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

JILLIAN ANN WOOLLEY

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 Jillian Ann Woolley, with an inquest held at Hobart in Tasmania, make the following findings:

Hearing Date

28 January 2022

Representation

Counsel Assisting: S Nicholson

Counsel for Department of Health: E Lim

Counsel for Professor Michael Ashby: T Cox

Counsel for Dr Alison Cleary: C Law

Introduction

Preliminary

1. Jillian Ann Woolley was born on 16 August 1956 and was aged 58 years at the time of her death. She was the mother of 5 children and was divorced. Mrs Woolley had suffered epilepsy since early childhood. However, until about 2008, she was active, enjoyed walking and darts, and was generally happy and in reasonable health.
2. In 2009 Mrs Woolley was hospitalised due to continuous and uncontrolled epileptic seizures which caused a brain injury. During that year, she was also diagnosed with fronto-temporal dementia (FTD). This diagnosis was possibly linked to her seizures. FTD is a progressive, irreversible and terminal neurodegenerative disease which typically commences between 50 and 60 years of age, with a life expectancy of 4 to 6 years from the time of diagnosis.[1] The disease causes atrophy of the frontal and temporal lobes of the brain, and therefore may cause progressive and extreme behavioural changes in the sufferer, amongst other debilitating effects.
3. Mrs Woolley's condition and symptoms over the following years worsened, and family members were required to assist with her care. Unfortunately, she began to suffer

[1] Exhibit C21 Affidavit of Dr Alison Cleary p 1.

marked behavioural and psychiatric symptoms, including wandering, aggression, frequent calling out and distress. She also needed significant assistance with activities of daily living.

4. In 2011 she was admitted as a resident of Strathaven Aged Care Facility and the Public Trustee was appointed as administrator of her estate.

5. In late 2013, Mrs Woolley started to deteriorate rapidly. At that time she was assessed by Dr Alison Cleary, geriatrician. Dr Cleary subsequently assessed and treated Mrs Woolley until her death.

6. On 6 January 2014 Mrs Woolley was transferred to ADARDS, a secure nursing home, under the authority of a short-term Guardianship Order, with the Public Guardian appointed as her guardian. Mrs Woolley's condition worsened further to the point where, on 27 August 2014, she was transferred to the Roy Fagan Centre (RFC) with the consent of the Public Guardian pursuant to a three year Guardianship Order made on 24 April which was limited in its terms to decisions concerning where Mrs Woolley was to live, either permanently or temporarily.

7. RFC is a specialised facility operated by Statewide Mental Health Services to assess and treat elderly persons with mental illness and dementia. It is also an approved assessment centre and approved hospital under the *Mental Health Act* 2013. Admission to RFC is either voluntarily, or under the authority of *Guardianship and Administration Act* 1995 or *Mental Health Act* 2013.[2]

8. During her admission to RFC, efforts were made to address any reversible causes of her escalating symptoms. However, she continued to exhibit severe and distressing behavioural and psychiatric symptoms arising from her condition. The evidence indicates that her mental state was such that she did not have capacity to make decisions in respect of her care or treatment. Additionally, Mrs Woolley was becoming increasingly physically dependent with numerous physical and bodily functions deteriorating as a consequence of terminal 'brain failure'. Significantly, her ability to swallow safely had started to deteriorate.[3]

9. At the time of her admission to RFC, Mrs Woolley was identified by her treating medical team as being in the "pre-terminal" stage of her disease and her Goals of Care were assessed as being in category "C". The Goals of Care framework is widely used by clinicians to make effective and consistent decisions relating to limitations of medical treatment and for documentation of those decisions.[4] Goals of Care Category

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[2]Roy Fagan Centre, 'Older Persons Mental Health Services', (Booklet, July 2022) https://www.health.tas.gov.au/sites/default/files/2021-12/OPMHS_Roy_Fagan_Centre_A5_Booklet_DoHTasmania2018.pdf.

[3] Exhibit C21 (n 1) p 4.

[4] Exhibit C20 Affidavit of Michael Ashby p 10 Annexure A, Thomas et al, 'Goals of care: a clinical framework for limitation of medical treatment' (2014) 201(8) *The Medical Journal of Australia* 452.

C signifies a treatment approach of palliative management and non-invasive medical support. For patients in this category, comfort and dignity preservation are the prime goals of medical treatment. The period of survival is no longer the sole determinant of treatment choice.[5]

10. Specialist review of Mrs Woolley by Professor Michael Ashby, consultant physician in palliative care, took place. In accordance with the Goals of Care, it was recommended that heavy sedation should be administered as the only way to overcome her severe distress, but with the consequence that Mrs Woolley would almost certainly die. Many discussions, comprehensive in content, were held between treating doctors, social workers and Mrs Woolley's children, who consented to this approach to their mother's treatment.

11. Therefore, from 4 September 2014, various medications (notably, levomepromazine and phenobarbitone) were used and doses titrated to induce sedation. Mrs Woolley was noted to gradually become less distressed with the sedation and she passed away on 18 September 2014.

The coronial investigation

12. Mrs Woolley's death was reported to the coroner and an investigation commenced.

13. I commenced an investigation into Mrs Woolley's death because, upon the basis of the medical evidence, her death was a reportable death under the *Coroners Act* 1995 ('the Act') being a death that *appeared* to have been unnatural as it resulted in significant part from the administration to Mrs Woolley of sedating substances. The forensic pathologist reported that Mrs Woolley died as a result of aspiration pneumonia following palliative treatment for FTD. Further, initial opinion received in the investigation suggested that Mrs Woolley's prognosis for her FTD (and absent palliative sedation) may have been several years post her actual date of death. With the benefit of all the evidence, I am now satisfied that this was not the case and that her death was expected to occur in the months after her arrival at RFC.

14. Alternatively, in assuming jurisdiction, I considered that Mrs Woolley may have been a *"person held in care"* because she could be said to have been detained in RFC, being an "approved hospital" – as that term is defined under the *Mental Health Act* 2013.

15. As the investigation progressed, and particularly prior to the more recent receipt of an opinion of an independent palliative care specialist, questions arose concerning, *inter alia*:

    - The appropriateness of the trajectory of sedation;
    - The information provided to family members;

[5] Ibid p 3[19]; p 1[5].

- The role of an independent advocate for Mrs Woolley; and
- The desirability of a guardian being appointed to make medical decisions on her behalf.

16. In addition, questions arose regarding the ability of the family to understand the process, given their own limitations. Concerns were also expressed by some family members regarding the process of palliative sedation leading to her death. These issues were important because of Mrs Woolley's own inability to consent to sedation that may contribute to or hasten her death.
17. The investigation has unfortunately been protracted. Much of the delay has been as a result of attempting to obtain independent expert opinion and the complexity of the matter generally. Other delays have been within the Coronial Division and my own.
18. Given the issues under consideration in the investigation, I determined that, at the very least, an inquest should be held pursuant to my discretion under section 24 (2) of the Act.

Jurisdiction

Was the death reportable?

19. As the matter approached inquest, counsel for the Secretary of the Department of Health, counsel for Professor Ashby and counsel for Dr Cleary all submitted that Mrs Woolley's death was not a reportable death under the Act and therefore I had no jurisdiction to hold an inquest. On 23 December 2021, I ruled that Mrs Woolley's death was a death reportable to the coroner. My ruling is attached to this finding, although I will replicate some of my reasoning below.
20. Under the Act, a coroner has discretion to hold an inquest into a death which *"the coroner has jurisdiction to investigate"*.[6] A coroner has jurisdiction to investigate a death if it *appears* to the coroner that the death is or *may be* a reportable death.[7] Relevantly to Mrs Woolley's death, a reportable death is defined under the Act as a death that *appears* to have been unnatural.[8] For good policy reasons, a coroner is not required to be positively satisfied that death is unnatural before assuming jurisdiction to investigate.
21. Upon the evidence available to me at the time of reporting, at the time of my ruling and prior to inquest, Mrs Woolley's death reasonably appeared to be a death that may have been categorised as "unnatural". By this, I mean that one significant cause of her death may have been the external administration of palliative medication. The

[6] *Coroners Act 1995* (Tas) s 24(2) ('*CA*').
[7] Ibid s 21.
[8] Ibid s 3.

definition of "reportable death" in the Act does not, on its face, make any exception for circumstances where death appears to have occurred when it did because of the external administration of palliation substances (causing aspiration pneumonia as the terminal event) rather than wholly as a result of the natural course of her underlying condition.

22. What is a natural or unnatural death is not defined in the Act and the concepts are not without difficulty in many cases. I have recently dealt with this vexed issue in the context of death resulting from mesothelioma.[9] Assessment of causative or contributing factors in death is also difficult in many cases. For example, coroners regularly encounter cases of falls in the elderly which lead to death where palliative care medications are ultimately and properly administered. In such cases, the cause of death is most often found to be only the effects of the injury and pre-existing co-morbidities.[10] These issues involve consideration of circumstance and degree, and sometimes, an assessment of whether any deficits or breaches of duty by any person have played a significant causal role.

23. Noting the low threshold test, and the issues arising on the evidence, I found that Mrs Woolley's death *appeared* to be unnatural and I determined that I had jurisdiction to investigate and hold an inquest on the ground that it *may* have been reportable.

Death in care

24. Before my ruling, counsel for the Department of Health also made comprehensive submissions that Mrs Woolley was not a person held in care immediately before her death and therefore I was not required by the Act to hold an inquest.

25. I did not deal with this issue in my ruling, given the proximity to inquest. Regardless of whether Mrs Woolley's death was a "death in care", I ruled that, pursuant to section 24 (2) of the Act that it was desirable to hold an inquest for reasons including the following:

    a) To assist family members in understanding the medical processes prior to the death of Mrs Woolley; and

    b) To hear oral evidence from witnesses who were capable of assisting me in understanding Mrs Woolley's condition, the prognosis, the processes and principles applicable to her palliative sedation, communications with the family and guardianship issues.

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[9] Investigation into the death of David Mann.

[10] See *Bell v The State Coroner* [2017] WASC 97 where the Supreme Court of Western Australia upheld a coroner's decision that a death was not reportable where someone died by natural causes in the context of palliative treatment with medications and doses expected to be used in a palliative patient with his serious existing conditions. However, each case must turn upon its own facts in respect of contributing causes of death.

26. I now find, accepting counsel's submissions, that Mrs Woolley was not a person held in care for the following reasons.

27. If a person is held in care immediately before their death, that death is a reportable death and an inquest is mandatory.[11] In such cases, there is an additional requirement imposed on the coroner to report on the care, supervision or treatment while that person was held in care.[12]

28. A person held in care is defined in the Act as "*a person detained or liable to be detained in an approved hospital within the meaning of the Mental Health Act* 2013 *or in a secure mental health unit or another place while in the custody if the controlling authority of a severe mental unit, within the meaning of that Act.*"[13]

29. The guardianship order for Mrs Woolley that was current at the time of her death did not extend to health care decisions, and throughout her admission to RFC those decisions were made by Mrs Woolley's children as responsible persons within the meaning of section 4(1)(c)(iv) of the *Guardianship and Administration Act* 1995.[14]

30. Recently, in another investigation, I determined (giving detailed reasons), that a deceased person who died as a result of advanced dementia in RFC and who was subject to coercive orders under the *Guardianship and Administration Act* 1995, was not a person held in care.[15]

31. I made this determination because the phrase "*within the meaning of the Mental Health Act 2013*" attaches to the entirety of the clause "*a person detained or liable to be detained in an approved hospital*". I found that the result of this interpretation meant that the detention or liability to detention of a deceased person must apply only to persons with a mental illness within that definition under the *Mental Health Act*, and not otherwise. This is the case even if death occurred within an approved hospital. Therefore, not being a person held in care, an inquest was not mandated under the Act.

32. The same approach applies to the facts surrounding Mrs Woolley's death. Fronto-temporal dementia is not a mental illness under the *Mental Health Act* and she was not, consequently, detained or liable to be detained under any provision of that Act. Mrs Woolley was therefore not a person held in care.

33. I am not therefore required on this ground to hold an inquest and I am under no requirement to report upon her care, supervision and treatment.

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[11] CA (n 6) s 24(1)(b).
[12] Ibid s 28(5).
[13] Ibid s 3.
[14] Meaning a person who is aged 18 years or older and a relative of the person subject to the Order.
[15] *Kirk, Rodney* 2022 TASCD 198; see also *Callinan, Damien* 2022 TASCD 199.

Scope of inquest

34. This inquest considered the following:

    a) The matters required for finding under section 28 (1) of the Act;

    b) Whether Mrs Woolley was a person 'held in care' under the Act (dealt with above);

    c) Whether the consultation with the family regarding the decision to palliate Mrs Woolley was adequate; and

    d) Whether the decision to palliate Mrs Woolley was in accordance with current, appropriate and ethical practice.

Evidence in the investigation

35. The documentary evidence in the investigation, which was tendered at inquest, comprises exhibits C1 to C21. The exhibit list is annexed to this finding.

36. At inquest, the following witnesses provided oral testimony:

    - Mr James Ratcliffe, son of Mrs Woolley;
    - Dr Christopher Lawrence, the forensic pathologist who examined Mrs Woolley;
    - Dr Michelle Gold, independent expert witness who reviewed Mrs Woolley's treatment and palliative care decisions;
    - Dr Alison Cleary, the geriatrician who treated Mrs Woolley; and
    - Professor Michael Ashby, the palliative care consultant who treated Mrs Woolley.

Circumstances surrounding death

37. Mrs Woolley's care records from ADARDS nursing home indicate that, at the time of her admission, she was observed to be mostly quiet and very dependent. She required assistance in relation to her personal care needs. Although she required assistance, she was continent with scheduled toileting and would eat when prompted. It was noted that Mrs Woolley could become agitated by new surroundings and people. However, she took medication easily and generally accepted care.[16] Soon after arriving in January 2014, Mrs Woolley's condition began to steadily and rapidly deteriorate. The notes detail increasing agitation, including confusion and anxiety, as well as aggressive and violent behaviour, both physical and verbal.

[16] Exhibit C9 ADARDS Records, Progress Note 3 January 2014.

38. Dr Alison Cleary was Mrs Woolley's treating geriatrician and was asked to review her on 11 August 2014. This was after staff at ADARDS reported a further worsening of symptoms of FTD.

39. Dr Cleary reviewed her condition on 13 August 2014 and assessed Mrs Woolley as having deteriorated to a pre-terminal stage.[17] Her advice was that the aim for care would be a palliative approach with admission to RFC under her care.[18] She noted that she discussed with Mrs Woolley's sons and daughter the management plan and promoted a comfort care plan. She specifically advised her daughter, Vanessa Burke ("Vanessa") that her mother's life expectancy was weeks to a few months and that the aim was for comfort and to provide dignity. At that time, Vanessa said she would discuss the care plan with her brothers, James Ratcliffe ("James") and Michael Buckley ("Michael"). At that stage, James and Michael were expressing distress at their mother's terminal decline.

40. On 27 August 2014 Mrs Woolley was therefore admitted to the Jasmine Unit of the RFC –due to her high care needs, severe agitation and distress. As noted above, a Goals of Care Plan for Category C was completed on 27 August 2014 specifying the goals of care as palliative, with Mrs Woolley "*not for CPR, intubation or ventilation*".

41. In her affidavit, Dr Cleary described in detail the severe ongoing distress experienced by Mrs Woolley and also explained that at her severe stage of dementia, a person becomes increasingly physically dependent with numerous physical and bodily functions deteriorating as a consequence of terminal "brain failure". She explained, for example that bladder and bowel functions may be lost as well as the ability to swallow and mobilise. In Mrs Woolley's case, Dr Cleary stated that her agitation and tormented distress was evidenced by screaming, physical resistance, rejecting personal care and nutrition, lashing out, aggression with staff in harm to herself (thus sustaining injuries which added to her suffering.) Mrs Woolley had increasingly substantial care needs and reached a point of demonstrating almost constant agitation, screaming, and unsettledness. Regularly, she required up to three nurses to administer basic care. Dr Cleary said that these caring duties were being performed "at risk" to Mrs Woolley and the staff due to her highly combative and aggressive responses.

42. Dr Cleary stated:

> *"...without the provision of palliative care, a person in this phase of dying may have immense suffering, often screaming in torment, physically distressed and in mental agony. If they are unable to have basic hygiene provided, clothing changed, bedding changed and receives skin care and protection from injuries, that person is then at risk*

[17] Exhibit C21 (n 1) p 3.
[18] Exhibit C7 letter dated 20 August 2014.

of suffering pressure sores, lying in faeces, skin wounds and bleeding, severe infections and probable bone fractures occurring from falls whilst attempting to mobilise. If fractures occur they may be untreatable e.g. to the ribs or pelvis. A person is then in untreatable pain until death."[19]

43. Dr Cleary said that following Mrs Woolley's admission to RFC supportive counselling was provided to all family members by herself, social workers, medical registrars and senior nursing staff on a daily basis. She said that the medical team met regularly with the family and provided multiple phone updates.[20]

44. Dr Mark Campbell, geriatrics registrar, was also involved in Mrs Woolley's care at RFC. A review by Dr Campbell on 1 September 2014 noted that both non-pharmacological and pharmacological attempts to calm Mrs Woolley's behaviours had been unsuccessful.

45. On 2 September 2014 a geriatrics multidisciplinary meeting involving Dr Cleary was held regarding Mrs Woolley's ongoing and escalating agitation and aggressiveness with staff and the lack of success with medications. At that meeting it was decided that Professor Ashby, palliative care specialist, would review Mrs Woolley's treatment and care. Professor Ashby, as a consequence of the request for advice, attended and arranged a family meeting to discuss Mrs Woolley's future management. Before attending the meeting, Dr Ashby saw Mrs Woolley and was provided with significant information about her condition from Dr Cleary.

46. The family meeting involving Professor Ashby took place on 3 September 2014. The recorded notes of the meeting were as follows:

> *"Family meeting – staff present: Dr Cleary, Professor Ashby, palliative care registrar Amy, geriatrics registrar Mark, social worker Dimity Davies, family members – Michael and James (sons), carer Cory, daughter Vanessa (on speakerphone).*
>
> *After introductions were made Dr Cleary did a brief re-cap of Jillian's history with regards to her progressive dementia and her previous hospitalisation at RFC and subsequent stay at ADARDS NH.*
>
> *She discussed the symptoms (distress, agitation, calling out and physical aggression) that Jillian has manifested during the last several months.*

[19] Ibid p 4.
[20] Exhibit C20 (n 4) p 9.

In spite of extra sedatives, anti-psychotic medications at varying doses, analgesia and empiric treatment of a UTI Jillian continues to manifest these behaviours and does seem to be suffering.

Professor Ashby discussed the fact that we have run out of tools to keep Jillian calm, comfortable and awake. He advocated for the idea of heavy sedation to keep her comfortable and preserve her dignity and that over days to weeks her body would shut down and she would die.

Dr Cleary discussed terminal care and how Jillian would be unable to eat, and mouth care would be performed so she would unlikely feel any hunger or thirst and the use of any type of tube feeding or nutrition would not be undertaken.

Prof Ashby reiterated that the goal of this therapy would be to provide comfort and dignity and not necessarily hasten the dying process but that this might occur as a secondary effect.

Jillian's sons were quite tearful and emotional during the course of the discussion

Vanessa stated her intention to come to town this Friday – she would like to take several days to discuss this with her brothers and the rest of her family prior to any initiation of the type of sedation being proposed.

The family will spend some time discussing the above and will revisit this on Friday."[21]

47. Following that meeting, Dr Cleary discussed with Professor Ashby his advice regarding suitable medication for sedative, anxiolytic and anticonvulsant effects for Mrs Woolley. Dr Ashby recommended levomepromazine and phenobarbitone which Dr Cleary had not used previously in clinical practice but accepted his advice due to Mrs Woolley's complex needs and to provide safe delivery of care to her and promote her dignity. Dr Cleary noted that as of this date, the overall aim of treatment for Mrs Woolley was to reduce her significant episodes of agitated distress and suffering, acknowledging that the secondary effects of the treatment were sedation and reduced oral intake during the terminal phase.

48. On the same day, Dr Cleary met again with family members who had questions. Dr Cleary's notes of this meeting are as follows;

"Family asked me to re-attend after their discussion:

[21] Exhibit C8 p 590-591.

Answered questions re medication, doses and expected effects

Discussed likely take days-weeks

Vanessa expressed their wish that we initiate medication this week. They want some relief from distress for their mother

I proposed initially using Nosenan at 25 mg BD and up-titrating.

Also explained use of phenobarb if Nosenan becomes less effective

Family are happy with this plan

Explained we will take each day 'as it comes' and titrate medicines and care as appropriate

Re-informed that Jillian will remain at RFC for this ...indecipherable... *and for terminal phase*

Plan: order treatment via pharmacy

Initiate Nosenan when available at 25 mg BD

Ongoing palliative care input as required

Family counselling"

49. Professor Ashby said in his affidavit for the inquest that he believed that Mrs Woolley's family received full information on diagnosis, prognosis and the treatment plan. He said that they did not appear to object at any stage to the treatment proposed and implemented. He said that it was made clear that there was no way to retrieve dignity and comfort without sedation to the point of being confined to bed and sleepy, and that this would lead to unconsciousness and death. He said that it was made clear that she had nothing to look forward to except more extreme symptoms, that more gentle sedation had failed, and that there was no prospect of recovery or remission of symptoms. He said that he did not receive any communication from the treating team at the time that there was any family disagreement about the treatment plan and its inevitable outcome.[22]

[22] Exhibit C20 (n 4) p 7[35].

50. On 4 September 2014 a geriatrics multidisciplinary meeting was held and the notes of that meeting indicated that the family were agreeable to Mrs Woolley's increased sedation.[23]

51. On 4 September 2014 levomepromezine (Nosenan/Nozinan) commenced at a low initiation dose, and her medications were rationalised due to her variable and high risk swallowing safety. However, the records indicate that over the following four days, Mrs Woolley remained extremely distressed, hostile and physically aggressive towards staff. She was also noted to have struck her son, James, twice in an unprovoked manner.

52. On 8 September 2014, the plan for delivery of Mrs Woolley's medications by syringe driver commenced. Notes indicate that this syringe driver contained midazolam, morphine and levomepromazine.

53. The medical notes for this day indicate that James and Vanessa were agreeable to commencing the syringe driver. Dr Campbell's notes state: "*they express understanding that Jillian's response to sedation might be unpredictable and it is unclear how long it will take before she enters a terminal phase. All questions answered.*" It is also noted that, on the same day, family members were also spoken to by the RFC social worker, who offered support and information.

54. The following day, Mrs Woolley was still agitated and highly distressed. The levomepromezine was increased, and increased again the next day. The midazolam was also increased. Despite further review of syringe driver medications by Dr Campbell, she was still in agitated distress. At this time Mrs Woolley was still accepting some soft foods orally and was being given some medications as oral syrup.

55. By late in the day of 11 September 2014, Dr Cleary noted that with the increasing doses of medication, Mrs Woolley's mobility had decreased as had her oral intake. However, she was overall more settled and at peace. Dr Cleary then commenced phenobarbitone in a second syringe driver. Before doing so, she discussed Mrs Woolley's management with James and Vanessa and, in particular the plan for commencing the second syringe driver with phenobarbitone to help with her seizures and agitation. She also explained to the family Mrs Woolley's significant loss of oral intake and anticipated physical decline.

56. Mrs Woolley's phenobarbitone increased on 12 September 2014 on the advice of Dr Amy Chow, palliative care registrar under Professor Ashby. Notes for 13 September indicate that she had become generally peaceful and was rouseable to physical contact.

57. The following day, 14 September 2014, Mrs Woolley was no longer responsive to stimuli and not accepting fluids or nutrition. She did not rouse with hygiene care.

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[23] Ibid p 593.

58. On 15 September 2014 Mrs Woolley's breathing had become shallow, and she was not in distress. Dr Campbell met with James and Vanessa and discussed her clinical course towards death expected over the following days. Dr Campbell offered them counselling and pastoral services. No further changes were made to Mrs Woolley's medication. Dr Cleary contacted the coroner's office regarding reporting Mrs Woolley's impending death. It appears that, apart from one episode of restlessness, Mrs Woolley remained quiet and unresponsive. Family members spent much time by her bedside over the last days before her death. The medical notes over the several days before her death indicate that Mrs Woolley was in progressive terminal decline with changes in breathing patterns and an increase in lung secretions.
59. At 6:08am on 18 September 2014 nursing staff noted that Mrs Woolley had ceased breathing and had passed away. Her family members were notified and her death formally reported to the coroner.

Medical evidence regarding cause of death

60. Forensic pathologist, Dr Christopher Lawrence, performed an autopsy upon Mrs Woolley in commencement of the coronial investigation. In concluding his autopsy report, he stated regarding cause of death;

> *"This 58 year old woman, Jillian Ann Woolley, died as a consequence of aspiration pneumonia following palliative treatment for fronto-temporal dementia.*
>
> *The decedent developed dementia in 2008. She had an episode of status epilepticus and got an acquired brain injury in 2009. She has been in a nursing home since 2011. She has been a complex management problem and was transferred to the Roy Fagan Centre on the 27th August 2014. She was a difficult management problem due to her behaviour. She was treated with palliative care and ultimately died.*
>
> *Autopsy reveals brain changes consistent with fronto-temporal dementia. There is no evidence of vascular dementia. There is consolidation of the lungs which is probably a consequence of aspiration pneumonia.*
>
> *Toxicology reveals therapeutic levels of phenobarbitone, olanzapine, morphine, citalopram and midazolam."*[24]

61. In his court evidence, Dr Lawrence explained that in a healthy and conscious person, there are a number of reflexes and controls preventing inhalation of food. In cases of

[24] Exhibit C4 Post Mortem Report p 11.

sedation, he said, those reflexes are depressed and food can be inhaled. When this occurs, it causes infection. Dr Lawrence also stated that aspiration pneumonia is often a terminal feature of dementia. He said that aspiration could also occur as a result of epilepsy. He examined Mrs Woolley's lungs at autopsy and gave evidence that the aspiration process had been happening for a period of likely weeks. He gave evidence that Mrs Woolley appeared well cared for upon examination of her physical state.

62. Dr Lawrence, in evidence at inquest, was unable to determine the extent to which the sedating medications caused or contributed to death. He stated in evidence;

> *"-as her sedations increased, she – it, you know – there has been an increase in the amount of aspiration, I think. It – so, that – I, I guess it all comes down to what you'd view the absolute cause of death here, whether it's the dementia, or whether it's the sedation."*[25]

63. It is clearly apparent from the evidence of Dr Lawrence, Professor Ashby and Dr Cleary that the palliative sedation administered to Mrs Woolley, at the very least, hastened death. For example, Professor Ashby said that effective treatment in such cases entailed sedation to the point of the patient being bedridden and usually semi-conscious or unconscious, and unable to take food or fluids and that death would follow in the short term.[26] He also stated that death usually ensues within 72 hours of initiating the barbiturate, phenobarbitone, in a palliative setting similar to that of Mrs Woolley.[27] Dr Cleary said in her affidavit that suffering is treated and alleviated with a secondary consequence of death then ensuing.[28]

64. I find that the palliative sedation was a contributing factor in the death of Mrs Woolley at the particular time that death occurred. This is notwithstanding that her irreversible and severe dementia process would have led to her death in the weeks or months following without the administration of the sedation.

Comments

Whether the consultation with family members regarding the decision to palliate Mrs Woolley was adequate

65. James expressed concerns about lack of communication and explanation from his mother's treating team surrounding her palliation. He expressed a lack of knowledge about how the process worked and why other options for treatment may not have

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[25] Transcript p 22[30].
[26] Exhibit C20 (n 1) p 4[22].
[27] Ibid p 6[29].
[28] Exhibits C21 (n 4) p 11[37]; Transcript p 44.

been taken. He expressed difficulty in understanding why his mother, a 58-year-old who still had lucid periods, was to be the subject of this treatment plan.

66. I have had regard to the extensive RFC documentation and the evidence of Dr Cleary and Professor Ashby. I have also been assisted by the affidavit of Ms Joanne Triffitt, Assistant Director of Nursing at the RFC, who summarised the many instances of contact and communications between staff and doctors at the RFC and Mrs Woolley's family members. Many of those instances of contact have been referred to above.

67. Dr Cleary said that the questions surrounding Mrs Woolley's pre-terminal and terminal phases of treatment were addressed with James and the family and are well-documented in the notes. Similarly, Professor Ashby stated that Mrs Woolley's family received full information on diagnosis, prognosis and the treatment plan. He said that it was conveyed in clear terms to the family that Mrs Woolley had no prospect of recovery or remission of symptoms and that more gentle sedation had failed to relieve her distress.

68. In his affidavit, Professor Ashby said:

> *"Despite this high level of well documented family support and information giving, it is my experience of working with human grieving, that despite apparent acceptance of the patients dying and the treatment plan, some family members or close friends later question whether a death was preventable. This can be part of an oscillatory pattern of grief behaviour that is well recognised in the academic grief literature (see Stroebe and Schut). However, I see no evidence in the notes, nor did I receive any communication from the treating team at the time, that there was any family disagreement about the treatment plan and its inevitable outcome."*[29]

69. Dr Michelle Gold provided an independent report in the investigation and oral evidence at inquest. Dr Gold is an experienced palliative medicine physician and director of the Palliative Care Service at Alfred Health Victoria. Dr Gold, in her report and oral evidence, was of the clear view, having considered the documentation, that there was consensus regarding decision-making on the part of Mrs Woolley's children and the involved family members. All had good opportunities to ask questions and seek clarification regarding their mother's treatment. Like Professor Ashby, she indicated upon reviewing the notes that the family members did not appear to be showing concern about the medical decisions being made. She said that her overwhelming impression was that the medical team had actually taken considerable efforts to keep the family informed and had done so to a very good standard.[30]

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[29] Exhibit C20 (n 4) p 7[35].
[30] Transcript pp 27-28.

70. Dr Gold stated in her report that the evidence indicated that the family members, including James, had a good understanding of the decisions about their mother that they were being asked to make and the process generally. She said that the descriptions of discussions between RFC staff and family members were clear as was information and medical opinions provided to the family about the treatments and their effects. She noted that concerns were shared by RFC personnel with family members relating to the difficulty of managing Mrs Woolley symptoms, the distress that she was experiencing and that her disease had progressed to a palliative stage. She said that as Mrs Woolley's situation evolved, the family members were kept informed.[31]

71. The evidence of the three specialists regarding the high quality of family communication is consistent. Their opinions in this regard are valuable, given their vast experience in communicating with and supporting families whose loved ones are receiving end-of-life care and treatment. From my consideration of the expert evidence and my own reading of the medical notes, I agree that there was a regular flow of documented communication and conveying of information in appropriate terminology by members of Mrs Woolley's treating team and staff to family members, particularly Vanessa and James. It is apparent that much effort went into regularly engaging with family members to provide medical updates on her condition. I find that the communication was very good and that both James and Vanessa understood and endorsed the decision that their mother be administered with sedation and knew that shortly thereafter she would pass away.

72. The observations of Professor Ashby referred to above are apt in respect of how James may have subsequently viewed issues surrounding communication with family and his mother's treatment generally. However, I have no hesitation in finding that he understood his mother's treatment and palliation plan at the time and also that she would imminently pass away. It may be that James felt quite a deal of pressure to make such difficult decisions in respect of his mother and may not perhaps have felt equipped to do so.

73. Dr Gold dealt in her report with Mrs Woolley's lack of capacity to make her own medical decisions and stated that;

> *"Mrs Woolley had not completed an Advance Care Directive and there is no indication that she had discussed such wishes at any stage with her loved ones and therefore neither the treating team nor her family were able to know what she would have wished for herself.*

[31] Exhibit C17 Report by Dr Gold [6].

> *Where there is no Advance Care Directive or other such documentation, a decision may need to be made by medical staff, next-of-kin and/or appointed guardians about what approach will be in the best interest of the individual. In Mrs Woolley's case, the treating team recommended a palliative approach to her care and the family agreed. I have no concerns about the approach taken.*[32]

74. An Advance Care Directive (ACD) is an individual's own written wishes regarding health care decisions at the end of life if they lack decision-making capacity at some future time.[33] The Tasmanian Health Service recognises the legal validity of an ACD, which is based upon common law principles concerning the individual's right to self-determination.[34] This written document helps to provide clarity and accountability for a patient, their family and health professionals. An ACD will be used when the individual lacks decision-making capacity. It is the responsibility of treating doctors to check for an ACD, take into account the wishes expressed, and to discuss these wishes with the responsible family member/s.

75. In hindsight, it would have been most beneficial for Mrs Woolley to have been advised to complete an ACD at an earlier time in the course of her disease when she possessed decision-making capacity. A written expression of her wishes may have alleviated some of the difficulty and burden of responsibility felt by her children. This burden was not relieved by the Guardianship Order, which only gave the Public Guardian power over where Mrs Woolley was to live and not her medical decisions.

76. There was some evidence regarding the desirability of an advocate or guardian for the making of Mrs Woolley's medical decision. Again, this may have been beneficial in hindsight but there can be no criticism of a failure to extend the guardianship order in circumstances where there was consensus among family members and consensus between family and the medical team.

Whether the decision to palliate Mrs Woolley was in accordance with current, appropriate, and ethical practice

Current palliative practice

77. In the early stages of the investigation, I requested and received a helpful report from Dr Lisa Eckstein, Lecturer in Law and Medicine, Faculty of Law, University of Tasmania. Dr Eckstein's report focused upon the ethical acceptability of medical actions that hasten the dying process. In her report, she stated;

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[32] Ibid [4].
[33] Advance Care Directive, *Department of Health – Specialist Palliative Care Service* <https://www.dhhs.tas.gov.au/palliativecare/advance_care_planning_for_healthy_dying>.
[34] *Hunter and New England Area Health Service v A* [2009] NSWSC 761.

> *"The ethical acceptability of medical actions that hasten the dying process are often linked to demonstrating respect for the wishes of the patient and the doctrine of double effect, which explains that effects that would be morally wrong if caused intentionally are permissible if the effects are foreseen but unintended. The following conditions have been identified to satisfy the doctrine:*
>
> *1. The nature of the act must be good, such as the relief of pain;*
>
> *2. The agent must intend the good effect (e.g., pain relief) and not the evil effect (e.g., hastening of death);*
>
> *3. The bad effect must not be a means to the good effect;*
>
> *4. There must be a proportionately grave reason for the good effect as compared with the bad effect."*[35]

78. The doctrine of double effect was the invention of 12th century philosopher, St Thomas Aquinas[36] and was first established in England as a defence at common law to a homicide charge against a doctor, it being held lawful for a medical professional to shorten a person's life with medication for the purposes of alleviating pain.[37]
79. Therefore, there exists established ethical guidelines supported by the medical profession and also the establishment of the doctrine of double effect as a defence under common law in England. To date in Australia, there is "*no such case that squarely deals with the question of whether the act of a medical practitioner who administers medication with the intention of relieving pain while foreseeing the medication will probably cause or hasten the death of their patient, is justifiable in law.*"[38]
80. In several jurisdictions in Australia and internationally, there are legislative protections for medical practitioners when legitimately providing care and symptom management that may also contribute to death. In Tasmania, there is no legislative provision to this effect.[39] It is the opinion of Dr Gold that it is extremely important for medical practitioners and nurses to have an appropriate degree of legislated protection when involved in such treatment.[40]

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[35] Exhibit C14 Ethics consultation report p 2.
[36] Kieran Tapsell, 'Why Do I Have to Keep Waking Up? Terminal Sedation and the Law in Australia' (2019) 27 Journal of Law and Medicine 178.
[37] *R v Adams*[1957] Crim LR 365.
[38] Scott Davison, 'The Doctrine of Double Effect and Potential Criminal Liability of Medical Practitioners in Australia' (2021) 28 *Journal of Law and Medicine* 503, 517.
[39] Exhibit C17 (n 31) [11]; See *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s 17(1); see also *Criminal Code Act 1899* (Qld) s 282A; see also *Criminal Code Act Compilation Act 1913* (WA) App B s 259.
[40] Exhibit C17 (n 31) [11].

81. Dr Gold accepted the analysis by Dr Eckstein and agreed with her discussion and summary in her report. Like Dr Eckstein, Dr Gold stated that there are different versions of Palliative Care Principles, but that the most widely adopted are those set out by the World Health Organisation (2009). She said that the principles extracted from those guidelines most relevant to Mrs Woolley's case are as follows:

- To provide relief from pain and other distressing symptoms;
- To intend to neither hasten nor postpone death;
- To integrate the psychological and spiritual aspects of patient care;
- To offer a support system to help the family cope during the patient's illness and in their own bereavement; and
- To use a team approach to address the needs of patients and their families, including bereavement counselling, if indicated.[41]

82. I note that Professor Ashby has written and been published extensively on death causation and palliative care. I did not have access to his published material and he was not, in his evidence, required to deal to any great degree with ethical principles of palliative care. However, for the purpose of this inquest, it was clear that he fully adopted the principles articulated by Dr Cleary and Dr Gold.

The palliative care received by Mrs Woolley

83. Dr Eckstein stated;

> *"While the doctrine of double effect is not the only ethical framework that can be used to analyse the ethical acceptability of Mrs Woolley's care, it helps to highlight some of the key issues for consideration. In particular, these appear to be:*
>
> - *Whether the use of sedation was appropriate for FTD symptoms*
> - *Whether there was a clear and acceptable link between the amount of sedative drugs administered by the treating team and Mrs Woolley's FTD symptoms*
> - *The role of Mrs Woolley's family in making decisions about and authorising aspects of her care, including the quantity of sedatives and the decision not to administer artificial nutrition and hydration.*
>
> *The use of sedation for FTD symptoms*
>
> *Mrs Woolley's medical notes show a clear picture of mental distress and agitation: symptoms that were largely refractory to medical and nursing care. Undoubtedly, relief of such suffering presents a compelling case for medical intervention. While these*

[41] Exhibit C17 (n 31) pp 7-8.

> *symptoms are somewhat distinct from the intractable physical suffering for which palliative sedation is more commonly administered, they have close similarities to agitated terminal delirium, for which palliative sedation is well established. At least conceptually, the mental distress Mrs Woolley faced due to the late-stages of FTD is just as worthy of relief as physical pain."*[42]

84. This analysis by Dr Eckstein is consistent with Dr Cleary's evidence that the medical concept of terminal sedation as a treatment in cases of severe distressing agitation and torment has been accepted and implemented for at least the last 10 to 15 years and is well understood in palliative care practice and supported in studies in the scientific literature. She stated that such treatment sits properly within the doctrine of double effect where suffering is treated and alleviated with a secondary consequence of death then ensuing.[43]

85. Professor Ashby provided evidence that he did not believe there was any other reasonable option that would retain the dignity and comfort of Mrs Woolley, stating:

> *"... I deploy the same principles that I would in the management of cancer pain. And, to not deliver adequate levels of drugs, and of new drugs where the old ones are showing resistance, where the body is showing resistance, which is very common these days, it – you know, you actually risk making the matters worse."*[44]

86. Dr Gold emphasised in her evidence the severe distress experienced by Mrs Woolley and that she presented as a risk of harm to herself.[45] In her oral evidence, Dr Gold said that her interpretation of Mrs Woolley's experience was that she would be moving "between different nightmare states" and in "terrible fear" a lot of the time. She explained that a patient in Mrs Woolley's state would constantly feel threatened, with a lack of understanding of the world around them.[46]

87. Similarly, Professor Ashby gave evidence that a patient with Mrs Woolley's condition would experience a form of "hell on earth" without the aid of medications. He based his opinion upon her presentation, verbal utterances and responses to stimuli.[47]

88. Dr Gold reported that "It is evident that the doctors did what they believed was necessary to relieve distressing symptoms, including agitation. This culminated in the use of sedation after other measures were unsuccessful."[48]

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[42] Exhibit C14 Ethics consultation report p 2.
[43] Exhibit C21 (n 1) p 11.
[44] Transcript p 51.
[45] Exhibit C17 (n 31) p 4.
[46] Transcript p 33.
[47] Transcript p 50.
[48] Exhibit C17 (n 31) p 8.

89. Both Dr Eckstein and James raised the issue of whether there was the possibility of balancing the use of sedatives to lessen (but perhaps not completely remove) Mrs Woolley's agitation with the maintenance of some level of consciousness and perhaps natural food and fluid intake.

90. Dr Gold was asked by counsel assisting whether other options for a more gradual process of sedation could have been employed, she answered:

> *"Again, I had – and, and, and this was the reflection that I had right at the beginning, only admiration for the nursing staff in this situation, who had provided fabulous behavioural support, and distraction techniques, and are often at considerable risk to themselves, but nonetheless, they kept a very consistent pattern of that behaviour, and behaviour modification for Mrs Woolley. And, I – you know, they, they did their upmost to maintain her dignity in that situation. So, by the time the medications were being used, I think those simpler measures had really been tried, to be quite honest, beyond a lot of what I see in practice in other institutions."*[49]

91. Dr Gold continued in her evidence to emphasise that there are was a clear and thorough attempt by the treating team to find any reversible causes and treat contributing factors. She acknowledged the difficult decision in many cases to commence sedation but, in Mrs Woolley's case, she found it clear that her condition could not be treated in any other way. In providing such evidence, she noted that intermittent dosing of sedatives had already been tried with only limited success. She also responded to counsel assisting's question about whether Mrs Woolley could have been treated with less sedation which would relieve most of her distress but not all of it. She discussed the difficulty of finding a balance of accepting a degree of agitation for less sedation and explained that no matter how detailed the documentation, it could not reflect actual interactions with the patient, their distress and how the family members are feeling.[50]

92. Dr Gold also dealt in her evidence with the uncertainty of being able to give family members a time frame from the commencement of sedation until death. She commented that timeframes are a case-by-case situation and can be unpredictable, particularly if pneumonia develops with a patient not moving around. She stated that with a patient not eating, that can provide a general guide. However, she stated that beyond indicating that a patient may live for "some days, maybe a week" it is difficult to be more accurate when the day by day proposition.[51]

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[49] Transcript p 28.
[50] Transcript p 29.
[51] Transcript p 30.

93. Based upon the evidence, I am satisfied, and I find, that the decision to provide palliative care in the form of terminal sedation to Mrs Woolley was in line with current ethical medical practice.

Concluding comments

94. As would be apparent from the foregoing content of this finding, I have relied heavily upon the evidence of Dr Gold, Dr Cleary and Professor Ashby. The written and oral evidence provided by each was learned, clear and helpful. The opinions of all three specialists were consistent in all respects. The treatment and decision-making in respect of Mrs Woolley by Dr Cleary and Professor Ashby was carefully considered and in accordance with recognised ethical guidelines. There was no alternative treatment that could reasonably have relieved her suffering. The level and content of communication by Dr Cleary and the staff at RFC with James and other family members was of a high standard. The family were aware of the severity of Mrs Woolley's condition and that the palliative sedation of their mother would lead to her death.

95. I have found that Mrs Woolley's FTD and her terminal sedation were contributory factors in her death by aspiration pneumonia. In making these findings, I am satisfying the requirement under section 28(1)(b) of the Act to find "how death occurred". In this context, "how death occurred" has been determined to mean 'by what means and in what circumstances', and involves the application of the ordinary concepts of legal causation. The authorities hold that a causative factor is one that is a substantial or operative cause determined by applying common sense to the facts as found, and one which may operate together with other causes. A coronial investigation necessarily involves a consideration of the particular circumstances and contributors to death so as to discharge the obligation imposed upon the coroner by that section.[52]

96. In finding contributory factors as part of the question of "how" death occurred, such finding is limited to the facts of this case, as every finding must be. The topic of end-of-life medical treatment and death causation is complex, legally and ethically, and has invoked global debate. Palliative care practitioners have been said to hold a view of causal "neutrality", whereby the process of dying is stated to be neither hastened nor prolonged by the human agency of practitioners in this care context.[53] There is also

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[52] *Atkinson v Morrow* [2005] QCA 353; *March v E. & M.H. Stramare Pty. Limited and Another* [1990 – 1991] 171 CLR 506; *Royall v The Queen* [1991] HCA 27; (1991) 172 CLR 378 per McHugh J at 442; *R v Smith* (1959) 2 QB 35; *Keown v Khan* [1999] 1 VR 69 per Callaway JA at p76; *R v Doogan; ex parte Lucas – Smith and Ors* (2006) 158 ACTR 1 at paragraph 24.

[53] Michael Ashby, 'How We Die: A View from Palliative Care' (2016) 16(1) *QUT Law Review* 5, 17.

uncertainty in the application of the doctrine of double effect and the insufficiency of legal protection for health practitioners.[54]

97. Having determined the circumstances of death and that the practitioners concerned provided appropriate care and treatment to Mrs Woolley in accordance with ethical principles, it is not my role or within the scope of this inquest to make further comment on any other matter.

Formal findings required by section 28(1) of the Coroners Act 1995:

98. I find that:

a) The identity of the deceased is Jillian Ann Woolley;

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

c) The cause of Ms Woolley's death was aspiration pneumonia; and

d) Mrs Woolley died on 18 September 2014 at the Roy Fagan Centre, Hobart in Tasmania.

99. I convey my sincere condolences to the family and loved ones of Jillian Ann Woolley.

Dated: 12 August 2022 at Hobart in the State of Tasmania

Olivia McTaggart

Coroner

[54] Scott Davison, 'The Doctrine of Double Effect and Potential Criminal Liability of Medical Practitioners in Australia' (2021) 28 *Journal of Law and Medicine* 503, 520.

MAGISTRATES COURT TASMANIA

MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

LIST OF EXHIBITS

Record of investigation into the death of JILLIAN ANN WOOLLEY

No.	TYPE OF EXHIBIT	NAME OF WITNESS	DATE TENDERED
C1	REPORT OF DEATH	CONST KATRINA MARCUS	
C2	AFFIDAVIT OF LIFE EXTINCT	DR CHRIS HOLDEN	
C3	AFFIDAVIT OF IDENTIFICATION	CONST CAMERON BROWN	
C3A	AFFIDAVIT OF IDENTIFICATION	ANTHONY CORDWELL	
C4	POST MORTEM REPORT	DR CHRISTOPHER LAWRENCE	
C5	TOXICIOLOGY REPORT	NEIL MCLACHLAN-TROUPE	
C6	REPORT	DR ALISON CLEARY	
C7	MEDICAL NOTES	DR ALISON CLEARY	
C8	MEDICAL RECORDS	RHH & ROY FAGAN CENTRE	
C9	RECORDS	ADARDS NURSING HOME	
C10	ADMISSION NOTES	ADARDS NURSING HOME	
C11	INCIDENT REPORTS	ADARDS NURSING HOME	
C12	AFFIDAVIT	CRAIG FRASER	
C13	AFFIDAVIT	JAMES RATCLIFFE (17/04/2015)	
C14	ETHICS CONSULTATION	DR LISA ECKSTEIN	
C15	RECORDS	GUARDIANSHIP & ADMINISTRATION BOARD	
C16	RECORDS	STRATHAVEN	
C16A	RECORDS	STRATHAVEN	
C17	REPORT	DR MICHELLE GOLD	
C18	AFFIDAVIT	Joanne TRIFFITT	
C19	AFFIDAVIT	JAMES RATCLIFFE (29/09/2021)	
C20	AFFIDAVIT	Prof Michael ASHBY	
C21	AFFIDAVIT	Dr Alison CLEARY	

MAGISTRATES COURT of TASMANIA

CORONIAL DIVISION

Inquest into the death of Jillian Ann Woolley

Ruling

1. The deceased, Jillian Ann Woolley, died on 18 September 2014.

2. The documentary evidence in the investigation indicates that she suffered from frontotemporal dementia (FTD) that was formally diagnosed in 2009. Her condition over the following years deteriorated to the point where she required high level of care and she developed marked behavioural and psychiatric symptoms of dementia, requiring care in a specialised facility. In 2014, her condition worsened further to the point where, on 27 August 2014, she was transferred to the Roy Fagan Centre with consent from the Public Guardian pursuant to a Guardianship Order which was limited in its terms to decisions concerning where Mrs Woolley was to live, either permanently or temporarily.

3. During her admission to Roy Fagan Centre, efforts were made to address any reversible causes of her escalating symptoms. However, she continued to exhibit severe and distressing behavioural and psychiatric symptoms of dementia. The evidence indicates that her mental state was such that she did not have capacity to make decisions in respect of her care or treatment. At the time of her admission to the Roy Fagan Centre she was said to be in the pre-terminal phase of her dementia and the approach to her care was to be "palliative". Following reviews by her geriatrician and palliative care specialist regarding options to ease her symptoms, it was recommended that palliative sedation should be used, with the consequence that Mrs Woolley would almost certainly die. Discussions were held with the family members who assented to this approach.

4. From 4 September 2014, various medications were used and doses titrated to induce sedation. Mrs Woolley was noted to become less distressed with the sedation and she passed away on 18 September 2014.

5. After autopsy, it was the opinion of the then State Forensic Pathologist, Dr Chris Lawrence, that Mrs Woolley died as a consequence of aspiration pneumonia following

palliative treatment for frontotemporal dementia. In the final section of his affidavit under the heading "Cause of Death", Dr Lawrence lists: 1(a) Aspiration pneumonia and 1(b) Palliative treatment of frontotemporal dementia.

6. Mrs Woolley's death was reported to the coroner and an investigation ensued. Some concerns were expressed by some family members regarding the process of palliative sedation leading to her death.

7. I commenced an investigation into Mrs Woolley's death because, upon the basis of the medical evidence, her death was a reportable death under the *Coroners Act* 1995 being a death that appeared to have been unnatural as it resulted from the administration to Mrs Woolley of sedating substances. In this regard, medical evidence suggested that Mrs Woolley's prognosis in respect of her FTD (and absent palliative sedation) may have been several years post her actual date of death. Alternatively, I considered that Mrs Woolley may have been a "person held in care" because she could be said to have been detained in the Roy Fagan Centre, being an approved hospital within the meaning of the *Mental Health Act* 2013.

8. As the investigation progressed, and particularly prior to the relatively recent receipt of Dr Michelle Gold's report, questions arose concerning, *inter alia*:

    a) the appropriateness of the trajectory of sedation;
    b) the information provided to family members;
    c) the role of an independent advocate for Mrs Woolley; and
    d) the desirability of a guardian being appointed to make medical decisions on her behalf.

9. In addition, questions arose regarding the ability of the family to understand the process, given their own limitations. The importance of such issue was, in my view, enhanced because of Mrs Woolley's own inability to consent to treatment that would cause her death.

10. This matter has unfortunately been protracted in the coronial investigation. As I indicated to counsel in the initial case management conference, some of the delay has been as a result of obtaining appropriate expert opinion and the complexity of the matter generally.

11. Given the issues under consideration in the investigation, I determined that an inquest should be held pursuant to my discretion under section 24 (2) and that I was probably obliged to hold an inquest under section 24 (1) (b).

12. Counsel for the Secretary of the Department of Health, Professor Ashby and Dr Cleary all submitted that Mrs Woolley's death is not a reportable death under the Act and therefore I have no jurisdiction to hold an inquest.

13. I have had full regard to all submissions, particularly the detailed submissions of Counsel for the Secretary of the Department of Health. Counsel submitted that, for the reasons set out in her submissions of 6 December 2021, Mrs Woolley was not a person held in care immediately before her death. The submissions in this regard contain persuasive arguments and I intend to deal with this issue in my finding, with the benefit of any further submissions from counsel.

14. Regardless of whether Mrs Woolley's death was a "death in care", I have decided that, pursuant to section 24 (2) of the Act that it is desirable to hold an inquest for reasons including the following:

    a) to assist family members in understanding the medical processes prior to the death of Mrs Woolley; and
    b) to hear from witnesses who are capable to assist me in understanding Mrs Woolley's condition, the prognosis, the processes and principles applicable to her palliative sedation, communications with the family and guardianship issues.

15. Under that provision I have discretion to hold an inquest into a death which "the coroner has jurisdiction to investigate". By section 21, a coroner has jurisdiction to investigate a death if it *appears* to the coroner that the death is or *may be* a reportable death. Relevantly to Mrs Woolley's death, a reportable death is defined under the Act as a death that *appears* to have been unnatural (my emphasis).

16. Upon the evidence available to me at this time, Mrs Woolley's death reasonably appears to be unnatural or may reasonably be said to be unnatural. As such, there is jurisdiction to investigate and also the power to hold an inquest if I consider it desirable to do so. I have formed this view on the basis that Mrs Woolley's death appears to have occurred when it did because of the external administration of

palliation substances (causing aspiration pneumonia as the terminal event) rather than as a result of the natural course of her FTD, her underlying natural condition.

17. What is a natural or unnatural death is not defined in the Act and the concept is not without difficulty in many cases. It may also be a question of circumstance and degree. For the reasons given, Mrs Woolley's death appears to be unnatural and I have jurisdiction to investigate and hold an inquest.

18. The inquest will proceed on 28 January 2022. I will request that Counsel Assisting provides to counsel a witness timetable as a matter of priority.

Dated 23 December 2021 in Hobart in the State of Tasmania

Olivia McTaggart
Coroner