MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Simon Cooper, Coroner, having investigated the death of Yvonne Dawn Cohen

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

a) The identity of the deceased is Yvonne Dawn Cohen;
b) Mrs Cohen died 6 days after being discharged from hospital after treatment as an inpatient for abdominal pain, vomiting and diarrhoea;
c) The cause of Mrs Cohen's death was pneumonia; and
d) Mrs Cohen died on 21 February 2018 at 1/3 Armitage Crescent, Shorewell Park, Tasmania.

In making the above findings I have had regard to the evidence gained in the investigation into Mrs Cohen's death. The evidence comprises an opinion of the pathologist who conducted the autopsy; a report from the medical advisor to the Coroner's Office; and Mrs Cohen's medical records.

The evidence satisfies me that prior to her death Mrs Cohen was admitted twice to the North West Regional Hospital (NWRH), once on 10 December 2017 and then again on 7 February 2018. On the second occasion she was discharged from the NWRH on 15 February 2018 and died six days later at her home.

Pathologist Dr Terry Brain conducted an autopsy upon Mrs Cohen's body and provided a report in which he expressed the opinion that the cause of Mrs Cohen's death was pneumonia. I accept Dr Brain's opinion.

Dr Anthony Bell MD, FRACP, FCICM, medical advisor to the Coroner's Office reviewed Mrs Cohen's medical records and provided a report. In addition to confirming the cause of Mrs Cohen's death, he expressed the opinion that staff at the hospital apparently failed to recognise the significance of Mrs Cohen's rapid weight loss (13.6kgs in 139 days or 1kg every 10 days). Dr Bell also said that the clinical assessment of Mrs Cohen

was of a poor standard. Finally, he criticised the decision to discharge Mrs Cohen from hospital on 15 February 2018 without a diagnosis.

The NWRH was written to by the Coroner's Office on 22 August 2018 outlining the substance of Dr Bell's criticisms. The hospital was provided a full copy of Dr Bell's report, advised that I intended to rely upon it in making my findings, invited to respond to the criticisms in that report within 21 days and told I would have regard to any response before making my finding.

By letter dated 26 September 2018 the Acting Director of Medical Services, Tasmanian Health Service – North West said that she had asked the surgeon involved in Mrs Cohen's care to review and respond to the issues raised by Dr Bell. The surgeon did not dispute Dr Bell's opinion and specifically took no issue with the criticism of the care received by Mrs Cohen whilst at the NWRH, although he noted that the case was 'complex' and said 'to be honest the cause of death we would find difficult to be conclusive about'.

I accept Dr Bell's opinion as to the treatment received by Mrs Cohen at the NWRH. I am affirmatively satisfied that the care afforded to Mrs Cohen by the NWRH fell short of an acceptable standard.

Comments and Recommendations

The circumstances of Mrs Cohen'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 Mrs Cohen.

Dated 5 November 2018 at Hobart, Tasmania.

Simon Cooper
Coroner