**FINDINGS, COMMENTS and RECOMMENDATIONS of Coroner Olivia McTaggart following the holding of an inquest under the *Coroners Act* 1995 into the death of:**

# MARY MARGUERITE DICKINSON

# Contents

# Record of Investigation into Death (With Inquest)

*Coroners Act* 1995
*Coroners Rules* 2006
*Rule* 11

I, Olivia McTaggart, Coroner, having investigated the death of Mary Marguerite Dickinson with an inquest held at Hobart in Tasmania make the following findings.

**Hearing Dates**

7 February and 10 March 2020
Final submissions received 12 April 2020

**Representation**

Counsel Assisting the Coroner: Ms D Earley
Counsel for Tasmanian Health Service: Ms G Chen
Counsel for family members (Sarah Ringsell, Shaun Cranny and Jonathon Cranny): Mr J Crotty

**Introduction**

Mary Marguerite Dickinson, aged 58 years, died on 20 January 2018 in the Magnolia Unit at the Roy Fagan Centre (RFC) of pneumonia after having received palliative care in respect of severe medical conditions, including the consequences of a broken scapula and severe cognitive decline. At the time of her death, Mrs Dickinson was the subject of an Emergency Guardianship Order in favour of the Public Guardian. I deemed that a public inquest was required to be held in respect of Mrs Dickinson's death as she was a person "held in care" under the *Coroners Act* 1995 (the Act).

Before and during the inquest, Mrs Dickinson's husband and children raised several issues in respect of the guardianship, care and treatment of their mother, which I address in this finding.

In making the below findings I have had regard to the documentary evidence gained in the investigation into Mrs Dickinson's death. The evidence includes the Police Report of Death; identification and life extinct affidavits; an opinion of the State Forensic Pathologist regarding cause of death; an opinion of the Coronial Medical Consultant regarding the care and treatment of Mrs Dickinson; documentation from the Guardianship and Administration Board and the Public Guardian; reports from Dr Alison Cleary; affidavit of Dr Scott Chamberlen; affidavit of Joanne Triffitt; affidavits of family members; and Royal Hobart Hospital (RHH) and Roy Fagan Centre medical records and reports.

At the inquest itself, I heard oral evidence from the following persons:

- Ms Sarah Ringsell, Mrs Dickinson's daughter;
- Mr Jonathan Cranny, Mrs Dickinson's son;
- Mr Shaun Cranny, Mrs Dickinson's son;
- Mr John Dickinson, Mrs Dickinson's husband;
- Dr Alison Cleary, Geriatrician, who treated Mrs Dickinson;
- Dr Scott Chamberlen, Geriatrician, who treated Mrs Dickinson;
- Ms Joanne Triffitt, Assistant Director of Nursing, Roy Fagan Centre; and
- Ms Nicky Targett, Senior Guardian with the Office of the Public Guardian.

**Was Mrs Dickinson a Person "Held in Care" Under the Act?**

If a person is, immediately before their death, a person *"held in care",* then under the Act, a coroner is required to hold a public inquest.[1] The coroner is also required to report on the care, supervision or treatment of that person while they were held in care.[2] Relevantly, a *"person held in care"* under the Act is *"a person detained or liable to be detained in an approved hospital within the meaning of the Mental Health Act 2013*"[3]. Roy Fagan Centre is a specialised hospital operated by the Tasmanian Health Service (THS) to assess and treat older persons with psychiatric illness and / or cognitive impairment.

Ms Chen, counsel for the THS, submitted that Mrs Dickinson did not satisfy the definition of a *"person held in care"* during the period of her admission to the RFC. She submitted that firstly, the Guardianship and Administration Board (GAB) specified in its decision that, whilst Mrs Dickinson did not have the ability to consent to her place of accommodation, there was no source of lawful authority to detain her. Secondly, it was submitted that, by virtue of the provisions of the *Guardianship and Administration Act* 1995 any consent by the Public Guardian to transfer and keep Mrs Dickinson at the RFC had effect as if it were given by Mrs Dickinson herself.[4]

Counsel Assisting, Ms Earley, submitted that a guardianship order was in place reflecting Mrs Dickinson's clear incapacity to make reasonable judgements concerning her treatment and place of residence. She submitted that Mrs Dickinson was unable to leave the approved hospital by virtue of the Public Guardian's decision pursuant to the order and was therefore detained in the hospital. Further, Ms Earley submitted that the fact that the decisions made or acts done by the Public

[1] Section 24(b) of the Act
[2] Section 28(5) of the Act
[3] Section 3 of the Act
[4] Section 26(2) of the *Guardianship and Administration Act* 1995

Guardian have legislative effect as if they had been made or done by Mrs Dickinson (and that she had the legal capacity to do so) does not alter the reality that Mrs Dickinson was not *actually* free to leave the RFC at the time of her death.

In my findings following the inquest into the death of *Molly Jesse Smith*[5] I stated that *"the public policy rationale for the requirement in section 28(5) of the Act to report on the care, supervision or treatment is to ensure that the death of every person who is coercively held in any state-run institution is carefully, independently and transparently examined…"*[6]. Further, I stated that *"It is therefore a question of fact as to whether the aspects of control or compulsion are present such that a person can be found to be detained, notwithstanding the absence of a formal order legitimising that detention".*[7]

I am satisfied that, as a matter of fact, Mrs Dickinson was detained at the RFC. She was not free to leave the approved hospital or to make her own medical decisions by virtue of the decision of the Public Guardian. I am therefore required to report upon her care, supervision and treatment at the RFC as well as determining the other matters required by the Act – identity, cause of death, and how death occurred.

**Background**

Mrs Dickinson was born on 28 October 1959. She grew up in Derwent Park, Tasmania, went to St Mary's school and completed her schooling at Rosetta High School. During her working life, Mrs Dickinson held various types of employment; her last being as an accountant.

In 1977 Mrs Dickinson married Lindsay Francis Cranny. They had three children together; Shaun Francis Clifford Cranny, born in 1982; Sarah Marguerite Ringsell, born in 1984; and Jonathan David Cranny born in 1985.

Mrs Dickinson and Mr Cranny divorced in 1987.

In 1999 Mrs Dickinson moved to Wyong, New South Wales. In 2001 she met John Arthur Dickinson and married him in 2003. She then commenced work as an accountant in a business, working in this capacity for two years before retiring in 2005 and then acting as full-time carer for her husband who had suffered a major heart attack.

In 2009 Mrs Dickinson moved back to Tasmania with her husband, and they settled in Black Hills, New Norfolk.

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[5] [2017] TASCD 444
[6] Ibid p13
[7] Ibid p14

Throughout the majority of Mrs Dickinson's adult life, she consumed alcohol heavily. It was not uncommon for her to drink up to four litres of wine in one night. She also smoked an average of 40 cigarettes per day.

Mrs Dickinson's past medical history included alcohol dependence, hypertension, depression, chronic lower back pain, osteoporosis, gastro-oesophageal reflux disease and Type II diabetes. Although her husband stated in his affidavit that she was in reasonable health before her final hospital admission, it is clear from the medical evidence that Mrs Dickinson suffered serious underlying health conditions, including cognitive decline.

In relation to past medical treatment, Mrs Dickinson had presented to the RHH's Emergency Department (ED) on several previous occasions. In May 2015 she had a fall at her home following an argument with her husband and broke her humerus. She was admitted for a few days at this time and this injury also saw her re-present to the RHH ED in June, July and August with complications related to the original humerus fracture. On 19 October 2017 she presented to the ED again following a fall. At this time she reported that this was her third fall this year. She also reported issues with urinary incontinence. She was not admitted at that time as she did not require inpatient treatment for her injury.

**Mrs Dickinson's Fall and Hospitalisation**

On 21 December 2017, Mrs Dickinson presented by ambulance at the ED of the RHH after falling to the ground when her dog accidently pulled her down the stairs when her finger became caught in its collar. She may have lost consciousness for a period of up to 20 minutes. Mrs Dickinson sustained a complex right scapula fracture in addition to demonstrating a lack of insight into her current level of function. She was assessed by Dr Alexander Tucker who reported:

> *"Mary has demonstrated global deficits on cognitive testing and lack of insight into her cognitive and physical abilities and functioning level. Due to this, both myself and Dr Scott Chamberlen (Geriatrician) have assessed her as lacking capacity to make decisions about her place of accommodation and care requirements."*

Mrs Dickinson was admitted as an inpatient of the RHH. Dr Tucker made the subsequent diagnosis of alcoholic dementia. At the RHH it was apparent that Mrs Dickinson tried to mobilise when she had no ability to do so, as evidenced in an incident of her trying to climb out of bed on 3 January. She also expressed the wish to go home which was not a realistic option given the severity of her condition and the treatment required.

Dr Chamberlen reviewed Mrs Dickinson on 3 January 2018 and formed the view that she was suffering dementia and delirium. He commented in evidence that Mrs Dickinson was exceptionally frail, with her fall demonstrating that frailty rather than causing it. In evidence he said that Mrs Dickinson's long history of alcohol consumption was largely responsible for her frail condition and dementia.

Dr A J Bell, Medical Advisor to the Coronial Division, reviewed the medical evidence and provided a report at my request. Dr Bell summarised Mrs Dickinson's health conditions in his report as follows:

> *"On the medical ward a number of significant medical illnesses were found. The major problem was the consequence of alcohol abuse (2 L wine per day for 30 years). There was poor brain function. The Montreal Cognitive Assessment is a widely used screening assessment for detecting cognitive impairment. In this case the score was 7/30, with global cognitive deficits, and associated poor insight into function and abilities. A CT scan of the brain showed atrophic brain and mild chronic ischaemic changes. A diagnosis of alcoholic dementia was considered likely. There was evidence of cirrhosis of the liver with an episode of decompensation with hepatic encephalopathy. There was evidence of cerebellar dysfunction with ataxia (impaired muscle coordination) and peripheral neuropathy both associated with alcohol excess. Other diagnoses included iron deficient anaemia, osteoporosis, and vitamin D deficiency."*

I accept Dr Bell's unchallenged evidence concerning Mrs Dickinson's conditions diagnosed during her hospitalisation.

Dr Chamberlen recommended that Mrs Dickinson be transferred for ongoing assessment and treatment in the Jasmine Unit at the RFC. In his evidence he gave reasons for that recommendation, primarily Mrs Dickinson's lack of insight and the secure nature of the facility. He was of the view that she did not have capacity due to her cognitive deficits to make decisions in respect of her place of accommodation and care requirements.[8] I accept that his judgement as to her placement in this regard was sound. The aim of treatment at the RFC was rehabilitation. The family expressed concern about the placement at the RFC but gave no reasons for their view that she should have been instead placed at the Repatriation Centre.

On 5 January 2018, an Emergency Guardianship Order under the *Guardianship and Administration Act* 1995 was made appointing the Public Guardian for 28 days as Mrs Dickinson's emergency guardian. The Order allowed (and required) the Public Guardian to make decisions concerning the following:

[8] See also C8 – Health Care Professional Report, part of the GAB application.

i. Where Mrs Dickinson was to live, whether permanently or temporarily; and
ii. Consent to any health care in the best interests of Mrs Dickinson and to refuse or withdraw consent to any such treatment; and
iii. To consent to any reasonable measures required to convey Mrs Dickinson to, and cause her to remain at the place of residence, as determined by the guardian.

On 8 January 2018 the Public Guardian consented to transferring Mrs Dickinson to the RFC to a secure unit and consented to her remaining at the unit whist undergoing assessment for her cognitive capacity and discharge planning.

In the application for the Order it is noted that Mrs Dickinson's husband and son, Shaun, were informed of the transfer to the RFC and the making of the Guardianship Order. Both did not raise any issue regarding the transfer and indicated that they wanted *"whatever is best"* for Mrs Dickinson. In the same application, it is stated that Sarah said that her mother had *"no sense of reasoning"* and that family members could not provide the level of care that she needed. I accept that these family members were advised of the making of the Order and expressed that they were content with the situation.

**Mrs Dickinson's Time at the Roy Fagan Centre**

On 8 January 2018 Mrs Dickinson was admitted to the Jasmine Ward of the RFC. In the below chronology, I have relied upon the very helpful report and affidavit of Ms Joanne Triffitt, Assistant Director of Nursing, which sets out clearly the daily treatment and care of Mrs Dickinson and details of her changing medical condition. It is apparent that there were significant efforts by doctors, nursing staff and allied health professionals to treat and assist Mrs Dickinson in her rehabilitation.

Mrs Dickinson was initially under the care of Dr Chamberlen, who had assessed her at the RHH and determined that she was suitable for slow stream rehabilitation and conservative care at the RFC. During this time she was to be managed for her complex right scapula fracture, involving six weeks non-weight bearing with a sling.

When Mrs Dickinson arrived at the RFC, she was medically reviewed. She was observed to be very sleepy with limited response to questions. Her management plan included close observations, falls risk strategies, physical observations (twice daily for three days then daily), risk assessment and behavioural observations, pressure area screening, capacity to swallow assessment, fluid balance and bowel charts to be commenced, bloods to be taken, allied heath assessments, Goals of Care to be completed and a family meeting to be held.

Dr Chamberlen reviewed Mrs Dickinson on 9 January and 12 January and communicated by phone with Dr Gillian Mee, the Geriatric Medicine Registrar at RFC who reviewed Mrs Dickinson daily. During the first two to three days after admission, Mrs Dickinson was noted to be in increasing pain with basic nursing care (hygiene for incontinence, pressure area care, feeding support and mouth care), she was agitated, delirious and sleep-disturbed. Ms Triffitt stated in her report that Mrs Dickinson had become increasingly combative which impacted upon the staff's ability to safely meet her basic care requirements.

On 9 January 2018 Dr Mee met with Sarah and her husband. The RFC notes record that Sarah said that, upon reflection, her mother's cognitive decline had been occurring over some years. She also described her unsteady gait, use of furniture to walk around the house and incontinence of urine and faeces over the past "couple of years". Sarah said that Mrs Dickinson had reduced her alcohol intake over the last 12 months but her unsteadiness remained. Sarah said that a "public guardian" and a "public administrator" would be the best for her mother's long-term care needs and financial decisions.

On 15 January 2018 Mrs Dickinson was assessed by Dr Mee who discussed her assessment with Dr Cleary, who had been transferred the care of Mrs Dickinson. They assessed that due to her frailty, pain and suffering, she could not participate in any active rehabilitation and the care approach should focus on comfort and dignity.

The Public Guardian was not notified at this time, even though several of her medications were ceased on 15 January and the Goals of Care changed to palliation. Dr Mee discussed Mrs Dickinson's care and palliation with Sarah the following day. The medical notes indicate that Sarah agreed to communicate the situation to her brothers. Mr Dickinson and Jonathan also had discussions with staff on 17 January regarding Mrs Dickinson's poor prognosis. It is clear that all family members agreed on a comfort and palliative care approach which they believed to be in accordance with Mrs Dickinson's previously expressed wishes.

Mrs Dickinson continued to suffer pain and agitation, with the medical and nursing approach focusing upon providing her with appropriate analgesia and care to try and achieve good levels of comfort.

**Circumstances Surrounding the Death**

At 11.00am on 18 January 2018, Mrs Dickinson was reviewed by Dr Alison Cleary. Dr Cleary also saw her that same afternoon. She was recorded as very frail, agitated and restless and in ongoing pain and distress. Her care needs were adapted, observations were ceased, and she was offered soft foods and fluids and oral medications as she was able to swallow. The treating team discussed

progression to "terminal phase" with her family and arranged for her to move to a palliative suite so they could stay overnight if requested.

Later that day, Mrs Dickinson was moved to the Magnolia Ward at the RFC and had a more settled night with increased analgesia (pain relief).

On 19 January, Mrs Dickinson was reviewed by Dr Mee. Her medication was reviewed and adjusted to provide Mrs Dickinson with end-of-life comfort. At this point, the Public Guardian was notified by Dr Mee who forwarded a *Consent for Medical and Dental Treatment* form which sought consent to provide Mrs Dickinson with a number of medications for palliative care. The guardian signed and returned the consent form.

During the night of 20 January, Mrs Dickinson's respirations became shallow and rapid, and Sarah was contacted. A subcutaneous line was inserted into Mrs Dickinson's abdomen and PRN *("when necessary")* medications were administered following a phone order from after-hours medical staff. An order for a syringe driver was also given. A syringe driver is a powered device used to continuously deliver prescribed medication. Mrs Dickinson continued to be restless at times and family members attended.

The on-call geriatrician, Dr Chamberlen, reviewed Mrs Dickinson between approximately 8.00am and 9.00am and requested a syringe driver be commenced to administer an infusion of morphine, midazolam, haloperidol and gylcopyrrolate (for secretions). He also advised that Mrs Dickinson should have a bolus dose of the same medications to ease her acute pain and distress until the infusion could commence.

A syringe driver was ordered at about 5.00am, likely by Dr Chamberlen's colleague. Dr Chamberlen gave evidence that a syringe driver was only one aspect of providing symptom management in the palliation process. He said that good pain relief may be achieved without a syringe driver.

As it transpired the syringe driver malfunctioned and there was a delay of 5 hours whilst another syringe driver was sourced from the RHH. In respect of this delay, Dr Chamberlen said in evidence that the delay was not overly long, particularly as Mrs Dickinson was being administered medication subcutaneously and this was being carefully monitored. He stated that, ideally, a spare syringe driver should have been available at the RFC. Ms Triffitt gave evidence that the RFC now has two operational syringe drivers and therefore this situation will not arise in future.

I am satisfied that the delay in instituting the syringe driver did not affect Mrs Dickinson's care.

Between 10.00am and 11.00am Mrs Dickinson was noted by staff to be declining, with an altered breathing pattern. She further deteriorated and passed away at 2.15pm. Police and the Coroners Office were notified, along with senior nursing staff and the relevant on-call consultant. Nursing staff spent time with family members, explaining the processes relating to the coronial investigation and the availability of the grief counsellor service. The communication with the family by staff of the RFC was of a high standard.

At autopsy, the then State Forensic Pathologist, Dr Christopher Lawrence, formed the opinion, which I accept, that the final medical cause of Mrs Dickinson's cause of death was pneumonia, likely aspiration pneumonia. I find that her dementia, scapula fracture, liver disease, severe emphysema and palliation medications all contributed to her pneumonia and death.

**Issues at Inquest**

***The family's concerns regarding Mrs Dickinson's care***

Numerous concerns about the quality of Mrs Dickinson's care were raised by Sarah, Shaun and Jonathan. I found it difficult to distil their concerns, as they varied to a degree between their affidavits and oral evidence and were expressed in very broad terms. I will deal below with what I perceive to be their main issues, although it should be clear from the above that I am of the view that Mrs Dickinson was given a high standard of care at the RHH and RFC.

*The lack of an available syringe driver*

I have dealt with this issue above. The delay in commencing medication infusions by syringe driver did not affect the administration of appropriate medication. It is apparent from the evidence of Dr Chamberlen and Dr Cleary that obtaining the correct balance of palliative medication for any individual is a complex process. Unfortunately, in this process, Mrs Dickinson suffered a degree of agitation attributable to her conditions, even though she had full specialist care. The RFC now keeps two operational syringe drivers, so that delay is minimised when they are required for use.

*Mrs Dickinson's diagnosis*

In her oral evidence, but not in her affidavit sworn on 12 February 2020, Sarah said that she believed her mother's correct diagnosis was delirium rather than dementia and, on that basis, she could have overcome that delirium. Sarah also said in her oral evidence but not in her affidavit that her mother's diabetes played a part in her delirium. Sarah, a registered nurse, said in her affidavit that she had come to these realisations concerning her mother's diagnosis during her current studies into dementia care. I do not accept that Sarah is correct in her beliefs regarding Mrs Dickinson's

diagnosis. Dr Chamberlen, a qualified geriatrician, stated in evidence that Mrs Dickinson did have dementia, and that the diabetes did not play a significant role in the dementia or the delirium. Dr Cleary, also Mrs Dickinson's treating geriatrician, diagnosed Mrs Dickinson with dementia. Dr Bell, an independent medical professional specifically tasked to review the medical care, was of the view that Mrs Dickinson suffered, amongst her other serious conditions, irreversible dementia. I accept the evidence regarding diagnoses of Mrs Dickinson's conditions given by the three qualified medical practitioners.

*Alleged lack of oral care*

Shaun, Sarah and Jonathan expressed concern that RFC staff did not sufficiently attend to their mother's cracked lips (due to malnutrition, alcohol abuse and liver disease) and requirements for hydration. I do not consider there is any substance in this criticism. In her thorough consideration of the medical records, Ms Triffitt set out comprehensively the degree to which daily oral care in various forms was assiduously provided to Mrs Dickinson from the time of her admission to RFC until her death. Ms Triffitt's detailed report on this issue was not challenged by counsel, Mr Crotty. Dr Cleary also described the significant efforts that were made in respect of mouth care. I accept that the condition of Mrs Dickinson's lips and mouth was distressing to her children, as was her inability to take adequate oral fluids. However, the efforts of the RFC staff to address these matters throughout her admission was commendable.

*Other concerns*

Other concerns were raised by Mrs Dickinson's children in respect of her care which may be dealt with briefly. These included Mrs Dickinson being left alone in a locked room for long periods of time, refusal of requests for pain relief for Mrs Dickinson and failure to have Mrs Dickinson's arm in a sling. I am satisfied that they are without substance. These issues were addressed by Ms Triffitt and Dr Cleary in their affidavits and were not challenged. Further, there are no entries in the RFC medical records of Sarah, Shaun or Jonathan making such complaints throughout admission. I find that Mrs Dickinson was not left in a locked room and was provided with appropriate pain relief at all times. In respect of the sling, Mrs Dickinson was assessed by a physiotherapist at the RFC. The physiotherapist did not require Mrs Dickinson to wear a sling as she had commenced ambulation with a four wheel walker. The appropriateness of such assessment was not challenged.

*General comments*

I have found that the criticisms of the RFC by Mrs Dickinson's family members have no merit. In coming to this conclusion, I note that the RFC records contain detailed notes of only positive interactions between staff and doctors of the RFC and members of Mrs Dickinson's family. These

notes include complimentary comments by the family members of the care provided to Mrs Dickinson. In oral evidence at inquest, Sarah, Shaun and Jonathan were not able to clearly and credibly articulate specific instances of lack of care and, through their counsel, did not challenge much of the important medical evidence or call their own expert. Dr Bell, in reviewing Mrs Dickinson's care, found that it was of good standard and that, due to her severe underlying illnesses, she followed a not unexpected course of deterioration and there was no ability to improve her medical situation, particularly in respect of her cognitive function. The family members did not call Dr Bell to challenge his conclusions and I accept his opinion.

Understandably, Mrs Dickinson's deterioration in health and cognitive function came as a shock to her family members. It seems that their issues regarding Mrs Dickinson's care are likely a manifestation of their grief. She was relatively young, although her large consumption of alcohol over many years had caused irreversible physical and cognitive damage. Her decline and death over the one-month period of her hospitalisation has undoubtedly caused Mr Dickinson, Sarah, Shaun and Jonathan to question whether more could have been done to treat her. I am satisfied, however, that no other medical treatment could have improved her conditions.

***Alleged objection to autopsy***

Mrs Dickinson's husband and children alleged that an autopsy upon Mrs Dickinson should not have occurred as Shaun (on behalf of Mr Dickinson as Senior Next of Kin under the Act), objected to the performing of an autopsy. This objection was in accordance with Mr Dickinson's wishes. Mr Dickinson, however, did not wish to have communication with the Coroners Office and allowed Shaun to do so on his behalf. The records indicate that the coroner's associate had a discussion with Shaun on 22 January 2018 and conveyed to him that the coroner had determined that an autopsy was necessary. Subsequently, the Coroner's Associate forwarded an email to Shaun requesting confirmation that the family no longer wished to continue with a formal objection. On that same day, Shaun sent an email to the coroner's associate stating that he gave permission for the autopsy to occur. In the circumstances of Mr Dickinson's withdrawal of communication, it was appropriate to take Shaun's "permission" for autopsy to occur as being on behalf Mr Dickinson. In evidence at inquest, Shaun accepted that he was the author of the email and abandoned this complaint, stating that his memory was poor.

***The making of an Emergency Guardianship Order and appointment of the Public Guardian***

The family expressed the view that there was no need to appoint a guardian for Mrs Dickinson and, if there was such a need, then one or more family members should have been appointed rather than the Public Guardian. They also expressed that there was insufficient consultation with them before

the making of the order. It appears that the plan to transfer Mrs Dickinson to the RFC for further assessment and treatment was made at the RHH on 3 January. By that stage, it was apparent that she did not have the cognitive capacity to consent to her transfer and it was deemed appropriate to apply for an Emergency Guardianship Order. I make several comments about this issue.

Firstly, the decision to seek a guardianship order was, in my view, entirely appropriate. I heard evidence from Dr Cleary that the RFC, as a matter of policy, requires patients (I assume those without decision-making capacity) to be covered by formal guardianship orders. This requirement is sound and allows certainty as to the identity of the person from whom consent to medical and residential decisions must be obtained.

Secondly, in Mrs Dickinson's circumstances where an immediate transfer to the RFC was proposed, the only order available was an Emergency Order under section 65 of the *Guardianship and Administration Act* 1995. The provisions of section 65 allow for only the Public Guardian to be appointed, with the order being in force for a period of 28 days. Under the provisions of the *Guardianship and Administration Act,* other persons, including family members, may be subsequently appointed to fulfil the role of guardian. However, the evidence from Ms Targett at inquest was to the effect that this process, under separate provisions of the *Guardianship and Administration Act* took some weeks to complete and certainly could not have been completed by the time Mrs Dickinson needed to be transferred to the RFC.

Thirdly, there was good communication by staff of the RHH to family members concerning the Emergency Order application. The RHH notes contain entries from 4 January onwards about Mrs Dickinson's proposed transfer to RFC and the application for an Emergency Guardianship Order. On 4 January a RHH social worker telephoned Shaun to inform him of the plan for his mother and the application, and Shaun indicated he would speak to his siblings. On the same day the social worker called Mr Dickinson about the plan and Mr Dickinson indicated that he agreed and wanted *"whatever is best for her"*. The Order was made on 5 January, appointing the Public Guardian as Mrs Dickinson's guardian until the Order expired on 2 February 2018. On that date, Ms Targett telephoned one or more of Mrs Dickinson's family members to advise of the Public Guardian's provision of consent for Mrs Dickinson's transfer to the RFC. It appears that one or more family members expressed reservations about the RFC because of a past experience when Mrs Dickinson's mother was a patient several years before. Ms Targett suggested that there be regular communication between staff at the RFC and family members regarding Mrs Dickinson's progress. As discussed, this did occur to a good standard.

In contrast, Ms Targett, on behalf of the Public Guardian, expressed concerns were that there was insufficient consultation between the RFC with the Public Guardian in respect of medical decision-making regarding Mrs Dickinson's treatment between 9 and 19 January 2018. In her report, Senior Guardian, Ms Nicky Targett stated:

> *"I note from the report prepared for the Coroner by Joanne Triffitt, Assistant Director of Nursing, that various medications were administered during Mrs. Dickinson's admission. My consent was not requested for any of Mrs. Dickinson's medical treatment (other than the admission to the RFC) until 19 January, 2018. I was not contacted by any THS staff at all between 9 and 19 January. Therefore I do not consider there was adequate consultation with me or appropriate / lawful medical consent sought for treatment provided during that period of time."*

The terms of the Order required the Public Guardian to consent to all treatment. Apart from Mrs Dickinson's medications prescribed upon her admission to RFC, the evidence indicates that between 9 and 19 January at least seven of Mrs Dickinson's medications (including vitamins) were ceased, no new medications were introduced and there was an increase in the dosage of her Norspan patch on 12 January 2018. Consent should have been sought by the RFC from the Public Guardian to all such changes.

I observe that it was on 15 January that the seven medications were ceased. It was on this date that the medical notes indicate a change of treatment from rehabilitation to "comfort care" in the end-of-life phase. As part of this change the notes indicate that a "rationalisation" of Mrs Dickinson's medications was to take place. The Public Guardian should have been notified of this significant change in Mrs Dickinson's Goals of Care. With the appointment of a guardian comes an obligation to comply with the terms of the Order, which provided independent oversight of important medical decisions.

**Summary of Formal Findings**

I find pursuant to section 28(1) of the *Coroners Act* 1995 that:

a) The identity of the deceased is Mary Marguerite Dickinson;
b) Mrs Dickinson died in the circumstances set out above;
c) Mrs Dickinson died as a result of pneumonia; and
d) Mrs Dickinson died on 20 January 2018 at the Roy Fagan Centre, Lenah Valley in Tasmania.

**Comments and Recommendations**

I **comment** that, for the reasons contained in this finding, the care, supervision and treatment of Mrs Dickinson at the RHH and the RFC was of a very good standard at every level.

I **comment** that the communication by doctors and staff of the RFC with Mrs Dickinson's family members was of a high standard.

I **comment** that it was appropriate for the Public Guardian to be appointed as Mrs Dickinson's Emergency Guardian and that the guardian made reasonable decisions in respect of both Mrs Dickinson's accommodation and medical treatment. However, the RFC should have sought the guardian's consent to all of Mrs Dickinson's medical treatment.

I **recommend** that the RFC implement any necessary procedures to ensure that the consent of the guardian of a patient (whose consent is required in respect of medical treatment and decisions) is obtained in compliance with the terms of the guardianship order and in a timely manner.

In concluding, I convey my sincere condolences to Mrs Dickinson's family.

Dated 5 June 2020 at Hobart Coroners Court in the State of Tasmania.

**Olivia McTaggart**
**CORONER**