



MAGISTRATES COURT of TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

*Coroners Act 1995
Coroners Rules 2006
Rule 11*

I, Robert Webster, Coroner, having investigated the death of Susanna Elizabeth Heraghty

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

- a) The identity of the deceased is Susanna Elizabeth Heraghty;
- b) Ms Heraghty died as a result of action taken by her alone, with the intention of ending her own life;
- c) Ms Heraghty's cause of death was mixed prescription drug toxicity (oxycodone, metoprolol, diazepam); and
- d) Ms Heraghty died between 6 and 8 November 2021 at Westbury, Tasmania.

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

- Tasmania Police Report of Death for the Coroner;
- Affidavits as to identity and life extinct;
- Affidavit the forensic pathologist Dr Donald Ritchey;
- Affidavit of the forensic scientist Mr Neil McLachlan – Troup of Forensic Science Service Tasmania;
- Affidavit of Ms Emma Burrows;
- Affidavit of Sergeant Gavin Chugg;
- Affidavit of Mr Glenn Dawson (Tasmania police) rank not stated;
- Affidavit of Senior Constable Caroline McGregor;
- Email of Detective Sergeant Andrew Hanson;
- Medical records obtained from Ms Heraghty's general practitioner (GP);
- Medical records obtained from the Launceston General Hospital (LGH);
- Letter from the Executive Director of Medical Services, LGH, Dr Joshi; and
- Photographs and forensic evidence.

Background

Ms Heraghty was 68 years of age (date of birth 27 June 1953), single and she resided alone at Franklin Gardens which is an age and disability care facility at Westbury at the date of her death. The facility provided supported independent living on site. She had been a resident for a number of years.

Ms Heraghty's parents are deceased and she has a brother, sister, niece and nephew from whom she is estranged. She herself never had any children as she never wanted them.

When she was younger, she had a drug abuse problem. She had advised her carer, Ms Burrows, she used drugs recreationally and they included acid, marijuana and whatever was available at the time. She had however not taken illicit drugs for many years.

She had no friends and would only leave her home if she required something or needed to go to an appointment. She had no visitors to her unit and it was believed she spoke to one of her neighbours infrequently.

She suffered from depression, bilateral knee pain and osteoarthritis, chronic pain, rheumatoid arthritis, hypertension, hypercholesterolaemia, chronic obstructive pulmonary disease, gastro oesophageal reflux disease, incontinence, chronic obstructive airways disease and Asperger's syndrome amongst many other conditions. She was in very poor health.

Ms Burrows was aware Ms Heraghty was wheelchair-bound and that she required a right total knee replacement. She was in a lot of pain and was prescribed narcotic pain medication. She also had weight control issues and she was obese but her weight gain was as a result of being wheelchair-bound.

Ms Heraghty had previously had support workers to assist her with everyday tasks like showering and dressing, meal preparation and domestic assistance. However in the last four months prior to her death she withdrew from her support service and Ms Burrows' role essentially became one of caring for Ms Heraghty's cat.

Ms Heraghty had advised Ms Burrows on a number of occasions she was thinking about taking her own life because she was stuck at home, in a wheelchair and in constant pain. She also indicated she was sick of the LGH cancelling her knee surgery and she was frustrated because she could not leave her home. She knew she did not have a social life and could not make friends. This depressed her. She indicated every couple of weeks or so there was sufficient medication in her unit for her to easily take her life whenever she wished to. Ms Burrows thought one day she would take her own life but she did not think it would be so soon.

Circumstances Leading to Death

At 2:50pm on Friday, 29 October 2021 Sergeant Chugg was tasked to attend Ms Heraghty's address to speak with her as there was a concern for her welfare. Sergeant Chugg was advised Ms Heraghty had been informed during a telephone call from the LGH that planned surgery had been postponed. During that call Ms Heraghty advised the employee of the LGH that she intended on committing suicide. I infer the concern for Ms Heraghty's welfare was raised with Tasmania Police by staff at the LGH.

Sergeant Chugg arrived at about 3:25pm. He introduced himself and asked if he could enter her unit and speak with her. Ms Heraghty consented to that. He asked her how she was feeling and she said she felt *"like shit"*. She began to cry and said the LGH had cancelled her knee surgery for the fourth time. She went to the computer and advised Sergeant Chugg she was cancelling some orders. He engaged in conversation and she asked who had called police and he advised somebody from the LGH. During their conversation she confirmed she was suicidal and that she had *"had a gut full."* He asked her how he could help and she advised *"there is nothing you can do"*. Ms Heraghty advised Sergeant Chugg the hospital would not do anything, that she was supposed to be the first cab off the rank in so far as knee surgery was concerned but they now want to do more tests and for her to get healthier prior to going through the surgery. She complained they could not tell her how long that process will take *"so they can get fucked and I told them that."* She advised him that it was not until she was 60 years of age that she had been diagnosed with autism and Asperger's syndrome. Ms Heraghty also said she was waiting for a vet because she did not want her cat to be left alone. With her permission Sergeant Chugg contacted Ambulance Tasmania (AT) in order to have her assessed. While waiting for AT Ms Heraghty advised him she would not be taken into protective custody.

Just in excess of 11 minutes later two officers from AT arrived. They were invited into the unit and they spoke to Ms Heraghty. They spoke to her about her health and her medication which they checked. One of the paramedics spoke to Ms Heraghty's GP about future arrangements which could be made in relation to the surgery and what arrangements could be made in relation to her post operative recovery. These discussions were relayed to Ms Heraghty and she appeared to have a more positive outlook. Her GP was to contact the orthopaedic surgeon and Ms Heraghty was to contact the GP on the following Tuesday that being 2 November 2021. In addition one of the paramedics explained to her what the hospital aged care liaison team (HALT) was and that team could assess her to determine what her needs were, in so far as assistance was concerned, during rehabilitation post surgery. The paramedic agreed to make

a referral to that team. As a result of these discussions Sergeant Chugg was satisfied Ms Heraghty was not a danger to herself and that it was not necessary to take her into protective custody.

That day Ms Burrows received a number of text messages from Ms Heraghty which said:

"No need to come and look after Coco anymore, she's going to be put down this afternoon. Thankyou for being such an angel to both her and me."

"Did you get your money this morning, if so then goodbye."

"Emma, I am so sorry for the message I sent you earlier, had cops and ambos here ready to section 10 me (which means psych ward) am still not in a good shape/place, but Coco still here and needs her carer as much as I do. Ambos rang and spoke to my GP he's taking over to get onto surgeon etc on Tuesday, from new practice at Legana, to sort things out. Ambos and cops could see that it was more frustration than anything else in that hospital staff not listening and I or caring."

"Ambos etc left here, confident after speaking with GP. Can't promise, just take one day at a time. Text you tomorrow. But thankyou for being you and caring, I know I'm a pain in the arse."

Following this message Ms Burrows' contact with Ms Heraghty returned to normal with no indication from her that she was going to self-harm. She continued to provide assistance to Ms Heraghty as per their arrangement and she last visited her on Saturday 6 November 2021. Ms Burrows was at her unit from approximately 1:00pm until about 2:10pm. At that time Ms Burrows says she did not seem unusual or out of sorts and they had a regular chat. As Ms Burrows was leaving, the last thing Ms Heraghty said was, "See you Monday."

Ms Burrows did not hear from Ms Heraghty on the Sunday and at approximately 8:45am on Monday 8 November 2021 she attended Ms Heraghty's unit again to provide assistance. She retrieved the door key from the combination lock box that is on the outside of her unit. The door was locked and she let herself in. As she walked in, she observed Ms Heraghty's wheelchair in the lounge next to the computer desk. She thought this was unusual as Ms Heraghty would ordinarily still be in bed at this time. Ms Burrows walked into the lounge and observed Ms Heraghty lying on the floor on her right side in front of her armchair. Ms Burrows knew immediately she was deceased and that it appeared as though she had been for some time. On the coffee table she observed a jar and plastic container with about 40 or more loose tablets in them and some bottled water. There were also two empty blister packs of medication nearby.

Ms Burrows rang an ambulance and was told to commence CPR. She informed the operator that it appeared to be a drug overdose using Diazepam and that she had been deceased for a while. She also told the operator Ms Heraghty had indicated she was not to be resuscitated. Ms Burrows looked outside the unit and noticed another carer attending to a separate unit. Ms Burrows approached the carer and asked for assistance in moving Ms Heraghty onto her back to commence CPR. The carer and Ms Burrows commenced doing chest compressions until the ambulance arrived.

Investigation

Constable Dawson was tasked to attend Ms Heraghty's address with Sergeant Greenwood at approximately 9:30am on 8 November 2021. On arrival he spoke with a paramedic from AT and Ms Burrows who identified herself as Ms Heraghty's carer. After inspecting the scene both officers came to the conclusion Ms Heraghty died by suicide as a result of a medication overdose. On the table in the middle of the living room/lounge area was an open and partially finished bottle of water and a number of tablets near it in a jar and in the lid of the jar. Ms Heraghty was found lying on the floor. No suicide note was found. Constable Dawson requested assistance from Launceston CIB and forensics and Sergeant Hanson and Senior Constable McGregor attended from those units respectively. They both inspected the scene and photographs were taken. Constable Dawson determined as a result of his investigations the circumstances of Ms Heraghty's death were not suspicious and he believed she took own life by overdose due to a number of health problems and the fact she had been on the public waiting list for a knee replacement for a number of years and that operation had been postponed on a number of occasions. Sergeant Hanson and Senior Constable McGregor agreed there was nothing suspicious about Ms Heraghty's death, no other person contributed to it and her death was likely to have been caused by an overdose of prescription medication. I accept the opinions expressed by the police officers.

Dr Ritchey conducted a post-mortem examination on 11 November 2021. As a result of that examination and his consideration of toxicological, microbiological and radiological results he determined the cause of death to be mixed prescription drug toxicity (oxycodone, metoprolol, and diazepam). He says significant contributing factors were morbid obesity (body mass index 47.3), osteoarthritis and Asperger's syndrome. He noted Ms Heraghty was found on the floor of her home adjacent to a jar containing benzodiazepines and oxycodone. He also noted a suicide note was not found at the scene however her threat of suicide was recorded in an outpatient note in the records of the LGH. He noted the results of testing conducted by Mr McLachlan – Troup revealed markedly elevated concentrations of oxycodone and metoprolol

in addition to diazepam and its many active metabolites. He says all of these drugs are strong central nervous system depressants that produce central nervous system depression by distinct neurochemical mechanisms causing increasing drowsiness, stupor, unconsciousness and coma which results in death by way of respiratory arrest. I accept Dr Ritchey's opinion.

The relevant history set out in the records of the LGH is as follows:

- 16 February 2018: orthopaedic progress note (OPN) – six months post right tibial plateau fracture, increasing disability and pain, seen by Mr Penn, for total knee replacement (TKR);
- 13 September 2018: preoperative assessment, proposed surgery date 24 October 2018;
- 26 September 2018: the aged care assessment team assessed her and approved her for higher-level respite and a home care package at level four;
- 24 October 2018: TKR right knee postponed as Ms Heraghty had atrial fibrillation. The anaesthetist who assessed her says the risks of proceeding with surgery were too great. Ms Heraghty became upset and declined any further management and investigation. The risk of not having the atrial fibrillation managed was explained to her but she refused treatment for that as well. She was advised to remain as an inpatient to facilitate appropriate reviews and management in order to have the surgery in a timely manner. She declined and discharged herself against medical advice. She was advised to take metoprolol, undergo a cardiology review and have any further investigations which were recommended. She remained on the waiting list and once she had been appropriately investigated, reviewed and managed with respect to the atrial fibrillation then surgery would be reconsidered;
- 30 October 2018: in a phone call to the surgical short stay unit Ms Heraghty complained about her treatment on 24 October 2018 and indicated she suffers from anxiety and panic attacks and this is why she discharged herself against medical advice. She was advised that while her frustration was understood there was little that could be done to assist her if she did not share her concerns. She was advised she remained on the waiting list but her position was currently suspended as she needs to follow-up cardiac concerns raised on admission with her GP for an eco-cardiogram and cardiology review. Both these requests were made of her on the day of her cancelled surgery but she refused to wait to see the cardiology team. She was frustrated because she had an "end-of-life care plan" and therefore she queried why the surgery did not proceed despite the risks. It was explained to her that elective surgery did not proceed

where there are significant concerns for her mortality. She was again advised what she needed to do. She received an apology on the basis that she felt she had been poorly treated but it was reinforced she needed to communicate any concerns with the health care team in future admissions;

- 23 to 29 April 2019: brought in by ambulance due to osteoarthritis in the right knee. The history was she suffered from chronic right knee pain for the last 5 years and had fallen 2 weeks ago. She was awaiting a TKR. Ms Heraghty discharged herself against medical advice;
- 17 May 2019: it was noted Ms Heraghty had seen Dr Barthwal from cardiology and had been given a clearance to proceed with the surgery;¹
- 7 June 2019: preoperative assessment, proposed surgery date 21 August 2019.
- 8 August 2019: Ms Heraghty advised she had been sent to her GP for review of a rash which arose from her incontinence pads. He has advised her the procedure can proceed;
- 15 August 2019: on review at the hospital it was suggested the surgery be postponed because of the infection. Ms Heraghty became very distressed and as a result she was kept on the list but there would need to be a skin assessment by the registrar and consultant prior to the operation proceeding on 21 August 2019. It appears the procedure did not proceed on that day due to the infection;
- During 2020: there are no notes and I suspect this was due to the COVID-19 pandemic and the restrictions and effects that had on the Tasmanian Health Service (THS);
- 21 May 2021: OPN – Ms Heraghty presented with right knee pain. It was noted she had been on the waiting list for a TKR since 2017 and that surgery had been cancelled on 3 occasions due to atrial fibrillation, infection and patient choice. It was noted Ms Heraghty had been wheelchair-bound since 2019 due to pain. She refused an examination but requested a date for surgery;
- 27 October 2021: OPN – it was noted her TKR surgery was scheduled for 29 October 2021 and that she was happy to proceed despite the risks of surgery being explained to her;
- 27 October 2021: there was an extensive review conducted by the preoperative high risk physician which noted her past medical history, her anaesthetic history, medications, social history and the review sets out the details of what was found with respect to her health. It is noted that after the surgery was cancelled in October 2018

¹ The GP's notes suggest this clearance was provided in early March 2019.

the plan was for cardiology review and Holter monitor² and anticoagulation. The Holter appointment did not take place and she denied any knowledge of anticoagulation. The subsequent admission in April 2019 is noted, the review in June 2019 is noted as is the surgery in August 2019 which did not proceed. Investigations were arranged prior to the surgery on 29 October 2021 and as she had refused a spinal block she was being assessed for a TKR under general anaesthetic. The refusal to be examined in May 2021 was noted as was the fact she had last been seen by an orthopaedic registrar in 2019. The doctor spent three hours discussing the perioperative issues with her and her immobility, medication regime and her shortness of breath. She was not willing to have any further spirometry³, plethysmography⁴, or blood gases performed. Her other symptoms were explored. The doctor was told that if the surgery does not proceed then *"the next time we see her will be on a body bag."* The doctor explored spinal anaesthesia again however Ms Heraghty threatened to leave but when she calmed down she explained she does not trust needles and does not want to become a paraplegic. It was explained to her a general anaesthetic posed extra risk and the doctor was extremely concerned about the ability to extubate her after surgery. She would then likely require a period of non-invasive ventilation which she adamantly refused and explained she would rather die. She went on to explain that should any life-threatening complications arise she would not want to be resuscitated and that is described in her advance care directive which was current. She explained both parents died from stroke related complications and she would not want to experience this herself but then would not discuss the role of anticoagulation to reduce her stroke risk in the context of atrial fibrillation. It was explained to her that for a period after surgery she would require some blood thinners for deep vein thrombosis prophylaxis but it was suspected she may not take them. There was an attempt to explain the post-operative care that would be required however Ms Heraghty was adamant she would not stay in hospital for rehabilitation but would attend a rehabilitation gym at her GPs practice. She said she would discharge herself against

² A Holter monitor is a type of portable electrocardiogram (ECG). It records the electrical activity of the heart over 24 hours or longer while the patient is not with any doctors. A standard or "resting" ECG is one of the simplest and fastest tests used to evaluate the heart.

³ The last spirometry was performed in 2017. A spirometry is the most common type of pulmonary function or breathing test. It measures how much air a person can breathe in and out of their lungs, as well as how easily and fast they can blow the air out of their lungs.

⁴ Plethysmography measures changes in volume in different parts of the body. The test may be done to check for blood clots in the arms and legs. It is also done to measure how much air a person can hold in their lungs.

medical advice if she was required to stay longer than a week. Because of the complexity of the case the doctor met with an anaesthetist and an intensivist in order to come up with a patient centred safe plan. Given Ms Heraghty's attitude that she was willing to take any risk and she was aware she may well die they decided they could offer to proceed if she was willing to compromise on the need for non-invasive ventilation post operatively. She agreed to a short-term trial of post-operative non-invasive ventilation if required but with the caveat that if she was not able to be weaned within 48 hours and was not tolerating the mask that she would prefer to focus on comfort care on the basis that she may not survive. Despite coming to this arrangement she then baulked at an up-to-date group and hold⁵ and she decided to leave. An orthopaedic consultant review was arranged for the next day but she refused to attend. It was then arranged for a surgeon to come down from theatre to review her that day. This assessment concluded with the following note:

"Susanna has made the informed decision to proceed with her knee replacement despite the significant perioperative risks. She requires very clear communication and team members should try to set aside significant time to put her at ease and make her feel listened to. She will likely require a pre-med given severe anxiety about this procedure. She will likely require NIV post extubation, and may develop rapid AF perioperatively. It is likely that she will not accept DVT prophylaxis (or stroke prevention anticoagulation) on discharge, and the risks and benefits need to be reiterated again given she is high risk for DVT/PE post op as well as her increased risk of stroke related to AF. It is also likely she will not be willing to remain in hospital for a period of rehabilitation, but she is determined to do outpatient rehabilitation on her terms at Westbury Doctor's Surgery. Should any complications occur in the perioperative period, please ensure her Advance Care Directive is adhered to, as Susanna is very clear about her wishes in this regard." ;

- 29 October 2021: OPN – Ms Heraghty sent a text message to an employee of the orthopaedic clinic noting ICU had cancelled her surgery and indicating further work was necessary so that she is healthier before they proceed with the surgery. She says in the message she told an employee of the LGH that if the surgery is cancelled once more her death warrant/certificate had been signed. She proceeded to criticise the health system. The employee took advice from two colleagues and attempted to telephone Ms Heraghty but she did not answer;

⁵Is the sample processing that determines a patient's blood group and screens for any atypical antibodies.

- 29 October 2021: the director of surgery at the LGH made a note that surgery was cancelled due to the extremely high risk. The suicide threat was brought to his attention and as a result police were contacted⁶. He notes an attempt to follow up Ms Heraghty would be made next week to explain the steps required before surgery would be undertaken;
- 5 November 2021: contact was made with Ms Heraghty by the HALT team as a result of a referral received that day by one of the paramedics. She explained her dire predicament, the care she received and the difficulties she experienced. An attempt was made to call the department of surgery elective admissions with no success and then the employee discussed the available options with colleagues and called Ms Heraghty back and advised her this matter would be followed up next week. Ms Heraghty replied “*don’t bother*” and hung up. The matter was to be followed up on the next Thursday, advice of this contact was to be provided to the preoperative high-risk physician and AT was advised of this contact;
- In further notes provided by the director of surgery, Dr Day, he indicates staff spoke to Ms Heraghty on 28 October 2021 at which time she was advised her surgery was postponed and the reasons why and that same person spoke to her again the next day. Their conversation on 29 October 2021 was a difficult conversation during which Ms Heraghty was abusive, agitated and she interrupted the staff member when attempts were made to speak. She confirmed she had contacted a vet to put her cat down and she wanted to commit suicide. There was a discussion about what further tests were required and why and which doctor she was to see but she appeared not to understand what could be done by way of improving her health or why further tests were needed. She requested more information and a call back but before the staff member could say anything further she hung up. Further discussions were had with colleagues and the suicide threat was escalated to senior management including the director of surgery after which police were contacted. In addition the GPs practice was contacted; and
- Finally there is a letter on file from Dr Day to Ms Heraghty which was written after her death but which confirms he is the person who made the decision to indefinitely delay the surgery. He says in that letter she remained at the top of the orthopaedic surgery waiting list and as soon as her health was optimised the surgery would be scheduled. The letter explains the surgery was delayed due to the extreme risk of death or major

⁶ As a result of this contact Sergeant Chugg attended Ms Heraghty’s home as outlined above.

life altering complications that surgery of any type posed to Ms Heraghty. He indicates the risk was so high he classed the surgery as futile after consulting with a number of specialists at the hospital. He says the LGH does not undertake futile surgery; that is surgery which is unlikely to improve the well-being of a patient and which may cause significant harm. He explains that in order for the surgery to proceed she needed to work with the doctors at the hospital to reduce her risk and if that occurs then the surgery is no longer futile. He explains her heart and lung function needs to improve amongst other things. Then an anaesthetic plan which offers the lowest risk to her needed to be agreed and a plan about post operative care including deep vein thrombosis preventing medication, physiotherapy and rehabilitation then needed to be agreed. He indicates during every step she can either agree or disagree with the recommendations made to her however while her risk of surgery remained extreme as a result of her not agreeing to any suggestion, investigation or treatments the surgery would not be offered. He was happy to arrange a second opinion from an anaesthetist in Hobart if she wished.

- Further information was sought from the LGH. Dr Joshi, the executive director of medical services, has advised prior to Dr Day's conversations with Ms Heraghty he consulted with the director of anaesthesia. He then advised Ms Heraghty, via several telephone calls, that she was considered a high risk patient who was not optimised and also expressed his major concerns regarding poor outcomes if surgery was to proceed. Dr Day advised Ms Heraghty it would not be safe to proceed with surgery unless her physical health became stable. On 29 October 2021 Ms Heraghty expressed suicidal ideation to Dr Day which was apparently caused by the cancellation of her surgery. On this occasion, surgery was cancelled due to concerns for her safety as she was considered to be extremely high risk. This matter was escalated to the then Executive Director of medical services, Dr Peter Renshaw, who facilitated a welfare check to be conducted by the LGH Department of Surgery.

The GP's care and treatment of Ms Heraghty was very thorough and to a high standard. I have no concerns about the prescription of medication by the GP in this case. It is quite clear from entries in the records the amount of medication in Ms Heraghty's possession was often checked with her and it was determined on each occasion she was not taking her prescribed medications to excess. To the contrary it appears she was able to cease taking any of the medications she was prescribed if she wished to do so.

Comments and Recommendations

Ms Heraghty died as a result of action taken by her alone, with the intention of ending her own life. The cause of death was mixed prescription drug toxicity (oxycodone, metoprolol, and diazepam). She took this step because of the difficult circumstances in which she found herself together with the fact she saw no relief of her pain and disability in sight because the TKR surgery had been postponed on a number of occasions. I am satisfied there are no suspicious circumstances surrounding her death and that no other person was involved.

There is no dispute Ms Heraghty required a right TKR. Her situation was dire. There is a dispute as to whether that surgery had been postponed on three or four separate occasions. Ms Heraghty suggested it was postponed on four occasions however the records suggest it was postponed on three occasions after being scheduled on 24 October 2018, 21 August 2019 and 29 October 2021. On the first occasion Ms Heraghty was suffering from atrial fibrillation, on the second occasion she was suffering from an infection and on the third occasion it was considered, by the director of surgery, that the risk of death or major life altering complications was too great. Despite Ms Heraghty understanding those risks she wished to proceed because her advance care directive was in place and her wishes were that her life should not be sustained by artificial means should she suffer certain conditions or post-operative complications. She wished to proceed with the surgery on her terms and would not accept the advice with respect to the tests and assessments which were required prior to the surgery taking place and what care and rehabilitation was required thereafter. Despite her wishes she was not in a position to dictate to the THS, and the doctors who treated her, how her treatment would proceed and/or pick and choose what recommendations she would comply with. This is because the doctors who treated her had the expertise to formulate a treatment plan that had the best prospects of success; not her. In my view the reasons set out in the letter from the director of surgery as to why he decided to postpone the surgery were appropriate as were his recommendations as to what further needed to be done before the surgery could proceed and what treatment was required thereafter. I agree with his assessment that given the circumstances which the doctors at the LGH were presented with, in late October 2021, the TKR surgery was futile. This position is consistent with the position of the medical profession generally that the health of a patient is a doctor's first consideration as is the maintenance of respect for human life.

Ms Heraghty had a difficult disposition which was made worse by her personality and the very difficult circumstances in which she found herself. In my view, despite these difficulties, the evidence discloses the staff and doctors at the LGH treated her with care and respect.

I thank the investigating officer, Constable Glenn Dawson, for his investigation and report.

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

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

Dated 18 march 2024 at Hobart in the State of Tasmania.

A handwritten signature in blue ink, consisting of a stylized, cursive 'W' followed by a vertical line.

Magistrate Robert Webster
Coroner