reviewed for her depression and Dr Martin Dunlop reviewed her rehabilitation prospects. Following the broken neck of femur she underwent an orthopaedic review. Extensive consultation considered her nutritional needs and vomiting.

20. On 9 August 2001, Pearl's condition deteriorated between her discharge from Calvary Hospital and her arrival at the CNH. Following a consultation with Dr Sandra Hogg at the CNH she was taken back to the Emergency Department at Calvary Hospital. Dr Hogg concluded that Pearl needed intravenous antibiotics, which could not be administered at the nursing home.

21. I was contacted by Emergency Department Registrar at Calvary Hospital, Dr Neil Walker, who advised that Pearl's mother was desperate for Pearl to be placed on life support. Dr Walker stated that he thought Pearl to be very unwell and was hesitating about life support. I discussed Pearl's prognosis with Dr Walker who advised that Pearl's prognosis was reasonable in terms of her getting back to where she was prior to the pneumonia. I consented to intubation in order to provide respiratory support and advised Dorothy, Pearl's mother, of this.

22. Pearl was re-admitted to hospital on 9 August 2001, under the care of Dr William Burke VMO.

23. On 10 August 2001, it appeared that Pearl may die. Because of this, I contacted the Executive Director of Corrective Services, Mr James Ryan, and the Clinical Director at the Calvary Hospital, Dr Robert Griffin and arranged for Mr Michael Ghobrial, who was a detainee at that time, to visit Pearl.

24. On 16 August 2001, a case management conference was held at the Calvary Hospital attended by myself, Dr Ken Khoo the admitting VMO, Dr Jim Keaney Director ICU, Ms Sue Hogan CNC, Ms Fiona Bailey Director of Social Work, and Margaret Haas Social Worker. Pearl's future care plan was discussed. It was reiterated that all medical conditions would continue to be treated, that she be kept hydrated and pain free. It was concluded, however, that it was not ethical for further intubation to occur as this was merely prolonging her suffering. Dr Khoo agreed to take this conclusion to the full Division of Medicine (Calvary's medical ethics committee) for endorsement. I agreed to consult Dr Hogg and requested that she discuss her opinion with Dr Khoo. Dr Khoo agreed to discuss this matter with Pearl's mother. Dr Sharmala was asked to keep Mr Michael Ghobrial informed about Pearl's condition.

25. On 20 August 2001, at the request of the OCA, Pearl was reviewed by Dr Roger Tuck, neurologist. He had earlier assessed Pearl in February 2001. He found no discernible neurological improvement in August. He advised that there was almost no prospect of any significant improvement.

26. On 21 August 2001, Pearl's case was referred to the Division of Medicine for advice. Consensus was reached by this group that endorsement be given to the recommendation against further intubation.

27. On 6 September 2001, Pearl was discharged from Calvary Hospital back to the CNH, under the care of Dr Sandra Hogg.

28. On 7 September 2001, Dr Kenneth Khoo prepared a report for the Guardianship Tribunal hearing planned for 17 September 2001 in which he advised that Pearl had severe brain injury with little chance of reversibility. She was emaciated, had marked physical and muscular atrophy, an increasing inability to cough up her secretions and was clearly unable to feed. He foresaw a gradual deterioration in her physical condition despite best care, and increased likelihood of aspirations as well as pneumonia as a result of her being unable to clear secretions.

29. On 17 September 2001, the Guardianship Tribunal met to hear the application made by Pearl's mother for review of the guardianship order. That morning, Pearl's mother was contacted by the CNH to advise that Pearl's condition had deteriorated and consequently she was not in attendance at the hearing. Soon after the commencement of the hearing, the OCA was contacted and advised that Pearl's condition was very serious. In anticipation of her death, I agreed that Mr Michael Ghobrial could visit Pearl accompanied by his solicitor Mr Darryl Perkins. However, Pearl died while Mr Ghobrial was on his way to the nursing home".

24. **The Role of the Community Advocate**

The Office of the Community Advocate is created by the *Community Advocate Act 1991* (the *Act*). Section 13 of the *Act* provides that the Community Advocate has a function amongst others to "*act as a guardian or manager when so appointed by the Guardianship Tribunal*".

25. Section 15 of the *Act* directs the Community Advocate, where the Advocate has been appointed as a guardian or manager under the *Guardianship and Management of Property Act 1991* to,

a) endeavour to find a suitable person to be appointed as the guardian or manager; and

b) if such a person is found – apply to the Guardianship Tribunal for the appointment of that person as guardian or manager.

The evidence indicates that no such person was ever found and that the Community Advocate continued to hold an appointment under the *Guardianship and Management of Property Act 1991* as the guardian of last resort from the date of her original emergency appointment on 22 January 2001. This appointment was reviewed by the Tribunal on 2 July 2001 and was again to be reviewed upon the application of Mrs Wojtkowski on 17 September 2001.

26. The Community Advocate has statutory powers flowing from the *Act* to "*do all things necessary or convenient to be done in connection with the performance of his or her functions* (s13 (2))". Additionally a Community Advocate, if appointed under the *Guardianship and Management of Property Act 1991,* has nominated statutory

powers, which includes a power for the guardian to give consent in relation to medical procedures or other treatment. The Office of the Community Advocate publishes a number of documents, which were handed up during the inquest setting out in some detail the role which the Community Advocate is to perform when appointed as a guardian of last resort. The principle document of relevance in this situation is the Guardianship Standards booklet (Standards) published in June 2002. Ms McGregor, who is the Community Advocate and was appointed pursuant to the *Guardianship and Management of Property Act 1991* as the guardian of Mrs Ghobrial, accepts that the Standards set out in the document of June 2002 were relevant and applicable at the time of her dealings with Mrs Ghobrial and more particularly in view of the criticisms levelled against Ms McGregor by Mr Ghobrial and Mrs Wojtkowski were the principles under which Ms McGregor dealt with the relevant interested parties and in particular with Mr Ghobrial and Mrs Wojtkowski. The Community Advocate also accepts, as I understand Ms McGregor's position, that the principles of the United Nations Declaration of the Rights of People with Disabilities also guide her operations.

27. The Standards indicate at page one "*The Community Advocate is responsible for making decisions on behalf of a person when acting as emergency guardian and as guardian of last resort*".

28. Paragraph 2 of the Standards refer to the responsibility of the Community Advocate in relation to seeking views before any decisions are made in relation to the protected person, is this situation Mrs Ghobrial.

29. Paragraph 2.1 is in the following terms; " *when a decision is needed, or there is a recommendation to be made, the wishes of the protected person are sought as far as this is possible, and paramount consideration is given within the context of other principles in the GMP Act*" (*Guardianship and Management of Property Act 1991).* Paragraph 2.2 says "*The view and wishes of key parties are sought as far as possible, and taken into account*".

30. The Standards define a 'key party' as "*a relative, friend, carer, health professional, neighbour or a member of the person's cultural group; is someone who knows the person well, is an important part of the person's life, and is able to provide input to deliberations about what is in the person's best interests*".

31. Paragraph 2.3 of the Standards says "*The opinions of all relevant professionals, and where appropriate those of a member of the client's cultural group, are sought and taken into account before a decision or recommendation is made*".

32. Paragraph 2.4 says "*The views of more than one medical professional are sought if a medical consent is involved, and if there is any difference of opinion*".

33. Paragraph 3 of the Standards indicates the nature of contact, which is to occur between the Community Advocate and the protected person.

34. Paragraph 4 of the Standards requires the Office of the Community Advocate (OCA) to record various matters relating to the conduct of the guardianship including the views and wishes of service providers and key parties.

35. Paragraph 4.5 of the Standards provides "*When the decision made is contrary to the expressed wishes of key parties, the reasons will be explained to those people prior to giving effect to the decision, and prior to any hearing. Review and appeal mechanisms will be explained*".

36. Paragraph 5 of the Standards sets out the principles which guide the Community Advocate in any decision making process required by the Community Advocate pursuant to the appointment under the *Guardianship and Management of Property Act 1991*. These requirements are as follows;

> *5.1 The Community Advocate as guardian will make decisions in accordance with the principles to be followed by decision-makers*
>
> > *5.1.1 The protected person's wishes, as far as they can be worked out, must be given effect to, unless making the decision in accordance with the wishes is likely to significantly adversely affect the protected person's interests*
> >
> > *5.1.2 If giving effect to the protected person's wishes is likely to significantly adversely affect the person's interests – the decision-maker must give effect to the protected person's wishes as far as possible without significantly adversely affecting the protected person's interests*
> >
> > *5.1.3 If the protected person's wishes cannot be given effect to at all, the interests of the protected person must be promoted.*
> >
> > *5.1.4 The protected person's life (including the person's lifestyle) must be interfered with to the smallest extent necessary.*
> >
> > *5.1.5 The protected person must be encouraged to look after himself or herself as far as possible*
> >
> > *5.1.6 The protected person must be encouraged to live in the general community, and take part in community activities, as far as possible.*
>
> *5.2 Before making a decision, the Community Advocate will consult with the primary carer of the protected person, unless doing so would, in her opinion, adversely affect the protected person's interests.*
>
> *5.3 The OCA will act or decide according to a clients' best interests in accordance with the following standard*
>
> > *5.3.1 Protection of the person from physical or mental harm*
> >
> > *5.3.2 Prevention of the physical or mental deterioration of the person*
> >
> > *5.3.3 The ability of the person to look after himself or herself; live in the general community; take part in community activities; maintain the person's preferred lifestyle (other than any part of the person's preferred lifestyle that is harmful to the person)*
> >
> > *5.3.4 Promotion of the person's financial security*
> >
> > *5.3.5 Prevention of the wasting of the person's financial resources or the person becoming destitute.*
>
> *5.5 An assessment leading to a substitute decision will commence within one working day of receipt of an application.*
>
> *5.6 As far as is practicable, the protected person will be visited or contacted prior to the making of a decision.*

5.7 Decisions will be made immediately after an investigation has been completed.

5.8 Written reasons for decisions will be provided on request to the protected person or a key party, within one week.

37. Reference is made in 5.1 to section 5 of the *Guardianship and Management of Property Amendment Act 2001*. Section 4 of the amendment of 2001 sets out a definition of a person's interest and sets out principles to be followed by decision-makers. These principles are found in section 5 of the Amendment Act and are as follows,

5. Principles to be followed by decision-makers

(1) This section applies to the exercise by a person (the ***decision-maker****) of a function under this Act in relation to a person with impaired decision-making ability (the* ***protected person****).*

(2) The ***decision-making principles*** *to be followed by the decision-maker are the following:*

(a) the protected person's wishes, as far as they can be worked out, must be given effect to, unless making the decision in accordance with the wishes is likely to significantly adversely affect the protected person's interests;

(b) if giving effect to the protected person's wishes is likely to significantly adversely affect the person's interests – the decision-maker must give effect to the protected person's wishes as far as possible without significantly adversely affecting the protected person's interests;

(c) if the protected person's wishes cannot be given effect to at all - the interests of the protected person must be promoted;

(d) the protected person's life (including the person's lifestyle) must be interfered with to the smallest extent necessary;

(e) the protected person must be encouraged to look after himself or herself as far as possible;

(f) the protected person must be encouraged to live in the general community, and take part in community activities, as far as possible.

(3) Before making a decision, the decision-maker must consult with the primary carer of the protected person, unless doing so would, in the decision-maker's opinion, adversely affect the protected person's interest.

(4) Subsection (3) does not limit the consultation that the decision-maker may carry out.

38. The effect of the powers given to the Community Advocate under the Act, *Guardianship and Management of Property Act 1991*, under the *Guardianship and Management of Property Amendment Act 2001* and under the Guardianship Standards 2002, clearly require the guardian to make decisions in the best interests of the protected person, in this case Mrs Ghobrial. The Standards require the Community Advocate to consult, where possible with the protected person and also to seek the views and wishes of key parties, in this situation including Mr Ghobrial and Mrs Wojtkowski. It should be noted that the overwhelming evidence is that Mrs Ghobrial

had no capacity to make her views known. There is no requirement under the *Act* for the guardian to follow the views expressed by the key parties and indeed it would appear that the guardian is not required to follow the wishes of the protected person. It is clear from the powers and guidelines that the Community Advocate must consult with various persons and parties and must then, where appropriate and necessary, make a decision based upon the various views and in a medical situation based upon the opinion and advice of all relevant professionals.

39. Complaint is made by Mr Ghobrial and Mrs Wojtkowski, that the Community Advocate did not either consult appropriately, or more importantly as I understand their position, failed to accept the views expressed by Mr Ghobrial and Mrs Wojtkowski. It is clear that the Community Advocate has no duty to accept the views of key parties and indeed it is clear in this case that the Community Advocate's decisions, particularly the final and critical decision concerning the ongoing care for Mrs Ghobrial, were taken on sound medical advice and in disagreement with the ongoing professed views of the key parties. The Community Advocate, in my view, cannot in any way be criticised for the decisions that she made concerning the ongoing care and treatment of Mrs Ghobrial. I will turn in due course to a more detailed consideration of the decisions referred to in Ms McGregor's evidence particularly the decision to provide only palliative care to Mrs Ghobrial, but at this point in time I am content to indicate that on the evidence before me there can be no grounds for criticism of the decisions made by Ms McGregor and that it is clear on the evidence before me that all the of decisions were made based on appropriate consultation, particularly with medical professionals, and were indeed on the medical evidence before me the only decisions that could have been at that time bearing in mind the Community Advocate's responsibility as the guardian of Mrs Ghobrial.

40. A particular criticism is made of the Community Advocate by Mrs Wojtkowski concerning, what was described by Mrs Wojtkoswki, as a lack of communication concerning particular decisions and especially the decision concerning palliative care. It is my understanding of the evidence of Dr Khoo and Ms McGregor, that Dr Khoo was, in effect, authorised by Ms McGregor to communicate to the family, particularly Mrs Wojtkoskwi, the medical advice and the medical decisions that had been made at the various meetings referred to above and more importantly the decision that had been made by the guardian to accept that medical advice which effectively required the palliative treatment of Mrs Ghobrial and did not require, other than by a specific further decision, any ongoing intervention such as had occurred prior to September 2001.

41. The communication of any decisions to Mr Ghobrial were complicated by the difficulties which existed between the Community Advocate and Mr Ghobrial. Ms McGregor in her statement (Exhibit 8) says that she requested Dr Sharmala to inform Mr Ghobrial of at least the advice and decisions of August 2001. The evidence also indicates that attempts were made to bring Mr Ghobrial to the Nursing Home to see his wife.

42. Ms McGregor's evidence, as I understand it, is that she does not accept that under the legislation that controls her appointment or under the Standards, there is a requirement upon her to communicate in a specific way any of her decisions concerning the protected person to the key parties. I accept that save for 5.8 of the

Standards, this position would seem to be correct, although it is clear that paragraph 4.5 of the Standards requires certain decisions to be explained to key parties. However it is clear in cases of the sort with which we are dealing in this inquest, there is a serious responsibility on the part of the guardian to ensure that the relevant key parties are fully aware of the decisions that have been made concerning their loved one and in particular decisions of the significance of the ones made in August and September 2001

43. I do not say that Ms McGregor had any statutory or Standards imposed responsibility to communicate her decision other than in the way that she attempted to have the decision communicated by Dr Khoo and Dr Sharmala. It must be accepted however that in the emotionally charged environment which had existed for a considerable period of time in this particular case, that it was perhaps inevitable that there was a substantial possibility of a lack of understanding on the part of the family of Mrs Ghobrial as to the precise nature of the information being communicated by Dr Khoo. Dr Khoo's principle role, at the time of the discussions referred to in the evidence, was to communicate to the family the medical opinion of the various medical professionals who had been consulted concerning the ongoing treatment of Mrs Ghobrial, and not necessarily to communicate a decision which had been made by the guardian based upon that medical advice.

44. It is true that Mrs Wojtkowski had been sufficiently advised by the Office of the Community Advocate, and perhaps others, as to options that were available to her in relation to the ongoing appointment of the Community Advocate as guardian and indeed the evidence indicates that on the date of the death of Mrs Ghobrial proceedings were on foot to seek a review of the appointment of Ms McGregor as the guardian.

45. It is difficult on all of the evidence to form a concluded view as to what precise knowledge the family had about the decision which had been made and more importantly what precise information they had received from any source as to what rights they had, if any, to attempt to challenge the decision that had inevitably been made following the meetings in August.

46. In those circumstances it would seem to be appropriate in cases of this sort that a decision of the magnitude of the one made by Ms McGregor, as the guardian, ought to be communicated in writing in a form easily understood by those receiving the information and with some form of support being made available to those persons, either through the Office of the Community Advocate, or some other source, to ensure that the decision is understood and to ensure that the affected persons are aware of what rights they may have in relation to that decision. Formal written communication of decisions would appear to be particularly important where there is a disagreement in the views of relevant parties. This suggestion of course presupposes that there is time for such steps to be taken.

47. **The Palliative Care Decision.**

Between March 2001 and August 2001 Mrs Ghobrial was admitted to the Calvary Hospital on a number of occasions for treatment relating in part to the difficulties that continued to exist concerning her feeding and also the development as a result at least in part, of that difficulty, of aspiration pneumonia. The medical evidence clearly

indicates that as a result of the physical condition of Mrs Ghobrial, she was at constant risk of contracting pneumonia. The procedures adopted in relation to the treatment of the pneumonia, were invasive and in the view of the medical professionals caused considerable discomfort to Mrs Ghobrial.

48. The evidence indicates that from at least early August 2001 Mrs Ghobrial's condition was deteriorating and a number of conferences took place between various medical professionals and the Community Advocate as to the proper treatment of Mrs Ghobrial. Mrs Ghobrial sustained a fracture to her leg during one of her visits to the Calvary Hospital when she fell off an X-ray table. This incident caused considerable concern to the mother and husband of Mrs Ghobrial, but it seems that the medical advice was that in all the circumstances it was inappropriate to surgically intervene to repair the fracture. A decision was made that the fracture would be treated by rest. This advice was accepted by the Community Advocate and a decision was made by the Community Advocate to approve the suggested form of treatment. There is nothing in the evidence that would suggest that this decision was inappropriate in the circumstances.

49. A case management conference took place on 16 August 2001 at the Calvary Hospital. This conference was attended by the Community Advocate, Dr Khoo, Dr Keaney and others. As a result of this conference advice was given to the Community Advocate that the best medical treatment that could be recommended for Mrs Ghobrial was that she was to be kept hydrated, pain free and that all medical conditions were to be treated, but that no further invasive procedures would be undertaken as it was the medical opinion that such procedures merely prolonged her suffering. Following this conference further consultations took place involving the Community Advocate and other medical practitioners. The Community Advocate arranged for a further examination to be conducted by Dr Roger Tuck, who had had earlier involvement with Mrs Ghobrial. Dr Tuck's advice agreed with the views expressed at the meeting of 16 August 2001. A further conference took place on 21 August 2001 when the results of the discussions of the meeting of 16 August 2001 were reviewed by the Division of Medicine at Calvary Hospital this group also agreed with the advice developed at the meeting of 16 August.

50. The conferences in August 2001 were organised by Dr Khoo, Dr Khoo in his statement dated 28 April 2003 (Exhibit 40) indicates that he had become responsible for Mrs Ghobrial initially in March 2001 and again in August 2001. Because his specialty was not specifically appropriate for the treatment of Mrs Ghobrial he arranged for the involvement of a number of other specialists and following these initial discussions after the 12 August 2001 he indicates that he had a lengthy meeting with Mrs Wojtkowski and her Husband. He indicates in his statement that he explained the view of the medical professionals and accepts that Mrs Wojtkowski and her Husband did not accept that medical opinion. The position explained by them to Dr Khoo was that they wanted Mrs Ghobrial to be nursed back to health. Dr Khoo indicates that he explained to them in some detail that that did not seem to be possible and that it was very unlikely that Mrs Ghobrial would ever recover.

51. Dr Khoo indicates that as a result of the disagreement between himself and Mrs Wojtkowski he arranged for the conference of 16 August to take place. Following this conference he again spoke to Mrs Wojtkowski and her Husband with the same

result. As a result of the continued disagreement between the medical advice and the attitude of Mrs Wojtkowski and her Husband the decision of the conference of 16 August 2001 was reviewed by the Division of Medicine at the Calvary Hospital. Dr Khoo in his statement indicates that the view of that review was that Mrs Ghobrial's condition could not be cured. Further bouts of aspiration pneumonia were inevitable and that this would require intravenous antibiotics and suctioning of her lungs. The combined medical opinion, of all of those consulted by Dr Khoo, was that Mrs Ghobrial's condition was "*so poor that she could not fight these recurrences, and would have inevitable succumbed to them*" (Exhibit 40). Following this review by the Division of Medicine Dr Khoo indicates that he again spoke with Mrs Wojtkowski and her Husband and advised of those recommendations, the recommendations were not acceptable to Mrs Wojtkowski and her Husband.

52. It is clear form all of the evidence that the position held by the medical professionals was in the circumstances correct and inevitable. It is also clear that it was the profound wish of Mrs Wojtkoswki and Mr Ghobrial that Mrs Ghobrial somehow be nursed back to health so that she might in due course recover. While I understand and accept that this was the position adopted by the family of Mrs Ghobrial it is clear on the medical evidence that the reality did not allow such a situation to occur.

53. Ms McGregor accepted the advice of the medical professionals as arrived at in the various conferences referred to above and instructions were given by the General Practitioner to the Canberra Nursing Home that no further interventions of the type referred to above were to occur, at least without specific instructions from the doctor and Ms McGregor. On 17 September 2001 Mrs Ghobrial's condition deteriorated rapidly as a result of the development of pneumonia. In light of the medical instructions, supported by the decision of the Community Advocate, no intervention occurred and Mrs Ghobrial died.

54. The Mother and Husband of Mrs Ghobrial are critical of the decisions made, not only by the medical professionals, but also Ms McGregor based upon that medical advice. While I have already commented upon the uncertainty as to the communication of the decisions, particularly that relating to palliative care, of the Community Advocate to the Mother and Husband of Mrs Ghobrial I am not able on the evidence before me to be critical in any way of that decision, as it is clear that it was based upon proper, and properly considered medical advice from a substantial number of specialist medical practitioners, all of whom had some contact with Mrs Ghobrial. The reality of Mrs Ghobrial's situation seems to have been, for a considerable period of time, that it was inevitable as a result of her general physical situation that she would develop pneumonia and that it was inevitable that she would die as a result of that condition. The medical evidence is clear that it would have been intrusive, dangerous and unpleasant for Mrs Ghobrial to have continued to undergone the invasive treatment necessary to vigorously attack the pneumonia once it developed. This I am satisfied was a relevant factor for the medical practitioners, and the Community Advocate to take into consideration in the decision making process which the Community Advocate was engaged in over a long period of time.

55. **Conclusion.**
The death of Mrs Ghobrial on 17 September 2001, was in my view a direct consequence of the incident on 15 March 2000 at the St George Hospital.

56. I have not, for the reasons already indicated, canvassed any issues which may arise in New South Wales as a result of her hospitalisation or of the injuries sustained by her on 15 March 2000, nor of any controversy which developed, particularly relating to her husband Michael Ghobrial. This inquest has been limited to the matters relevant to the manner and cause of death of Mrs Ghobrial in the Australian Capital Territory. I am aware that a dispute arose involving Mr Ghobrial and the Community Advocate, but I have not canvassed that dispute in any real way in this inquest as it does not, in my view, specifically relate to the manner and cause of death of Mrs Ghobrial. I accept that Mr Ghobrial, Mrs Wojtkowski and all family members were greatly distressed by the death of Mrs Ghobrial and had and probably still have grave concerns about her treatment between March 2000 and her death in September 2001. The evidence before me clearly suggests that the injuries sustained by Mrs Ghobrial in March 2000 were very severe and that her condition when she arrived in the ACT in January of 2001 was such that she had little prospect of recovery from the injury she had sustained. I have already commented upon the appropriateness of the facility at the Canberra Nursing Home and I must indicate that I do not in any way criticise the Canberra Nursing Home or on the evidence before me the Calvary Hospital in relation to the treatment provided to Mrs Ghobrial. Her ongoing treatment and rehabilitation clearly represented a challenge to the Canberra Nursing Home which it was not equipped to meet. This situation was clearly accepted by Ms McGregor at an early stage and no doubt also accepted by the family of Mrs Ghobrial, but it is clear on the evidence before me that no viable alternative accommodation was available for Mrs Ghobrial.

57. I accept that Mrs Wojtkowski and Mr Ghobrial had and no doubt continue to have concerns about the role of the Community Advocate. I have attempted to explain above the role of the Community Advocate and how by law the Community Advocate is required to operate in what the Community Advocate thought, in the circumstances of this particular case, was the best interests of Mrs Ghobrial. While the Community Advocate is required to give consideration to various interests and to take advice it is ultimately the onerous responsibility of the Community Advocate to make decisions which in the Community Advocate's mind are appropriate but which may not be regarded as appropriate by other interested parties.

58. I have indicated above that in my opinion the Community Advocate conducted herself within the scope of her legal requirements and I am satisfied that at all times Ms McGregor attempted to carry out her responsibilities with the best interests of Mrs Ghobrial in mind. Her role was clearly complicated by reason of the personal views and conduct of Mr Ghobrial, in particular, but also Mrs Wojtkoswki.

59. The death of Mrs Ghobrial was a tragedy, but I am not of the view that Ms McGregor or the medical institutions or the medical practitioners that were involved in her care in any way contributed to her death. I am not satisfied on the evidence that there is any appropriate adverse comment that might be made about any of those persons or organisations.

60. **Findings, Recommendations and Comments.**

Findings

I am required under Section 52 of the Coroner's Act 1997 to find, if possible,

(a) the identity of the deceased; and
(b) when and where the death occurred; and
(c) the manner and cause of death

I, accordingly, make the following findings:

(a) The deceased was Ivy Pearl Ghobrial
(b) The deceased died at the Canberra Nursing Home on 17 September 2001
(c) The deceased died as a result of bilateral acute bronchopneumonia. The evidence indicates that the bilateral acute bronchopneumonia developed as a result of the injuries sustained consequent upon the hanging, which occurred at the St George Hospital NSW on 15 March 2000.

Recommendations (Section 57)

Section 57 of the Coroner's Act allows a Coroner to make recommendations to the Attorney-General on any matter connected with an inquest including matters relating to public health or safety. There are no recommendations which I feel could usefully be made in relation to the death of Mrs Ghobrial.

Comments (Section 52)

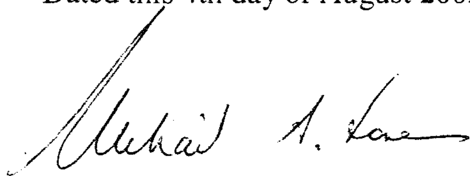
Section 52 of the Coroner's Act allows a Coroner to comment on any matter connected with the death, fire or disaster including public health or safety or the administration of justice. Based upon the evidence before me during the inquest I would make the following comments:

(1) Evidence was given during the inquest of a lack of facilities in the ACT to properly treat and rehabilitate persons, particularly younger persons, who have an acquired brain injury. The evidence suggests that the nursing home to which Mrs Ghobrial was transferred in January 2001 provided her with a high level of care but did not have the facilities, nor did they ever indicate that they had the facilities, to provide the intensive and ongoing treatment and rehabilitation which may well have been required by Mrs Ghobrial. It may be appropriate that consideration be given to investigations into providing more appropriate facilities for the treatment of persons with injuries such as those suffered by Mrs Ghobrial.

(2) I have already commented about the communication of decisions by the Community Advocate and I would reiterate that in my view it would be desirable in cases when significant decisions affecting a protected person are being made, that such decisions should be clearly communicated to key parties by the guardian in person, or where that is for some reason not appropriate, by

a member of the Office of the Community Advocate, where the Community Advocate is the guardian. Significant decisions ought, perhaps, be communicated in writing together with some advice to the key parties, particularly where there is a known disagreement as to the decision being made by the Community Advocate, of any rights which a key party may have in relation to challenging, if appropriate, the decision of the Community Advocate. I accept that under the statutory provisions applying to the Office of the Community Advocate and also under the Standards that there appears to be no capacity for a person to challenge a decision of the Community Advocate acting as a guardian, but there may be other avenues open to a key party.

Dated this 4th day of August 2003.



MICHAEL A. SOMES

Coroner