FINDINGS of Coroner Simon Cooper following the holding of an inquest under the *Coroners Act* 1995 into the death of:

Joan May Hughes

Record of Investigation into Death (With Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Simon Cooper, Coroner, having investigated the death of Joan May Hughes with an inquest held at Hobart in Tasmania make the following findings.

Hearing Date

4 and 5 February 2019

Representation

S Nicholson - Counsel Assisting the Coroner

G Chen for the Tasmanian Health Service

T Carr for the senior next of kin, Mr Peter Hughes

Introduction

1. Mrs Joan May Hughes, much loved mother of Peter, died in the early hours of Monday 16 June 2014 in the Department of Emergency Medicine at the Royal Hobart Hospital (RHH).

2. Mrs Hughes was born on 18 September 1928. A keen gardener and reader, her son's evidence was that his mother had suffered from bouts of depression and anxiety for many years. Mr Hughes said the first incident of this type of which he was aware occurred sometime early in the 1970s.[1] It is apparent that Mrs Hughes had periods of treatment as an inpatient over the years. Her physical health was, generally speaking, good and she had a high level of independence, continuing to live at home to the age of 85. The fact that she was able to remain at home no

[1] See exhibit C6 - affidavit of Peter Terence Hughes sworn 15 July 2015.

doubt reflects the high level of care, love and support she received from her son.

3. On 16 April 2014 Mr Hughes took his mother to the Department of Emergency Medicine at the RHH with clear symptoms of psychotic depression. He said in evidence at inquest that it had become apparent to him that his mother was no longer able to cope without constant care and he was therefore forced to make the difficult decision to place his mother into a care facility. A medical history was taken and recorded. Her "mini mental" state examination scored 26/30, indicative of no cognitive decline. The notes support the conclusion that Mrs Hughes was well-kempt and well supported by her son.

4. In addition to a significant worsening of her mental health, Mrs Hughes' physical health had also declined.

The role of the Coroner

5. At the time of her death Mrs Hughes was the subject of a treatment order made on 7 May 2014 pursuant to section 37 of the *Mental Health Act* 2013. That order was expressed to remain in force until 25 June 2014. Amongst other things, the order authorised Mrs Hughes' detention for treatment at the Roy Fagan Centre (RFC) as an inpatient. It also mandated her use of antidepressant, antipsychotic and other medication.

6. As the order under the *Mental Health Act* 2013 was current at the time of Mrs Hughes' death, she was consequently a person "held in care" in terms of section 3 of the *Coroners Act* 1995 ('the *Act*') at the time of her death. As such, an inquest into her death was mandatory and I am obliged to report on the care, supervision or treatment of Mrs Hughes while she was held in care.[2]

[2] See section 28(5) of the *Coroners Act* 1995.

7. Before an analysis of the circumstances surrounding Mrs Hughes' death is undertaken it is important to say something about the role of a coroner. A coroner in Tasmania has jurisdiction to investigate any death which appears to have been unexpected or unnatural. An inquest is a public hearing.[3]

8. When investigating a death and an inquest is held, a coroner performs a role very different to other judicial officers. The coroner's role is inquisitorial. She or he is required to thoroughly investigate a death and answer the questions (if possible) that section 28 of the *Act* asks. These questions include who the deceased was, the circumstances in which he or she died, the cause of the person's death and where and when the person died. This process requires the making of various findings of fact. It is important, however, to recognise that it is not part of the coroner's role to apportion legal or moral blame for someone's death. Other people of course may draw conclusions from the findings of fact that a coroner is required to make after hearing evidence at an inquest.

9. A coroner is also able, if she or he thinks fit, to make comments about the death.[4] If the circumstances are appropriate a coroner is required to make recommendations with respect to ways of preventing further deaths.[5] As I have already mentioned, a report on "the care, supervision or treatment of… a person held in care" is also required.

10. It is important also to recognise that a coroner does not punish or award compensation – that is for other proceedings in other courts, if appropriate. Nor does a coroner charge people with crimes or offences arising out of the death the subject of investigation.[6] In fact, a coroner in Tasmania may not even say that he or she thinks someone is guilty of

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[3] See section 3 of the *Coroners Act* 1995.
[4] See section 28(3) of the *Coroners Act* 1995.
[5] Section 28(2) of the *Coroners Act* 1995.
[6] The circumstances were materially different in the past, see, for example, section 16 of the *Coroners Act* 1957 (Tas).

an offence.[7] I should make it very clear that I do not consider anyone has committed any offence in relation to Mrs Hughes' death.

11. As was noted above, one matter that the *Act* requires is finding how the death occurred.[8] It is well-settled that this phrase involves the application of the ordinary concepts of legal causation.[9] Any coronial inquiry necessarily involves a consideration of the particular circumstances surrounding the particular death so as to discharge the obligation imposed by section 28(1)(b) upon the coroner.

12. The standard of proof in coronial inquests is the civil standard. This means that where findings of fact are made a coroner needs to be satisfied on the balance of probabilities as to the existence of those facts. However, if an inquiry reaches a stage where findings being made may reflect adversely upon an individual, it is well-settled that the standard applicable is that articulated in *Briginshaw v Briginshaw*, that is, that the task of deciding whether a serious allegation is proved should be approached with great caution.[10]

Issues at Inquest

13. In addition to the matters that the *Act* requires consideration of at any inquest, particular attention was focused upon the following issues:
    a) The various matters raised by Mr Hughes regarding his mother's care, including management of medication and communication between the RFC and him about his mother;
    b) Whether there were any issues with Mrs Hughes ingesting her medication, and this being monitored by RFC staff;
    c) How her symptoms were investigated after she began complaining of pain and vomiting on 14 June 2014;
    d) The response of GP Assist;

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[7] Section 28(4) of the *Coroners Act* 1995.
[8] See section 28(1)(b) of the *Coroners Act* 1995.
[9] See *March v E. & M.H. Stranmere Pty. Limited and Another* [1990 – 1991] 171 CLR 506.
[10] (1938) 60 CLR 336 (see in particular Dixon J at page 362).

e) What changes have been made at the RFC following the inquest into the death of Molly Smith;

f) In particular, relevant to this inquest, two further issues were identified:

i. Was there a failure on behalf of RFC staff to ensure Mrs Hughes took all of her medication; and

ii. Was there any delay in investigating her symptoms after lunch on 14 June 2014.

14. Much of the evidence at the inquest was directed to the issues set out above.

Treatment at the Roy Fagan Centre – mental health

15. The evidence was that Mrs Hughes was transferred from the RHH to the RFC on 17 April 2014.[11] The RFC is a four unit, 41 bed centre for the treatment of psychogeriatric and dementia patients operated by Mental Health Services. Mental Health Services was, and is, part of the State Department of Health and Human Services.

16. When admitted to the RFC, Mrs Hughes was the subject of an Assessment Order made under the *Mental Health Act* 2013. An Interim Treatment Order followed the Assessment Order (on 30 April 2014). Finally the Treatment Order, mentioned above, was made on 7 May 2014.

17. At the RFC Mrs Hughes was started on citalopram, an antidepressant of the selective serotonin reuptake inhibitor class. On 24 April 2014 Mrs Hughes was reassessed by Dr Martin Morrissey, a geriatric psychiatrist. Dr Morrissey diagnosed Mrs Hughes as suffering from depression with possibly the onset of dementia. The medical notes record that further diagnosis was considered to be needed and Mrs Hughes' dose of

[11] Exhibit C8 - affidavit of Joanne Marie Triffitt sworn 10 October 2018 at paragraph 23.

citalopram was increased.

18. On 30 April 2014 Mrs Hughes was seen again, this time by a psychiatric registrar who discussed her case with Dr Morrissey. No change to her management regime occurred as a result of that assessment other than to decrease Mrs Hughes' dose of oxazepam.

19. No appreciable improvement in Mrs Hughes' symptoms occurred. A decision was made to commence her on risperidone, an atypical antipsychotic drug. On 12 May 2014 medical notes at the RFC record Mrs Hughes was observed to be less paranoid and engaged more easily in conversation. However, two days later, on 14 May 2014, the same notes document that Mrs Hughes remained suspicious of medications.

20. After consultant psychiatric review her dosage of risperidone was increased on 30 May 2014. At the same time citalopram was ceased altogether. It was replaced with venlafaxine, an antidepressant medication of the serotonin-norepinephrine reuptake inhibitor class.

21. Further review took place on 6 June 2014, at which time the venlafaxine dose was increased because Mrs Hughes continued to exhibit symptoms of paranoid ideation. A number of notes record issues with Mrs Hughes refusing to take medications and/or articulating suspicions about them. The evidence was that it was necessary to supervise Mrs Hughes closely when she was administered her antidepressant or antipsychotic medication to ensure that she actually took the medication.

22. The medical notes record that on 13 June 2014 Mrs Hughes was noted to be continuing to suffer from paranoid ideation, suspicion and anxiety. Once again her venlafaxine dose was increased.

23. In all, Mrs Hughes' medical notes at the RFC record her being reviewed by a consultant psychiatrist on at least six occasions during her stay at

the facility.[12] Each review notes a need for nursing staff to ensure that Mrs Hughes was suitably supervised and monitored regarding her medication compliance. I am satisfied on the evidence at the inquest that those instructions from the psychiatric consultants was complied with by nursing staff at the RFC.

Treatment at the Roy Fagan Centre – physical health

24. Contemporaneously with her mental health treatment, Mrs Hughes also received treatment for various physical symptoms whilst at the RFC. The first mention in her RFC medical notes of physical symptomology is recorded on 27/28 May 2014 when the fact that she was experiencing a burning sensation in her stomach (for which Mylanta was administered) is recorded. Next on 8 June 2014 the fact that, at 5.20pm, she vomited a small amount of fluid appears in the medical notes. At 1.00am the next morning the notes record that she was coughing and vomited 100mls of fluid. She complained of hip pain which led to her being taken to the Calvary Hospital on 12 June 2014 for a hip x-ray. The following day, 13 June 2014, the medical notes record that she had commenced Ibuprofen for left hip pain.

25. On 14 June 2014 Mrs Hughes' medical records reveal, at a time not recorded but after lunch, she complained of stomach pain to staff. Later the same day, again at times not recorded, but after afternoon tea and dinner, she also complained of stomach pain. The records indicate her vital signs were within the normal range. She was treated with Mylanta, a so-called 'over the counter' antacid medication used to treat digestive problems and the like.

26. The following day, 15 June 2014, the medical records indicate continued complaints of stomach pain which were described by Mrs Hughes as "violent" and incidents of vomiting. At 5.30pm staff were sufficiently

[12] Exhibit C15.

concerned to call GP Assist.

27. After taking a history, the on call doctor prescribed Maxolon and esomeprazole. In addition, staff were advised to carry out regular observations, provide Mrs Hughes with clear fluids, and seek further assistance should her blood pressure fall below 100/60. The evidence was that the drugs prescribed were administered and observations regularly carried out. Mrs Hughes was noted as being anxious and complaining of pain. Again, the medical records record that Mrs Hughes' vital signs at this time were within normal range.

Mrs Hughes' last hours

28. Shortly after 1.00am on 16 June 2014, Mrs Hughes was observed to vomit what appeared to be blood. Her blood pressure was 97/77 mmHG, heart rate 73 bpm and her respiratory rate 33 bpm. Staff telephoned for an ambulance for transport to the nearby Calvary Hospital. Initially, the transportation was flagged as being non-urgent. Registered Nurse Steward spent time with Mrs Hughes. Just after 3.00am, and before the transport ambulance arrived, Mrs Hughes was left alone very briefly. Less than five minutes later she was found by a nurse to be unconscious and displaying no vital signs. Staff commenced CPR and called for an ambulance urgently to attend. The ambulance arrived at 3.20am (roughly 10 minutes after the 000 call). Ambulance Paramedics took over CPR. After considerable effort Mrs Hughes' vital signs were able to be restored and she was transported to the RHH. She was admitted at 4.25am, intubated and assessed. She had a Glasgow coma scale of 3/15 (that is she had no eye, verbal or motor responses at all), her temperature was just 29°C, and she had fixed, dilated and irregularly shaped pupils.[13] The Department of Emergency Medicine treating team concluded that she had no prospect of recovery. Mrs Hughes quickly became bradycardic, suffered a cardiac arrest and at 4.35am, she died.

[13] Exhibit C4 - Death Report to Coroner – Royal Hobart Hospital – 16 June 2014.

Forensic Pathology Evidence

29. Because Mrs Hughes' death was unexpected and because she was the subject of an order made under the provisions of the *Mental Health Act* 2013 at the time of her death, the fact of her death was reported under the provisions of the *Coroners Act* 1995. After formal identification, her body was transferred to the mortuary at the RHH. At the mortuary experienced forensic pathologist Dr Donald Ritchey performed an autopsy. Dr Ritchey expressed the opinion in a report tendered at the inquest that the cause of Mrs Hughes' death was aspiration of gastric contents following emesis (vomiting).[14] Dr Ritchey found that Mrs Hughes' stomach contained approximately 450 grams of dark granular material that appeared to be partially digested blood. However, he was unable to identify the source of gastrointestinal bleeding at autopsy.

30. I note also that Dr Ritchey was unable to identify the cause of Mrs Hughes' emesis or nausea at inquest. I accept Dr Ritchey's opinion as to the cause of Mrs Hughes' death.

31. I turn to consider the issues examined in detail at the inquest.

Mr Hughes' issues

32. In substance, Mr Hughes made a number of allegations relating to the care, supervision and/or treatment of his mother at the RFC. The allegations were made in his affidavit and also in his evidence at the inquest.

33. In summary the allegations were:

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[14] Exhibit C5.

a) That RFC staff failed to ensure that his mother took all of the medications apart from those administered to treat her psychosis, depression and anxiety;
b) That in the week prior to her death Mrs Hughes had vomited blood but RFC staff, although aware of that fact, had done nothing about it; and
c) That during the week prior to her death, Mr Hughes told RFC staff that his mother had told him that she had vomited blood (and by inference one supposes nothing had been done about that by those staff members).

I will deal with these allegations in the order set out above.

Monitoring of medication

34. I have already touched upon this issue earlier in this finding. Although I did not understand Mr Hughes to raise the issue in relation to anti-psychotic and depressant medication, it is important that, in dealing with the matter, that the issue of medication supervision be addressed as a whole. There is no evidence to substantiate a finding that RFC staff failed to monitor properly the taking by Mrs Hughes of her medication – medication associated with both her physical and mental health conditions.

35. In the same way, there is no evidence to substantiate Mr Hughes' allegations that there was a failure on the part of RFC staff to ensure his mother took the medications associated with her physical ailments. There are a number of reasons for reaching this conclusion. First, the objective evidence contained in the medical records does not bear out such an allegation. In fact the opposite is the case. The medication charts relating to Mrs Hughes record a number of drugs such as Maxolon and esomeprazole being administered to Mrs Hughes.

36. Second, in his evidence at the inquest Mr Hughes was unable to identify a single medication that he said ought to have been provided to his mother and was not, or which she failed to take. The names of various medications prescribed for his mother were expressly put to him in cross-examination. He did not recognise any of those drugs. This impacts upon, in my respectful view, his reliability as a witness on this point.

37. Third, Mr Hughes claimed in support of his allegation of the failure to ensure medication was taken by his mother that he had complained to senior staff and to Dr Morrissey. He was unable to identify a single member of staff to whom he said he had complained by name.

38. I note three senior nurses from the RFC, Ms Joanne Triffitt, Mr Tim Urbanc and Ms Nevin Steward, all gave evidence at the inquest. All were asked about any interactions with Mr Hughes. All three denied unequivocally that Mr Hughes had ever raised with them the issue of failings in relation to supervision of his mother's taking of medication. All three said that had such a complaint been made they would have expected it to be recorded in the progress notes kept at the RFC in relation to Mrs Hughes. No such complaint is recorded anywhere in those progress notes. Dr Morrissey provided a report that was tendered at the inquest.[15] The report detailed his dealings with Mrs Hughes and the treatment she received. In the report, Dr Morrissey expressly mentions meeting with Mr Hughes on 17 April 2014 and 13 June 2014. In addition to those dates in the report, he says, "throughout Mrs Hughes' stay at the [RFC] [he] met with her son on a number of occasions to discuss progress, treatment options and rationale for those treatment decisions". As counsel for the Tasmanian Health Service correctly points out, nowhere in the report is there any mention of Mr Hughes complaining about how medication was being administered to his mother.

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[15] Exhibit C13.

39. In addition to the evidence from nurses Triffit, Urbanc and Steward on the particular point raised by Mr Hughes regarding complaints, two senior staff each gave detailed evidence as to how medication was administered to patients at the RFC. Given the nature of the patients at the RFC, and it being a common occurrence there is suspicion about and/or outright resistance to the taking of medication, I accept that staff at the RFC are especially vigilant to ensure patients do in fact take their medication.

40. Each nurse said that if any patient, including Mrs Hughes, refused to take medication or endeavoured to secrete it, that fact would be recorded in the notes. There are four such entries in Mrs Hughes' medical records: 30 April, 10 May, 14 May and 17 May 2014. One of those entries, the entry on 10 May 2014 (pm) records a refusal on the part of Mrs Hughes to take Panadol.

41. Having had the advantage of seeing and hearing them give evidence, each of the nurses impressed me as careful, candid and honest witnesses, each of whom was doing their best to provide accurate evidence to the inquest. I accept the evidence of each. Their evidence about the administration of medication is objectively supported by the records kept at the RFC, both of medication administered and medication either refused or attempted to be secreted by Mrs Hughes. Where it conflicts with the vague, and unimpressive evidence of Mr Hughes (allowing for the fact that it is often difficult for witnesses at inquests concerning the death of a loved one) I prefer their evidence.

42. I am affirmatively satisfied that the suggestions advanced by Mr Hughes as to a failure to ensure medication was taken by his mother lacks any basis in fact.

Treatment in the week prior to Mrs Hughes' death

43. A particular focus of evidence at the inquest was the treatment that Mrs Hughes received at the RFC in the week leading up to her death. The allegations made by Mr Hughes about that treatment have already been set out, particularly so far as they relate to his mother vomiting blood.

44. The first point to make is that at no stage did Mr Hughes say he actually ever observed his mother vomit blood. Thus, at its highest, he could only have believed, on the basis of information provided to him by his mother, that that had occurred. Specifically, he said she had told him that on one occasion.

45. Second, as with the medication issue dealt with above, Mr Hughes was unable to identify any staff member or members to whom he reported his belief that his mother had vomited blood. This was despite the fact that he was a regular, virtually daily, visitor to the RFC to see her.

46. Third, again, as with the allegation relating to the failure to ensure medication was taken, none of the nurses (each of whom were equally impressive witnesses on this point as in relation to the medication issue) who gave evidence were aware of any such report. Once again, there is no record anywhere in Mrs Hughes' medical records indicating that Mr Hughes (or indeed anyone) has reported or complained about Mrs Hughes vomiting blood. I am quite satisfied that Mr Hughes was actively involved in his mother's care in the week leading up to her death. For example, he accompanied her on 13 June 2014 to the Calvary Hospital. He was transported with her to and from the Hospital in an ambulance. He engaged directly with numerous healthcare professionals that day before, during and after the investigative procedure that his mother underwent. Asked about whether he reported to anyone at all the allegation of vomiting blood that day he said that he did not. The explanation that he offered, being that he did not mention it to anyone

because he was focused on his mother's hip pain, lacked credibility.

47. I am quite satisfied that Mr Hughes did not report to anyone on the staff at the RFC, or indeed Calvary Hospital, the fact that he believed or suspected his mother had vomited blood. Implicit in the allegation is that staff at the RFC were somewhat less than vigilant in their dealings with Mrs Hughes. I am not satisfied that that was so. In fact, I am quite satisfied on the whole of the evidence that the care afforded Mrs Hughes was of an acceptable standard.

48. There is no evidence in fact that Mrs Hughes did vomit blood until 15 June 2014. Traces of blood were noted as being present in her vomit on that day and recorded appropriately.[16] Staff responded to that fact, appropriately, by contacting GP Assist. It follows that I am satisfied that there was no delay in investigating and/or dealing with Mrs Hughes' condition after lunch on 14 June 2014. I turn now to consider the role of GP Assist at the RFC in general and in relation to Mrs Hughes' death in particular.

The role of GP Assist

49. GP Assist is a telephone service designed to provide initial assessment 'out of hours'. The RFC is forced to rely upon it, as there are only medical practitioners present at the Centre between 8.30am and 5.00pm Monday to Friday. Put another way, no medical practitioners, at all, are at the Centre at night or on the weekend.

50. The obvious weakness with any system such as GP Assist, no matter how professional, well-staffed and well operated it is, is the fact that the medical practitioner cannot carry out a physical examination and assessment of the patient. She or he is entirely reliant upon the person seeking advice over the telephone - in this case a nurse at the RFC.

[16] And of course were also found by Dr Ritchey at autopsy, see exhibit C5 and paragraph 28 above.

51. Coroner McTaggart in relation to the death of Molly Jessie Smith considered the issue of the role of GP Assist. Her Honour observed at page 29 of that finding "in the absence of the allocation of resources to have a medical practitioner at RFC or on call 24 hours per day, the care and treatment given by GP Assist in non-acute cases can be beneficial. However, in acute cases, where there is a need for a physical assessment and examination, there is potential for the use of the service to mask the seriousness of the medical case". I respectfully agree. In the case of Mrs Hughes there was no evidence to support a conclusion that the advice given by GP Assist was deficient or inappropriate. Particularly important is the fact that nursing staff were advised to take careful observations (which they did) and take action in the event that blood pressure fell below a particular level. That action was in fact taken.

52. However, as the medical advisor to the coronial division, Dr Anthony Bell, stated in his evidence, there is a need in many cases of abdominal pain (and Mrs Hughes it will be remembered was suffering abdominal pain) to perform a physical examination of the patient and, for example, to listen to the bowel sounds. Obviously relying on a telephone advice line does not allow that to occur.

53. I am not persuaded that the use of GP Assist in Mrs Hughes' case was inappropriate. Obviously, a face-to-face consultation with the ability to carry out a physical examination of a patient is to be preferred to advice being furnished over a telephone line. However, I do also note Dr Bell's advice that no matter what method of assessing and obtaining advice about Mrs Hughes had been undertaken, it is highly unlikely that there would have been any different outcome in light of the fact that Mrs Hughes faced major medical problems.[17] I am not satisfied that the use of GP Assist on this occasion was something that caused or contributed to Mrs Hughes' death or was a poor choice or a decision that ought be criticised.

[17] Exhibit C19 - report Dr AJ Bell 28 1 2016.

RFC changes following the inquest into the death of Molly Smith

54. Ms Molly Jessie Smith died in the RHH on 16 August 2009 as a result of the consequences of a kidney infection. Ms Smith had suffered severe mental illness and resided in state operated facilities for 53 years prior to her death. In the immediate lead up to her death she had been a resident at the RFC. An inquest in relation to the circumstances of the death was held in Hobart in 2017. After that inquest Coroner McTaggart made four recommendations in relation to practices and procedures at the RFC. In advance of the inquest in relation to Mrs Hughes' death, it was identified that the RFC response to those recommendations would be scrutinised. Evidence was adduced at the inquest principally through the assistant director of nursing at the RFC, Nurse Joanne Triffitt.[18]

55. In summary, her evidence was that there had been significant changes and modifications to, in particular, the Adult Observation and Response Chart. Nurse Triffitt said that since the recommendations referred to above, the RFC has modified and implemented the current THS Mental Health and State services Adult Observation and Response Chart. She said that the current version had been in use since December 2016.

56. Nurse Triffitt also said that in March 2017 the RFC was assessed against national applicable standards and awarded full accreditation having met all essential criteria. Her evidence, unchallenged, satisfies me that the RFC has taken a number of steps to address the recommendations made by Coroner McTaggart.

[18] Exhibit C8 - affidavit of Joanne Mary Trifflt, sworn 10 October 2018.

Some final matters

57. Mr Hughes submitted that a number of recommendations should be made. The recommendations sought variously concerned the use of charts or records recording the dispensing of medication, discontinuing the use of GP Assist in the establishment, and regarding communication protocols with next of kin. I am not satisfied that any of the recommendations suggested should, in the circumstances of this case be made.

58. The medical records which were tendered at the inquest (which include medication charts) contain more than adequate information as to:

    a) the date and time at which medication is dispensed; and
    b) the fact that the medication has been taken; or
    c) the fact that medication has been refused; and
    d) the name of the medication, the dose and frequency with which it is to be administered.

    I do not consider that the treatment of any patient in the future would be enhanced in any way by requiring the recording of any additional information. Moreover, I observe that the medical records already record with sufficient detail all the matters that Mr Hughes suggested should be included.

59. I have already dealt at some length with the issue of GP Assist. Whilst it may be desirable that there be an extension of the use of an on-site doctor, no evidence was adduced at the inquest that explored this issue or that it was feasible. Nor was there any evidence, at all, that the use of GP Assist caused or contributed to Mrs Hughes' death. Finally, I observe that staff did call an ambulance for Mrs Hughes (as Mr Hughes' counsel suggests should have occurred).

60. I see no reason to make a formal recommendation in relation to communication protocols. I accept that it would have been preferable if RFC staff had contacted Mr Hughes when his mother was taken to the

RHH. However, there was no evidence of a systematic failure to communicate and I am not persuaded the making of a recommendation of any type is justified. I also note that RFC staff were unaware that Mrs Hughes died until after Mr Hughes was notified by RHH personnel.

Formal Findings

61. On the basis of the evidence at the inquest I make the following formal findings pursuant to section 28(1) of the *Act* that:

    a) The identity of the deceased is Joan May Hughes;

    b) Mrs Hughes died in the circumstances set out in this finding;

    c) The cause of Mrs Hughes' death was aspiration of gastric contents following vomiting; and

    d) Mrs Hughes died on 16 June 2014 at the RHH, Hobart in Tasmania.

Conclusion

62. For the reasons that should, I hope, be clear from the matter set out above, I do not consider it necessary to make any recommendations or comments in relation to the death of Mrs Hughes.

63. I wish to extend my thanks to all counsel who appeared at the inquest for their assistance.

64. I extend my sincere condolences to Mr Hughes on the loss of his mother.

Dated 28 June 2019

Simon Cooper
Coroner