MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Olivia McTaggart, Coroner, having investigated the death of Pamela Jacqueline Chamberlain,

Find, pursuant to Section 28(1) of the *Coroners Act* 1995, that

a) The identity of the deceased is Pamela Jacqueline Chamberlain;

b) Ms Chamberlain died in the circumstances set out in this finding;

c) Ms Chamberlain's cause of death was asphyxia; and

d) Ms Chamberlain died on 18 June 2018 at Hobart, Tasmania.

In making the above findings, I have had regard to the evidence gained in the comprehensive investigation into Ms Chamberlain's death. The evidence comprises:

- Tasmania Police Subject Report;
- Tasmania Police Report of Death;
- Affidavits confirming life extinct and identification;
- Opinion of the Forensic Pathologist regarding cause of death;
- Toxicology report, Forensic Science Services Tasmania;
- Affidavits of the four attending paramedics;
- Affidavits of 8 attending and investigating Tasmania Police officers;
- Affidavit of Alice Rene Rose Chamberlain, daughter of Ms Chamberlain;
- Affidavit of Shane Michael Grachan, caretaker of the Common Ground facility;
- Affidavits of Anthony Warwick Fagan, Program Manager of Common Ground;
- Tasmania Police video interview of Eric Brian Osmond;
- Tasmania Police Incident Report;
- ESCAD Incident Report;
- Knopwood Medical Centre records for Ms Chamberlain;
- Psychiatrist (Dr Philip Reid) records for Ms Chamberlain;

- Affidavit of Nicholas Bradford, Communications Team Leader, Ambulance Tasmania;
- Affidavit of Dr Con Georgakas, Director Medical Services, Ambulance Tasmania (Department of Health); and
- Ambulance Tasmania communications records.

Background

Pamela Jacqueline Chamberlain was born in Liverpool, England on 3 March 1963 and was 55 years of age at the time of her death. Ms Chamberlain was a twin and was one of six siblings. The family moved to Australia when she was about seven years old. Ms Chamberlain married Jeffrey Chamberlain in 1986 and they had three children together; Alice, Kyle and Tom. Ms Chamberlain separated from her husband at a time between 1999 and 2002. Ms Chamberlain spent most of her working life in the retail sector and hardware industry as a sales assistant. At the time of her death she was unemployed.

Health

Ms Chamberlain's physical and mental health began to deteriorate in the late 1990s with deaths in her family and the breakdown of her marriage. Records from Tasmania Police indicate that Ms Chamberlain attempted suicide in 2005, 2007 and 2013. Treating mental health professionals over a period of time considered, variously, that she suffered from mood disorder, substance abuse, personality disorder and late-onset schizophrenia.

Ms Chamberlain moved into the Common Ground housing facility on Campbell Street in approximately 2013. The Common Ground housing facility is operated by the Salvation Army in order to provide safe and secure accommodation for vulnerable members of the Tasmanian community who are eligible for social housing. The complex contains 51 independent accommodation units for the residents with staff member(s) on-site on a daily basis to conduct administrative functions, reception duties, cleaning and maintenance, security, visitor access, basic psychosocial support, reporting and CCTV monitoring.

In 2013 Ms Chamberlain began attending Knopwood Medical Centre where she regularly saw general practitioner, Dr Shaunagh Jones. Medical records indicate that Ms Chamberlain was being treated for depression, insomnia, alcohol abuse, schizophrenia, seizures, excessive weight gain, shortness of breath on minimal exertion, chronic back pain and addiction to prescription pain medication. At her time of death Ms Chamberlain was prescribed a number of medications including, diazepam, venlafaxine, risperidone, pregabalin and Suboxone.

In the months prior to Ms Chamberlain's death, Dr Jones had raised concerns about Ms Chamberlain's weight and health risks due to shortness of breath. Ms Chamberlain was characterised as morbidly obese, weighing 124.4 kilograms and being 163 centimetres in height at her time of death. Ms Chamberlain was referred to Dr Phillip Reid, psychiatrist, to investigate changing her antipsychotic medication to assist with weight loss and her shortness of breath. In April 2018 Dr Reid provided some suggestions regarding appropriate alternative medications for Ms Chamberlain.

Circumstances of death and the coronial investigation

On Monday 18 June 2018, Ms Chamberlain visited a friend, Mr Eric Osmond (who lived in another unit of Common Ground) for dinner. It was common for Ms Chamberlain and Mr Osmond to have dinner together. Mr Osmond prepared the dinner, consisting of scotch fillet steak with peppered mushroom sauce, roast potatoes, tomatoes and coleslaw. During this time, Ms Chamberlain used the bathroom four times. On the first and second occasions Ms Chamberlain went to the bathroom, she was in the bathroom for approximately five minutes and when she came back out, she complained of having difficulty going to the toilet. On the third occasion, she called out to Mr Osmond for help as she had her shirt over her head and needed assistance removing her bra. It is not clear what might have prompted Ms Chamberlain to wish to remove her bra.

Ms Chamberlain then began to eat her meal, which had been served by Mr Osmond. She had eaten a mouthful of steak when, again, she got up and went to the bathroom. Mr Osmond heard a thump and he began yelling out to Ms Chamberlain but she did not reply. It was not until the bathroom door closed that Mr Osmond went in to check on Ms Chamberlain. He located her lying on her left side on the bathroom floor and observed that her skin looked blue in colour and she was unresponsive. At 8.40pm Mr Osmond called an ambulance and begun to administer CPR, albeit ineffectively. Two Ambulance Tasmania units were dispatched immediately from Melville Street headquarters, a distance of approximately 100 metres from Common Ground.

Whilst attempting to administer CPR to Ms Chamberlain, Mr Osmond called the on-site caretaker for Common Ground, Mr Shane Grachan, to assist. Mr Grachan attended Mr Osmond's unit and took over communicating by phone with the Ambulance Tasmania operator.

Two Ambulance Tasmania units were dispatched at 8.42pm. One was a team of intensive care paramedics. Both units had arrived at the main door of Common Ground by 8.45pm. However, upon their arrival, the paramedic crew could not access the entrance to the

building as there was no staff member on the ground floor to provide access and they did not have in their possession access details for the building. At this time, several phone calls between the paramedics and Ambulance Tasmania State Operations Centre were made regarding access to the building. The Ambulance Tasmania telephone operator also made several requests to Mr Osmond, and then to Mr Grachan, to provide access to the paramedics through the front doors. As a result, Mr Grachan left the unit on the third floor where he had arrived to assist with CPR upon Ms Chamberlain and returned to the ground floor to open the front door. Upon allowing access, he led the paramedics up a lift and through a further two locked doors, requiring swipe access, to reach Ms Chamberlain.

The paramedics reached Ms Chamberlain at 8.50pm. They found Mr Osmond administering ineffective CPR to her and then took over resuscitative efforts. During resuscitation, paramedics retrieved a large piece of meat from Ms Chamberlain's airway. At 9.37pm Ms Chamberlain was taken by ambulance to the Royal Hobart Hospital where, despite advanced resuscitative efforts, she died in the Department of Emergency Medicine at 10.03pm.

It was established by the forensic pathologist, Dr Donald Ritchey, at autopsy that Ms Chamberlain died as a result of asphyxia due to choking on food. A contributing factor was the combination of multiple prescription and non-prescription drugs ingested by her. Most of the drugs identified in Ms Chamberlain's samples were central nervous system depressants that likely had the effect of depressing her pharyngeal reflexes, thus increasing the risk of choking. It is appears upon the evidence that not all of the substances detected in her system were currently prescribed to her and I note that her medical history involved addiction to pain medication. Dr Ritchey specifically stated that presence of the drug atropine in Ms Chamberlain's blood sample is likely to have had the effect of drying the normal gastrointestinal secretions such as mucous and saliva that may have increased the risk of choking. He further noted that Ms Chamberlain's obesity may have contributed to her risk of choking. I accept Dr Ritchey's conclusions.

I find, therefore, that Ms Chamberlain died as a result of her airways being blocked by a piece of steak. I am satisfied that there are no suspicious circumstances surrounding her death and that Mr Osmond did his best to assist her during the event.

Comments and Recommendations

A thorough investigation has taken place into the circumstances surrounding Ms Chamberlain's death. The particular issue of concern in this investigation involved a delay of approximately six minutes in the paramedics being able to gain access to Ms Chamberlain in the unit. If their access had been unimpeded, there would have been an earlier opportunity

to remove the obstruction from her airway and implement resuscitation measures in this critical period. If this had occurred, it is possible that she might have survived.

The evidence indicates that the manager of Common Ground had, in 2015, provided Ambulance Tasmania with the code to access Common Ground's lock box which contained the key or swipe card to access the relevant unit within the facility in the event that a staff member could not provide access.

The time taken to finalise this case has been partly due to delays in receiving information and from Ambulance Tasmania to adequately explain issues relating to its inability to access the units within Common Ground. Accordingly, I convened two case management conferences, after which I received a helpful and comprehensive affidavit of Dr Con Georgakas, Director Medical Services, Ambulance Tasmania.

In his affidavit, Dr Georgakas acknowledged that the manager of Common Ground had supplied the access information to Ambulance Tasmania in 2015 but explained the issue as follows:

> "In 2018 Ambulance Tasmania was using the Guardian Command Computer Aided Dispatch system (GCAD).
>
> The GCAD system did have the capability to hold property access information, however, the system did not have the capability to push information to the call-taker and then provide a link to this information to the call-dispatcher. GCAD also required a call-dispatcher to manually search for the information. This meant that even if information had been entered into the system, it was difficult to access. This impacted on ambulance dispatch times.
>
> GCAD was also unreliable in transferring information to mobile and data devices. If information such as access instructions needed to be conveyed to ambulance crews this could only occur via a non-encrypted radio network that would make access information accessible to any person with scanners. This meant that the use of the system to convey access information may have resulted in a significant security risk.
>
> Given the above deficiencies, it was not considered practical for Ambulance Tasmania to maintain and update this information in GCAD. This was because the system was unlikely to be able to be effectively used for the purposes of storing access information given the considerable search difficulties and issues with security.
>
> As a result of the above listed issues and concerns, it was not routine practice for Ambulance Tasmania to hold access information within Guardian Command and the

> access codes for Common Ground, received in 2015, do not appear to have been entered into this system.
>
> I am not aware whether any response was provided to Common Ground in 2015 to indicate that this code had, or had not, been uploaded into any of the Ambulance Tasmania systems."

I accept the analysis of Dr Georgakas above and also accept that the GCAD system was not conducive to securely, easily and efficiently conveying important information concerning the destination address to dispatched Ambulance Tasmania units.

I am satisfied that Ambulance Tasmania did not provide a response to Common Ground subsequent to 2015 to advise that the code provided had not been uploaded into Ambulance Tasmania systems and did not initiate any further discussions with Common Ground to address the issue of this crucial information not being readily available to ambulance crews dispatched to the building. From the perspective of Common Ground, provision of the code to Ambulance Tasmania was sufficient to provide ambulance crews with access to the front entrance and all levels of the building.

I observe upon the evidence that the attendance of Ambulance Tasmania at Common Ground is a common occurrence. I note, in particular, the evidence of Mr Anthony Fagan, Program Manager of Common Ground, that there is an average of about three ambulance callouts per fortnight to the facility *outside* the hours of 8.00am until 5.00pm. The evidence indicates that the facility was staffed outside those hours with only one staff member or no staff members at all (overnight). It was not within the scope of the investigation to determine how the ambulance access issues affected those callouts, although it appears that they did not involve a potentially preventable death until the callout in respect of Ms Chamberlain.

In 2019 Ambulance Tasmania implemented a new dispatch system to replace GCAD, being the Emergency Services Computer Aided Dispatch (ESCAD) system. The ESCAD system has the capacity to store access information and alerts and also for emergency services to share alerts and access information. Unlike the GCAD system, the ESCAD system flags information to the call-taker and provides a link to the call-dispatcher. This information can then be sent to crews' mobile data terminals as part of dispatch information in a timely and secure manner.

In June 2019 Ambulance entered into the ESCAD system the requisite Common Ground access details, lock box codes and a contact phone number.

I am satisfied that, with the introduction of ESCAD and the entering of the requisite details for Common Ground, this addressed the access issues impacting upon the ability of the paramedics to access and resuscitate residents requiring urgent medical attention.

I take this opportunity to encourage managers of housing and residential facilities to provide necessary access details to Ambulance Tasmania or to update Ambulance Tasmania with any changes in access details.

I extend my appreciation to investigating officer Constable Luke Von Wald and coroner's associate, Jessica Haight, for their assistance in this investigation.

The circumstances of Ms Pamela Chamberlain's death are not such as to require me to make any recommendations pursuant to Section 28 of the *Coroners Act* 1995.

I convey my sincere condolences to the family and loved ones of Ms Chamberlain.

Dated: 29 July 2022 at Hobart Coroners Court in the State of Tasmania.

Olivia McTaggart
Coroner