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

Molly Jessie Smith

Contents

Record of Investigation into Death (With Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Olivia McTaggart, Coroner, have investigated the death of Molly Jessie Smith with an inquest held at Hobart in Tasmania and make the following findings.

Hearing dates

21, 25, 26, and 27 July 2017 at Hobart, closing submissions received by 25 August 2017.

Representation

Ms S Taglieri	Counsel Assisting
Mr C Law	Dr Kanapathipilla Ratnagobal
Mr A Walker	Dr Joanna Bakas
Ms M Duvnjak	Roy Fagan Centre

Introduction

Molly Jessie Smith died on 16 August 2009 at the Royal Hobart Hospital ("RHH") as a result of the consequences of kidney infection. She suffered severe mental illness and had been a resident in state-operated facilities for 53 years. The documentary evidence in the coronial investigation suggested that Ms Smith's death may have been preventable if her condition had been correctly diagnosed and treated by those responsible for her care at her place of residence, the Roy Fagan Centre ("RFC"). Further, the evidence in the investigation prior to inquest did not sufficiently elucidate the issue of whether Ms Smith was a person "held in care" with the meaning of the *Coroners Act* 1995 ("the Act") such as to invoke a requirement under the Act to hold an inquest and also to make mandatory comment on her care.

The requirement to hold a public inquest in respect of deaths of persons held in care and the requirement to report on care, supervision and treatment pursuant to section 28 (5) reflects the public policy of ensuring that the death of every person who is held coercively in a state-run facility is examined independently and transparently.

In light of the issues, I decided that an inquest should be held. Regrettably, there has been a series of very lengthy delays in bringing this matter to inquest. Some of the delays were outside the control of the Coronial Division and some were not.

Ms Smith's life

Molly Jessie Smith was born in Tasmania on 17 August 1933. She became a ward of the state at the age of 11, being cared for by the Salvation Army Home whilst her mother received care for a severe psychiatric condition, manifesting in grossly delusional and disturbed behaviour. Ms Smith's mother was a resident at Lachlan Park Mental Hospital ("Lachlan Park") for many years. The documentary evidence indicates that Ms Smith's father had also been a resident of Lachlan Park.

Ms Smith never married and had no children. In her teen and early adult years, Ms Smith gained employment in Tasmania and then Melbourne. Upon returning to Tasmania in her early twenties she worked in the North Hobart Post Office. However, it appears that Ms Smith was unable to hold long-term employment due to her erratic behaviour and her emerging mental illness.

In 1955, at the age of 21, Ms Smith was first admitted temporarily to Millbrook Rise, a public facility in New Norfolk for the severely mentally ill. Ms Smith was diagnosed with thought disorder suggestive of early schizophrenia. In a second admission the following year Ms Smith presented as incoherent and hysterical after a failed love affair. Her response to treatment was poor. It was noted that Ms Smith was vague, withdrawn, mildly delusional, erratic in her speech, and unable to manage her own affairs, particularly emotional ones, in a competent manner. She refused to allow her brother to have any control over her, even though it appears he attempted to assist her and accommodate her in his house. It appears that, due to being unable to care for herself, her living conditions were very poor and her uninhibited behaviour placed her at significant risk. In a medical assessment, the prognosis for her mental illness was recorded as poor.

On 23 November 1956, at the age of 23, Ms Smith was admitted to Lachlan Park under a private order signed by her brother. The certifying psychiatrist stated that Ms Smith was of unsound mind and was a proper person "to be taken charge of and detained under care and treatment". It appears that she was then transferred to Millbrook Rise.

For a period of 53 years from that time, Ms Smith was continuously a resident of various care facilities operated by the State. Presumably, the first order only related to a discrete time period at the commencement of her admission to Lachlan Park. Subsequently, decisions to transfer Ms Smith were made as it was deemed appropriate, but without the formality of an order under the *Mental Health Act* 1963 (or its successor, the *Mental Health Act* 1996) or with the consent of an appointed legal guardian. Transfers between facilities were described as “voluntary” or “informal”. The records consistently described Ms Smith as a “ward of the state” (notwithstanding that she was an adult) who had no next of kin. Her psychiatric disorders were variously described in the medical records as schizophrenia, borderline personality disorder, bi-polar disorder, and intellectual disability or a combination of the same. It appears that she also suffered dementia towards the end of her life.

Ms Smith lived at Millbrook Rise from her admission in 1956 until 1973. She then spent almost 20 years until 1997 primarily as a resident of two nursing homes, Tara Nursing Home and Glenview Nursing Home. It appears that this was in an effort to provide Ms Smith with more normality in her life. Although Ms Smith’s brother was involved in her care initially, the records indicate that from an early time in her residency, he had no further contact with her.

A document from the Tara Nursing Home in 1992 stated in respect of Ms Smith that *“Molly is a mentally tortured soul who has always required a supportive and sheltered environment to enable her to have a veneer of normality. Her mixed psychiatric illnesses are not readily understood by others. She also has the unfortunate trait of becoming over demanding if any kindness is shown to her. This reduces her ability to communicate normally, resulting in isolation.”*

In 1997 it became apparent that Ms Smith was unsuitable for further care in nursing homes due to her agitated behaviours, poor sleeping patterns, rapid thought, disordered speech and poor response to medications. It seems that her condition had further escalated by this time. Therefore, she was admitted to Millbrook Rise, initially Ward 1, and subsequently the higher needs Clyde Unit.

In 1999, whilst residing at Millbrook Rise, Ms Smith commenced clozapine therapy to treat the symptoms of schizophrenia, including her delusions, paranoia and hallucinations. Behaviourally, she was described in the records as noisy, often distressed, overly affectionate and inappropriately flirtatious with male staff. The clozapine therapy improved

Ms Smith's functioning, however she remained resistant to treatment generally and continued to require institutional care at all times.

The Millbrook Rise records for the time leading up to her transfer to RFC indicate that Ms Smith was able to attend to her own personal hygiene, showering and dressing. She enjoyed attending occupational therapy sessions that included knitting, sewing and arts and crafts. She enjoyed interacting with staff and enjoyed helping in the kitchen at Millbrook Rise. She attended church regularly. She also made weekly shopping trips, accompanied by members of the occupational therapy staff in accordance with her documented Individual Services Plan.

During her latter residency at Millbrook Rise Ms Smith acquired a cat called "Tiddles" that stayed with her in her room. She cared for Tiddles independently, and purchased his food and litter from her own funds. Ms Smith's life and mental well-being came to revolve around her cat.

In 2008 all patients over the age of 65 years were required to be transferred out of the Clyde Unit at Millbrook Rise. Ms Smith indicated a preference for residency at Corumbene Nursing Home but that facility was unable to accommodate Tiddles. Therefore, Ms Smith was proposed for residency at RFC where Tiddles was able to live with her.

On 24 June 2008 Ms Smith commenced her residency at RFC at 54 Kalang Avenue in Lenah Valley. The RFC is a 41 bed facility operated by Mental Health Services ("MHS"), part of the Department of Health and Human Services. RFC provides inpatient treatment to older persons with mental illness and individuals with challenging behaviours related to dementia. The majority of residents are long-term, with a small proportion occupying beds for acute inpatient psychiatric care.

Ms Smith's diagnosis upon admission to RFC was that of schizophrenia with positive symptoms (hallucinations and delusions) and borderline intellectual disability.

Ms Smith also suffered chronic medical conditions which included Type 2 diabetes and polycythaemia rubra vera (a disorder of the bone marrow producing an excess of red blood cells). She also suffered recurring urinary tract infections.

Ms Smith's medical records indicate that her physical conditions were regularly monitored and treated. She had a basal cell carcinoma removed from her nose by a dermatologist. Her

polycythaemia rubra vera was reviewed by a haematologist and treated when necessary. She had pathology tests for monitoring of her diabetes and her platelet count. She underwent regular pap smears and mammograms. Her clozapine levels were taken regularly. Her other regular medication was monitored.

For the whole period of her residency in state-operated facilities Ms Smith did not have the capacity to make informed decisions in respect of her own living arrangements, medical care, or finances. Ms Smith was, unfortunately, not able to live independently outside the institutional setting. She was in receipt of a disability pension and, upon reaching 65 years of age, the aged pension. It appears that her money was managed on her behalf by a trust officer employed by the Department of Health and Human Services. It appears that members of staff also assisted Ms Smith with her spending when appropriate.

In the 1990s, Ms Smith became friends with Mrs Gillian Parton, a radiographer at the Royal Derwent Hospital. From the late 1990s Mrs Parton would visit Ms Smith regularly, about two or three times a week, and see her at church on Sunday mornings. In one of her affidavits for the investigation, Mrs Parton described Ms Smith as a very kind person who enjoyed giving gifts to people and who was particularly fond of Christmas. She stated that Ms Smith could talk continuously, often repetitively, for long periods of time. Mrs Parton also described Ms Smith's dedication to caring for Tiddles in her room in the evenings.

On 1 June 2009, by order of the Guardianship and Administration Board ("GAB"), Mrs Parton was appointed as Ms Smith's legal guardian until 31 May 2012. As far as the evidence establishes, this was the first appointment of a formal guardian for Ms Smith. By the order, Mrs Parton was given powers and duties in respect of deciding where Ms Smith was to live, whether permanently or temporarily, to make decisions concerning consent to any health care in the best interests of Ms Smith and to refuse or withdraw any consent to any treatment.

On 8 August 2009 Ms Smith became unwell. Over the following days until 15 August 2009, Ms Smith was treated and cared for by Dr Kanapathipilla Ratnagobal and nursing staff at RFC. Dr Ratnagobal was employed as a medical officer at RFC to provide psychiatric and general medical care for RFC residents. There were 46 residents at that time. RFC was not designed to treat patients with acute medical conditions and did not have the capacity to do so.

At this point I will deal briefly with Dr Ratnagobal's background. He gained his degree in medicine in Ceylon in 1976. He was granted conditional registration as an "area of need" doctor in 1989. Not having passed the Australian Medical Council examination he was not entitled to unconditional registration as a medical practitioner in Australia. From 1990 he commenced employment in Tasmania under supervision. He did not pass his Australian Medical Council exams in 1992, 1995 or 1996. He passed these exams in 2014. In 2002 it came to the attention of the Medical Council of Tasmania that Dr Ratnagobal was using alcohol to excess, and consequently further extensive conditions were placed upon his registration. For almost 20 years before Ms Smith's death Dr Ratnagobal worked in Tasmania in various government roles as a medical officer in psychiatry. For all of that period he operated under a conditional registration that was subject to conditions and undertakings, including supervision.

During the period of her illness, Ms Smith continued to be unwell, despite medical and nursing care, with patterns of high temperature, high respiratory rate, uncontrolled blood sugar levels and abnormal blood pressure.

On 15 August 2009 Ms Smith was therefore transferred to the Emergency Department of the RHH with a further worsening of her condition. There she was diagnosed as having pneumonia and kidney failure with a very poor prognosis. After consultation with Mrs Parton, she was managed palliatively with morphine. She passed away at 8.50am on 16 August 2009.

On 17 August 2009 Dr Christopher Lawrence, State Forensic Pathologist, performed an autopsy upon Ms Smith. He identified the causes of death to be pyelonephritis and pneumonia. Pyelonephritis is an acute inflammation of the kidneys causing kidney failure. In Ms Smith's case the condition was the result of progression of infection from the urinary tract to the kidneys.

Toxicological testing of Ms Smith's post-mortem blood sample revealed the presence of clozapine in greater than therapeutic levels. Ms Smith was given her prescribed doses of clozapine for her psychiatric condition and the doses were monitored. Ms Smith had taken clozapine for many years to control her symptoms. This medication has significant side-effects, particularly increased cardiovascular risk. However, I accept the expert evidence that clozapine did not play any direct role in Ms Smith's death.

Issues at inquest

The Coroner's functions are set out in section 28 (1) of the Act, which provides:

> "28. Findings, &c., of coroner investigating a death
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> (1) A coroner investigating a death must find, if possible –
>
> (a) the identity of the deceased; and
>
> (b) how death occurred; and
>
> (c) the cause of death; and
>
> (d) when and where death occurred; and
>
> (e) the particulars needed to register the death under the Births, Deaths and Marriages Registration Act 1999.
>
> (f) . . . . . .
>
> (2) A coroner must, whenever appropriate, make recommendations with respect to ways of preventing further deaths and on any other matter that the coroner considers appropriate.
>
> (3) A coroner may comment on any matter connected with the death including public health or safety or the administration of justice.
>
> (4) A coroner must not include in a finding or comment any statement that a person is or may be guilty of an offence.
>
> (5) If a coroner holds an inquest into the death of a person who died whilst that person was a person held in custody or a person held in care or whilst that person was escaping or attempting to escape from prison, a secure mental health unit, a detention centre or police custody, the coroner must report on the care, supervision or treatment of that person while that person was a person held in custody or a person held in care."

The evidence in the investigation prior to inquest suggested that Ms Smith's physical illness occurring in the last week of her life had not been diagnosed or treated adequately at RFC and that her death may have been prevented. The issues for examination at inquest fell broadly into the following categories:

1. Whether Ms Smith was a person who died whilst she was "held in care" as defined in section 28 (5) of the Act.
2. The adequacy of the treatment and diagnosis of Ms Smith by Dr Ratnagobal from 8 August 2009 until 15 August 2009 and the failure to order her transfer to the RHH.
3. The adequacy of the skill, qualifications and supervision of Dr Ratnagobal in relation to his treatment and care of Ms Smith and the medical conditions of RFC patients generally.
4. The adequacy of the nursing care of Ms Smith and/or records documenting such care.
5. Standards of treatment and care and policies and protocols for delivery of medical and nursing care to patients at RFC with medical problems.
6. Policies and protocols regarding when RFC patients with medical problems are to be transferred to an acute medical facility.

Was Ms Smith a person "held in care"?

Under section 3 of the Act, a person "held in care" was, relevantly, defined as:

> *" A person detained or liable to be detained in an approved hospital within the meaning of the Mental Health Act 1996 or in a secure mental health unit or another place while in the custody of the controlling authority of a secure mental health unit, within the meaning of that Act;"*

The definition now refers to the more recent *Mental Health Act* 2013. However, the question for determination is whether, at the time of her death, Ms Smith was a person "held in care" so as to invoke the mandatory requirement under section 28(5) of the Act to report on her care, treatment and supervision whilst she was held in care.

The evidence establishes that the RHH and RFC were, in 2009, both approved hospitals pursuant to the *Mental Health Act* 1996.

The evidence indicates that an initial order authorising the detention of Ms Smith for 72 hours may have been made on 13 February 2009 (as there had been appropriate paperwork prepared) but that no further order was made before Ms Smith's death. There is also no evidence that Mrs Parton formally exercised her guardianship powers to require Ms Smith to live at RFC. Ms Smith's medical record notes that the rationale for her transfer to RFC was

for continuation of care as she was unable to be considered for nursing home placement at that point in time. In his affidavit, the manager of RFC, Mr Christopher Fox, stated that Ms Smith's legal status at this time was voluntary and she was not subject to orders or requirements under the *Mental Health Act* 1996 or the *Guardianship and Administration Act* 1995.

Mrs Parton did not become Ms Smith's guardian until nearly 12 months after Ms Smith's transfer to RFC and did not give formal consent to Ms Smith residing at RFC at any time. Despite this, Mrs Parton accepts that there was no alternative facility at which Ms Smith could have been accommodated given her complex and chronic psychiatric condition.

The GAB was satisfied in granting guardianship to Mrs Parton that Ms Smith was, by reason of her mental condition, unable to make reasonable judgments in respect of her person and circumstances. I am also satisfied upon the evidence at inquest that Ms Smith did not have such capacity. Her understanding of her condition, treatment and circumstances was very limited, as was her ability to attend to her own needs. The decisions as to her treatment and circumstances of residence were made by those professionals responsible for her care in the various state-run institutions in which she was resident over many years.

Counsel assisting, Ms Taglieri, filed detailed and helpful submissions in which she submitted that Ms Smith was a person "held in care".

However, counsel for RFC, Ms Duvnjak, submitted that Ms Smith was not "held in care" because there was no order under the *Mental Health Act* and her guardian had never been required to exercise her powers under the guardianship order to require Ms Smith to be a resident at RFC. Those powers not having actually been exercised, Ms Smith was not *"detained or liable to be detained in an approved hospital".*

The statutory scheme requires analysis as to whether Ms Smith was "detained or liable to be detained" in an approved hospital. As an initial matter, I take the view that it is only the words *"approved hospital"* that attach to the phrase "*within the meaning of the Mental Health Act 1996*", as opposed to the phrase *"detained or liable to be detained*". I am reinforced in this view by the fact that there is no definition of *"detained or liable to be detained"* under the *Mental Health Act* although the concepts of detention and liability for detention are used throughout that Act. There is, however, a specific definition of "*approved hospital"* under that

Act. I also note that the *Coroners Act* does not define the phrase *"detained or liable to be detained".*

The *Mental Health Act* 1996 provides for the care and treatment of persons with mental illness. A person with mental illness may be admitted to an approved hospital. Admission may be voluntary or involuntary. By section 17 (as it was in August 2009) a person could be admitted as a patient to an approved hospital either (a) by consent of the person, in which case such person is a voluntary patient; or (b) under an initial order, a continuing care order or an authorisation for temporary admission. In these cases such a person is an involuntary patient.

Under section 22 a voluntary patient may, subject to section 23, discharge himself or herself from an approved hospital at any time. However, under section 23, if a voluntary patient seeks to be discharged, a medical practitioner or approved nurse may take the person into protective custody so that an assessment can be made of whether the person should be admitted and detained as an involuntary patient. The person may be held in protective custody under this provision for a period of not more than 4 hours for the purposes of examination and diagnosis. If, at the end of that period, an order for the involuntary admission of the person to the hospital has not been made, the person must be released from custody.

By section 24 a person could be detained as an involuntary patient in an approved hospital, if:

(a) the person appears to have mental illness; and

(b) there is, in consequence, a significant risk of harm to the person or others; and

(c) the detention of the person as an involuntary patient is necessary to protect the person or others; and

(d) the approved hospital is properly equipped and staffed for the care or treatment of the person.

The initial order for admission as an involuntary patient is made by a medical practitioner. Such an order continues for a maximum period of 72 hours (section 27). A further type of order, a "continuing care order", may be made by two medical practitioners based upon the

satisfaction of the same criteria for involuntary admission for a term not exceeding 6 months. Section 38 allows the use of force by a police officer to return a person subject to an order to the approved hospital.

In considering these provisions, it is evident that an involuntary patient detained under an order under that Act is a “person held in care” within the meaning of that term in the *Coroners Act* as they are either detained or liable to be detained. The death of such a person must be reported and an inquest held.

The important question in the context of this inquest is whether, in the absence of being subject to an order under the *Mental Health Act* at the time of her death, Ms Smith was *“detained or liable to be detained”.*

The public policy rationale for the requirement in section 28(5) of the Act to report on the care, supervision or treatment is to ensure that the death of every person who is coercively held in any state-run institution is carefully, independently and transparently examined. Usually, such a person will be detained by virtue of an order of a court or tribunal.

However, the Act does not envisage that this is necessarily the case if, in fact, the state (or a prescribed state officer) had control over the person at the time of death. For example, under the Act, “person held in custody” means, *inter alia,* (a) a person in the custody or control of a police officer, correctional officer or mental health officer; and (b) a person detained in a prison as defined in the *Corrections Act* 1997. In this latter instance, it may be that due to an administrative error, a prisoner remains incarcerated beyond the conclusion of his lawful sentence. In such situation, the prisoner remains detained as a matter of fact and the coroner is not relieved from either holding an inquest or commenting upon his/her care, treatment and supervision. Similarly, if a police officer exerts force or threats over a person outside the formal custodial setting such that the person is not free to leave, then this would fall within the definition of a “person held in custody”. The essence of the provisions is the element of state control over a person, whether lawful or not.

This approach is in accordance with the authorities. In *Smith v The Queen* (1957) 97 CLR 100 Williams J stated at page 129 that the term “in custody” is not to be seen as a term of art. In the context of police custody, His Honour stated that it is not confined to a person who has been arrested after a charge has been formally preferred against him; it includes the situation where a person believes that he must stay with the police and not leave, particularly

if the police intended him to believe that he had to remain with them and that they would have taken steps to prevent him leaving if he had attempted to do so. The assessment of whether such a person is “in custody” of the police depends upon the state of mind, intelligence and understanding of the person and the actions and behaviour of the police officers towards that person.

In relation to the term “detain”, the Oxford dictionary definition includes, relevantly, the following: “place or keep in confinement; withhold, retain; keep in a certain place or condition, hold; keep from proceeding; hold back, delay, stop; restrain from action.”

The decision of *Paul v Paul* [1954] VLR 331 dealt with the meaning of “detained in any hospital for the insane”, being relevant to Mr Paul’s petition for a dissolution of his marriage on the ground of insanity of his wife, Mrs Paul. It was held by Dean J that, notwithstanding that Mrs Paul had the status of either a temporary or voluntary patient pursuant to the relevant legislation, she was nevertheless “detained” in the hospital. The rationale of the decision was that Mrs Paul would have been certified as an involuntary patient had she attempted to leave. The evidence clearly indicated that she would “unquestionably have been certified as a person of unsound mind.” He stated that the authorities would be justified in holding her against her will until the expiration of the 72 hours’ notice is required by the legislation. She was therefore not entitled to freely depart, and she could lawfully have been prevented from doing so.

This decision is persuasive and the circumstances in which Dean J considered the meaning of “detained” were not dissimilar to the present circumstances albeit not in the coronial context.

It is therefore a question of fact as to whether the aspects of control or compulsion are present such that a person can be found to be detained, notwithstanding the absence of a formal order legitimising that detention.

In Ms Smith’s case relevant factors are as follows:

1. Ms Smith did not have the degree of cognitive functioning needed to provide informed consent to her treatment, to understand her legal options under the *Mental Health Act* or to make rational decisions about any other important aspect of her life or circumstances - and this had been the case for over 50 years;

2. Ms Smith had no family members to assist or advise; and no alternative places of residence available to her, other than possibly another state-operated facility;

3. The references in the records to Ms Smith as a “ward of the state” were indicative that the State took full responsibility for her care;

4. A guardianship order was in place acknowledging Ms Smith’s inability to make reasonable judgements concerning her treatment and residence;

5. The conditions for involuntary admission were satisfied, as evidenced by the preparation of an initial order under s26 of the *Mental Health Act* in February 2009 for detention of Ms Smith. The evidence clearly demonstrated that these factors existed continuously - Ms Smith had a serious mental illness and cognitive disability, was a risk to herself, and required constant care at an approved hospital, such as RFC, (which was properly staffed and equipped for her care and treatment);

6. If Ms Smith had attempted to leave either the RHH or RFC, there would inevitably have been formal processes instituted to lawfully require her detention at RFC. Mrs Parton as guardian may have made the decision on behalf of Ms Smith. Action to compel a person to reside where the guardian has decided may be lawful by operation of section 28 of the *Guardianship and Administration Act*. This may have rendered it unnecessary for action to detain her under the *Mental Health Act*. However, if Mrs Parton did not have such power (as it may not have been specified in the instrument) or did not chose to make such decision, the *Mental Health Act* procedures for involuntary admission would have been invoked to compel her detention at RFC;

7. For a period of 53 years the decisions in relation to almost all aspects of her life were made by those caring for her at the various facilities with no consent given by an appointed guardian.

Taking the above matters into account, I am satisfied that Ms Smith was “detained” at RFC and that detention remained extant whilst being treated at RHH, also an approved hospital.

One question relevant to Ms Smith’s case is whether a voluntary patient who, by reference to the criteria in section 24 of the *Mental Health Act*, would be assessed as requiring admission as an involuntary patient upon attempting to leave, is a person held in care

because they are “liable to be detained”. In other words, although a person may have been admitted as a voluntary patient and may, either themselves or by a guardian, seek to be discharged under section 22, they are not free to leave because after assessment they would be detained as an involuntary patient.

I have examined the use of the expression “liable to be detained” in the *Mental Health Acts* 1963, 1996 and 2013. The expression is used in provisions dealing with persons already subject to a formal order or direction in respect of involuntary admission but, for the time being, are not situated within an approved hospital. For example, in the *Mental Health Act* 1963, section 3 (2) provides; “references in this Act to a person liable to be detained shall be construed as references to a person who, in pursuance of any application, order, or direction, is liable under this Act to be detained in a hospital, whether or not he is for the time being absent from that hospital with leave or otherwise”. This concept carries through to the subsequent Acts; for example, section 205 of the *Mental Health Act* 2013, dealing with involuntary patients at large.

If Ms Smith had died whilst physically away from RFC or RHH (approved hospitals) it would be a question of degree as to whether she was still “detained” in the RFC, notwithstanding the temporary absence. It is possible in light of such a physical relocation, that she might instead be said to be “liable to be detained”, notwithstanding the different use of that phrase in the *Mental Health Act*. If the concept of “liability to be detained” extended to a category of persons who died away from an approved hospital and not subject to orders for involuntary admission but who nevertheless fell within the criteria under section 24, then the category of persons may be difficult to determine, possibly contrary to the intention of the provisions of the *Coroners Act* to impose additional requirements upon examination of those who die within the clear parameters of state custody. Alternatively, it may come down to a question of assessment of the circumstances and degree of control over the individual exercised by the state facility in any one case as to whether he or she can be said to be “liable to be detained in an approved hospital”. It is not necessary for me to further consider this point, as I have found that Ms Smith was, in fact, “detained”.

It will also be apparent from my reasoning that the question of detention as a precondition for a person being “held in care” does not depend upon the exercise of power by a guardian under a guardianship order. However, the exercise of such power to require the person subject to the order to live in an approved hospital may be strong evidence of actual detention, confirming a person’s incapacity and the likely control that is likely to be exerted

by the state. I therefore do not accept the submission that an exercise of power under a guardianship order relating to residency requirement is the determinative factor as to whether a person is “held in care”.

For the reasons above I find that Ms Smith was “held in care” and I am required to report on her care, supervision and treatment whilst held in care pursuant section 28(5) of the Act.

Course of illness until death

The issues for inquiry relate primarily to the adequacy of the medical care in the final week of Ms Smith’s life. I set out briefly the undisputed facts pertaining to her condition and care during this period.

At 12.30pm on Saturday 8 August, Ms Smith was found on the floor. She was confused, pale and cold with a high temperature of 38.8 degrees. Shortly after this, a registered nurse telephoned the “GP Assist” service for advice and spoke to Dr Helen Allison. GP Assist is a telephone triage and medical advice service that was (and is still) utilised by RFC nursing staff for after-hours medical care. Dr Allison, on the basis of the information provided, prescribed the antibiotic cephalexin 500mg to Ms Smith on the basis of a diagnosis of a respiratory tract infection. Ms Smith was monitored and treated by nursing staff throughout the day with paracetamol, metformin and cephalexin.

On 9 August Ms Smith stayed in bed. She was noted by nursing staff as confused and febrile. They monitored and treated her throughout the day with paracetamol, cephalexin and metformin.

On Monday 10 August Dr Ratnagobal saw Ms Smith upon resuming his usual weekly hours and noted her to have a fever. Her temperature was 38 degrees and he described her as ‘chesty’. Dr Ratnagobal suspected a chest infection. At his direction and in accordance with his diagnosis nursing staff monitored and treated Ms Smith through the day with cephalexin (as previously prescribed by GP Assist) and paracetamol.

On 11 August Ms Smith slept for most of the day. She had been incontinent. She was treated with cephalexin and paracetamol at intervals thought the day, still pursuant to the diagnosis of chest infection.

At 9.40am on 12 August Ms Smith was reviewed by Dr Ratnagobal. He noted that her temperature had lowered and she appeared better although she was still unwell. She was talking more clearly and was eating and drinking fluids to an appropriate standard. She was treated with cephalexin and paracetamol. At 4.00pm she was noted to have been incontinent. At 8.00pm she was found on the floor near her bed with no injuries found. She had further periods of incontinence and was found crawling on the floor during the night shift.

At 9.30pm on 13 August Ms Smith was reviewed by Dr Ratnagobal who noted "occasional crackles in lung" and that she was still feeling unwell but recovering. He noted that she was talking as well as she used to, was conscious and responding well, and that her face was not flushed. Dr Ratnagobal increased the dose of metformin and ordered blood tests and chest x-rays. Dr Ratnagobal telephoned Mrs Parton who had requested information about Ms Smith's condition. He told her that he had seen her and that she had improved. Mrs Parton expressed that she was happy. The nursing notes state that through the day Ms Smith had difficulty eating; she was gagging and unable to swallow. She was monitored and treated throughout the day with cephalexin, paracetamol and the new dosage of metformin. Overnight, Ms Smith spent the night in a chair and was restless with very little sleep; she was throwing covers off and picking at her clothes.

On 14 August Ms Smith was treated with the same medications. At 8.30am nursing staff noted her to be confused and had a temperature of 38 degrees. During the day she was incontinent of urine and faeces. A urine sample was obtained and bloods were also taken. She was noted to be very unwell overnight.

On 15 August nursing staff noted Ms Smith to be very unwell, with liquid bowel motions and skin breaking down on her buttocks. She was restless in bed, delirious and had a moist rattling chest. The same medications at the same doses were given throughout the day. Ms Smith's temperature remained above 38 degrees. She required full assistance to dress and move. At 2.30pm nursing staff again noted her as confused and delirious. They called an ambulance to transfer Ms Smith to the RHH for emergency treatment.

Upon arrival at the RHH, Ms Smith was critically ill. She was treated in the Department of Emergency Medicine where she was administered medication including an antibiotic, insulin and analgesia. However her prognosis was very poor and a decision was made with the involvement of Mrs Parton to treat her palliatively. At about 8.55am on 16 August 2009 Ms Smith passed away.

Issues for recommendation and comment pursuant to section 28(2) and 28(3)

Diagnosis of Ms Smith's illness

A primary focus of the inquest was the alleged misdiagnosis of Ms Smith's illness and the failure to recognise the severity of her condition. Further the inquest focussed upon the role of any such failures in causation for death.

Dr Anthony Bell gave expert evidence at inquest. Dr Bell is a former general physician, intensive care physician and nephrologist. He is currently the medical consultant in the Coronial Division. Dr Bell provided a written report that was tendered in evidence and gave oral evidence to the inquest. His evidence was based upon a review of the available medical records. In short, he gave evidence that there was a failure to recognise that Ms Smith was suffering from a severe bacterial infection, and that such failure contributed to her death because, with appropriate therapy at an earlier time, she had a significant chance of complete recovery.

In summary Dr Bell's evidence was as follows:

- A reasonably competent doctor with general practitioner qualifications ought to have recognised, in the time period between 8 and 10 August that Ms Smith had a kidney infection, that her condition was deteriorating and that hospitalisation with intravenous antibiotics were required. The positive urine dipstick result on 8 August showed the presence of white cells consistent with urinary tract infection, which infections were well known to occur in Ms Smith. Further, Ms Smith had conditions that made more probable and worsened the outlook for urinary tract infections, these being diabetes and polycythaemia rubra vera. She therefore required assessment and close monitoring to prevent any urinary tract infection developing into the more severe kidney infection, this requiring treatment with intravenous antibiotics;

- On 10 August Dr Ratnagobal diagnosed a chest infection instead of a urinary tract infection. By this date Ms Smith's symptoms were such that a registrar should have diagnosed pyelonephritis, being kidney infection;

- On 11 and 12 August the clinical observations indicated ongoing infection. There was a failure by Dr Ratnagobal to take into account the course of the observations as a whole rather than isolated sets of observations which may fluctuate;

- Dr Ratnagobal initiated inappropriate treatment for the high blood sugar levels by increasing the dose of metformin on 13 August. Fast-acting insulin was required;

- On 14 August the blood test taken showed an increased level of potassium and acute renal failure but there is no evidence that the blood test results were reviewed that day or that the chest x-ray was reviewed;

- Despite the evidence of a declining condition, no full blood test pathology was requested by Dr Ratnagobal. This should have occurred on 9 August as the clinical signs still demonstrated sepsis (severe infection). The request when made was not marked as urgent or followed up. Dr Bell considered both to be unacceptable clinical practice;

- There was a failure collectively between Dr Ratnagobal and the nurses to appreciate the seriousness of Ms Smith's illness, which ought to have been apparent to a competent general practitioner level doctor and competent nurses exercising reasonable care;

- That there was a failure to consider overall clinical information available, including high leucocytes in urine, consistently high temperature, other seriously abnormal vital signs as recorded by the nursing staff, and Ms Smith's declining condition in the face of oral antibiotics.

Associate Professor Craig Whitehead ("AP Whitehead"), consultant in geriatric medicine, also provided written reports and oral expert evidence. In general terms, his evidence accorded with that of Dr Bell. AP Whitehead said that there was a failure to recognise the severity of Ms Smith's illness at an earlier stage and to transfer her to hospital. Relevantly, AP Whitehead provided evidence as follows:

- That Ms Smith was febrile for seven days before her death;

- That there was a failure on the part of Dr Ratnagobal in not recognising the seriousness of Ms Smith's illness in light of the nursing observations, her history of recurrent urinary tract infections, abnormal blood sugar levels, and lack of oral intake;

- That the white cells detected in the urine dipstick on 8 August was not necessarily a critical sign of sepsis. However, when Ms Smith's fever had not abated by 12 August

as a result of the use of oral antibiotics, hospitalisation was required. Certainly by 13 August, when she was still very unwell, Ms Smith obviously needed hospitalisation;

- That on 12 and 13 August Ms Smith was noted to have a persistently elevated respiratory rate that was tolerated for 2 to 3 days without specific action by Dr Ratnagobal and nursing staff. He also noted that she was tachycardic and borderline hypotensive during this period;

- The presence of crackles in the lungs are not necessarily a sign of a chest infection and are a notoriously unreliable diagnostic indicator in frail and largely bedbound patients;

- Blood and urine should have been ordered on Monday 10 August by Dr Ratnagobal. This did not happen and represented a failure. Ms Smith was developing a hyperosmolar state (dehydration and hypoglycaemia) on the basis of uncontrolled diabetes within her last four days at RFC. If bloods had been ordered they would have alerted Dr Ratnagobal to Ms Smith's increasing state of hyperosmolarity;

- The bloods taken on 14 August, the results of which were not returned whilst Ms Smith was resident at RFC, showed obvious abnormality, reflecting marked dehydration associated with severe renal impairment. The bloods taken on arrival at RHH demonstrated that she was profoundly dehydrated associated with very high mortality independent of any underlying infective cause;

- If the bloods had been taken and treatment commenced by 13 August then by that date the condition would have been much more readily treatable. If the blood tests could not be obtained within 24 hours then Ms Smith should have been transferred to the hospital to have these tests completed;

- Increasing the dose of metformin in the setting of renal failure also poses certain risks and may have contributed to some of her acidosis. It was also inadequate to control the blood sugars as this only has a mild hypoglycaemic effect.

Dr Ratnagobal provided reports for the coronial investigation and gave oral evidence. Dr Michael McCarthy, Dr Ratnagobal's own general practitioner, gave evidence at the beginning of the inquest regarding Dr Ratnagobal's current poor state of health and decreased cognitive ability. He provided a report, tendered in evidence, that Dr Ratnagobal

was 66 years of age and suffered severe chronic kidney disease, significant vascular disease and other medical conditions that compromised his health. He gave evidence that the failure of Dr Ratnagobal's kidneys has produced lethargy, memory problems and worsening cognitive impairment and that he was on permanent leave from his work as a result of ill health. Dr McCarthy said that he suffered stress, low mood and anxiety as a consequence of his severe illness. Dr McCarthy was of the opinion that the stressful setting of court evidence may cause an increase in Dr Ratnagobal's stress to dangerous levels. Dr McCarthy's evidence was knowledgeable and helpful. As a result, Dr Ratnagobal gave evidence in a supported manner from a remote room by video-link. He had obvious difficulties in his evidence due to his memory, and, as such, his evidence was limited to the content of his previous reports.

Whilst Dr Ratnagobal gave evidence that he was diligent in monitoring and treating Ms Smith, he ultimately did not dispute that he made an error in not detecting her serious infection and transferring her to hospital at an earlier stage.

I accept the evidence of Dr Bell and AP Whitehead that the temperature patterns and other vital observations taken in respect of Ms Smith between 10 and 13 August 2009, demonstrated clearly that Ms Smith was very unwell with an infection and that she needed transfer to an acute medical facility where she could undergo urgent investigations and treatment with intravenous antibiotics. It is reasonable to find, on balance, that by 12 August, Ms Smith should have been transferred to RHH.

I find that Dr Ratnagobal, as the practitioner responsible, ought to have recognised the signs of need for acute care as a competent practitioner should have done. The evidence of the observations and clinical signs collectively indicated the serious state of Ms Smith's health. If Dr Ratnagobal had acted to have Ms Smith transferred to the RHH for acute medical care, including appropriate intravenous antibiotics, on or before 12 August there is a good chance that she would have survived.

Supervision and qualifications of Dr Ratnagobal

The evidence, including from the Medical Council of Tasmania ("MCT") file, indicates that Dr Ratnagobal was not prone to clinical or diagnostic errors, that he was diligent in his work, and compliant with the conditions placed upon his practice. At the time of Ms Smith's death,

he had no issues relating to consumption of alcohol and was fully compliant with the long-standing alcohol testing regime forming part of his undertakings.

Dr Ratnagobal had a good relationship with patients and staff at RFC and there was no criticism of his treatment of any patient prior to the five day period in question relating to Ms Smith's illness.

I therefore conclude that Dr Ratnagobal's failure to correctly diagnose and treat Ms Smith's illness was an isolated issue with no evidence of any propensity to make similar clinical errors. It may well have been that, at the time, the demands upon his time were high. The cephalexin prescription commenced by GP Assist may also have, consciously or unconsciously, influenced his ongoing judgment regarding diagnosis. It was also the case that Ms Smith was a complex patient who was, behaviourally, difficult to manage and suffered other physical conditions. These factors may have made diagnosis more difficult.

The inquest considered whether the failures on the part of Dr Ratnagobal to appreciate Ms Smith's condition and to initiate appropriate treatment (including the transfer to RHH), were due to (a) deficiencies in his clinical skills and knowledge, given that he had not passed the AMC exams; and/or (b) inadequacies in the supervision of his practice as was required by his conditional registration.

At the time of Ms Smith's death the conditions to which Dr Ratnagobal was subject relevantly included: to be employed as a Medical Officer at RFC under the supervision of Dr Joanna Bakas, not to undertake any after-hours, on-call or call-out functions, to have satisfactory supervisor's reports, to be actively involved in and satisfy the CPD requirements of the Royal Australian and New Zealand College of Psychiatrists, to comply with the undertakings and the performance agreement with Mental Health Services South. The undertakings included requirements for daily breathalyser testing under the supervisor's supervision, which required a nil alcohol reading for his continuing ability to work.

The inquest considered the nature and quality of Dr Bakas' supervision of Dr Ratnagobal. Dr Bakas was the staff specialist psychiatrist at RFC. She stated in her affidavit for the investigation that she signed an agreement to supervise Dr Ratnagobal in July 2008. She stated about the agreement, *"it was presented to me as a fait accomplit. I was not asked if I would supervise. I was directed by Mental Health Services to supervise"*.

Nevertheless, it was apparent from the evidence of Dr Bakas that she took seriously the role of supervisor and was diligent in that role. She stated that she was at RFC every day and did ward rounds together with Dr Ratnagobal. She said that she and Dr Ratnagobal had a weekly appointment for one hour to discuss Dr Ratnagobal's work, specific patients and any concerns. Dr Bakas held morning informal meetings with Dr Ratnagobal and the clinical nurse consultant without files and would see patients with him during the day as dictated by the outcome of those meetings. She estimated that she saw patients with Dr Ratnagobal for several hours per week. Dr Bakas stated that she regularly spoke to the nursing staff about Dr Ratnagobal's performance. She was aware of the requirement of his daily alcohol testing performed by the clinical nurse consultant at RFC. Dr Bakas also gave evidence of a weekly multi-disciplinary meeting, attended by herself, Dr Ratnagobal and others, to discuss each patient in detail with their file. Dr Bakas gave evidence that she did not sight a performance agreement for Dr Ratnagobal as was referred to in his undertakings. The evidence indicates that, at the time of Ms Smith's death, there was an outstanding request from the MCT to Mr Fox requesting confirmation as to whether a current performance agreement existed.

Dr Bakas stated that she recorded the notes of her supervision in a particular diary kept for that purpose. In that diary she made notes of the meetings, concerns discussed and reports made to the MCT. However, at some time in about 2014 she destroyed the diary by shredding it as she no longer worked at RFC and did not believe that she needed to retain it. Dr Bakas' evidence was that Dr Ratnagobal was performing well, was respected by the nursing staff and had a good relationship with his patients. More detailed evidence of supervision by Dr Bakas was lost due to the lapse of time and the unavailability of her diary.

The quality of Dr Bakas' supervision was put in issue by AP Whitehead in his report of 29 February 2012, a copy of which was provided to her and to which she responded on 6 December 2012. Although the delays in this matter have been most unsatisfactory, Dr Bakas was not advised that the matter had been concluded before deciding to destroy her diary. A simple enquiry with the Coroner's Office or Office of the Director of Public Prosecutions would have confirmed that the investigation was ongoing and that the diary was important evidence for retention. Her decision to destroy the diary was not motivated by any desire to prevent the evidence from being scrutinised, but it was ill-considered.

AP Whitehead queried the sufficiency of supervision of Dr Ratnagobal in general medical issues (as opposed to psychiatry issues). It may be that the ideal supervision regime for Dr Ratnagobal's general medical training was not in place. The inquest could not explore this

aspect in detail. However, there can be no adverse comment of Dr Bakas about the quality and extent of her supervision of Dr Ratnagobal. She was accessible to him, held sufficient meetings with him and spent substantial time seeing patients with him. She complied with her obligations to the MCT. Her completed supervisor's report to the MCT of June 2009 outlined her supervision and the fact that Dr Ratnagobal was working at or above the expected criteria in all aspects of his performance.

Despite this, the evidence does demonstrate that the process of supervision of Dr Ratnagobal as a conditionally registered medical practitioner was excessively loose and informal for such an important process. It was unacceptable that Dr Bakas was not anticipating such a role and was not given any option but to participate. The MCT and RFC documentation surrounding supervision procedures was unclear. It was difficult to ascertain how the supervision was done and whether to the set standard. Given the time lapse, it may have been that some further documentation existed. Fully documented standardised processes relating to all aspects of supervision should be undertaken by RFC, MCT and the supervisor.

Dr Ratnagobal was an experienced medical practitioner and had the ability and obligation to bring any cases of concern to the attention of his supervisor or a consultant as those cases arose. It was not the evidence that the supervisor had an independent duty to assess every patient even if no concerns were reported. I am not satisfied that Dr Ratnagobal discussed Ms Smith's condition with Dr Bakas on 11, 12, 13 and 14 August as he stated for the first time in his report in 2014. Dr Ratnagobal could not identify from where he obtained this information. It was not borne out by the medical file or other record. It appears that he may have relied upon an incorrect memory some years after the event. It is possible that he may have discussed Ms Smith informally with Dr Bakas in the morning meetings. If he did he did not report concerns regarding an acute condition. If he reported such concern, I am satisfied that Dr Bakas would have seen Ms Smith and made a written record as per her usual practice. There was no record of Dr Bakas having seen Ms Smith in this period.

Dr Bakas does recall that she was told by senior nursing staff that Ms Smith was sick but getting better. This may be consistent with a discrete period when Ms Smith's observations had fluctuated towards normal. Dr Bakas does not recall discussions with Dr Ratnagobal and did not examine Ms Smith. I cannot be satisfied that Dr Bakas was told that Ms Smith had an acute illness or there was cause for concern. Dr Bakas' supervisory processes in respect of Dr Ratnagobal occurred as usual in the week before Ms Smith's death. The weekly multi-

disciplinary meeting notes could not be located for that week which may (but not likely to) have assisted in respect of any discussion regarding Ms Smith.

I am therefore satisfied that Dr Ratnagobal's error regarding diagnosis and treatment of Ms Smith cannot be attributed to lack of supervision by Dr Bakas.

Nursing staff

Although the nursing staff had taken appropriate vital sign observations that ought to have alerted them to the seriousness of Ms Smith's illness and that her condition was deteriorating, no action was taken by them to recommend or ensure Ms Smith was transferred to hospital prior to 15 August 2009. The evidence of Dr Bell and AP Whitehead was that the nurses, as separate medical practitioners, had a coexisting responsibility to take action in response. I accept this is the case. Dr Bakas gave evidence that all staff had been instructed and directed not to hold acutely ill patients, but to transfer them to hospital. The nursing staff did not take that action until 15 August. Individual nurses ought not to be subject to adverse comment as the failure was collective in conjunction with Dr Ratnagobal. Whilst there was a variety of nurses caring for Ms Smith, each of them also had a duty to consider Ms Smith's condition.

There is no direct evidence about why the nurses did not act to transfer Ms Smith to hospital before 15 August when it was clear that she remained febrile after 48 hours of cephalexin evidenced by high respiratory rate, tachycardia and hypotension after 12 August. It would seem that the major reason was that Ms Smith was under the direct oversight of Dr Ratnagobal. A senior registered nurse ultimately arranged for Ms Smith to be transferred to RHH.

Policies and procedures

Upon the evidence of Dr Bakas and Mr Fox, there was likely to have been policies applicable to the escalation of care for physically deteriorating patients. They were not produced at inquest and Mr Fox stated that the policies were not kept after being replaced by more extensive policies and procedures in 2012. Mr Fox stated that the 2012 policy and procedure set was again replaced in 2016 as part of a process to seek accreditation for Mental Health and State-wide Services under the National Safety and Quality Standards. Mr Fox stated, and I accept, that RFC was contemplating national accreditation in 2009 and would have produced policies for that purpose. He stated, and I accept, that RFC policies and

procedures now align with the National Safety and Quality Standards for accreditation of MHS. Relevantly, the two policies "*Goals of Care and Advanced Care Directives Protocol"* and the "*Recognition, and Management of Clinical Deterioration in Community and Inpatient Settings Protocol"* are both fully operational at RFC. Policy and Procedure sets also routinely include protocols specific to the recording of clinical documentation.

I find that, whilst policies are likely to have existed in 2009 relevant to escalation of care for acute illness they were not well known nor widely promulgated and not clear in regards to how to identify the deterioration and what should be done once it was identified. AP Whitehead stated that the RFC ought to have had clear policies for escalation of care and I accept that as an approved hospital such procedures ought to have existed to meet good practice in medical care and treatment.

Nevertheless, I am satisfied that, as a basic principle, nursing staff were aware that the RFC could not manage acute deterioration, that they were aware of the need to transfer the patient to the RHH if the condition was concerning, and they had the authority to do so autonomously. Dr Bakas stated in an affidavit in 2012 that work was underway to provide staff with specific training in how to address acute medical illness in patients, as well as more explicitly documenting decisions regarding care and palliation.

Subject to my following comments regarding the role of GP Assist, the written policies and procedures now in place from 2016 have addressed the failure and appear to meet required and acceptable standards. As discussed following, one important guideline now in use is the Adult Observation and Response Chart for escalation of care ("the Chart").

GP Assist (Tasmania)

There was focus at inquest upon the role of GP Assist in Ms Smith's care and generally at RFC.

Dr Bell was critical of the use of GP Assist on 8 August 2009. Although he could not identify what information was given by nursing staff to GP Assist, he indicated that the treatment provided was inappropriate for the situation. He acknowledged that Dr Allison of GP Assist may have lacked the details required for a full assessment. He was of the view that the use of GP Assist should cease as the patient group at RFC is not suitable for telephone advice and that nursing staff require direct access to medical advice.

AP Whitehead was also critical of the prescription of antibiotics to an undifferentiated febrile patient without clinical review. He indicated that this is not good practice in a patient with such complexity. He stated in his report that a review was required due to Ms Smith's history of urinary tract infections and her allergy to norfloxacillin. AP Whitehead did not otherwise deal with the general issue of the suitability of the GP Assist telephone service at the RFC.

I am not able to determine, due to lack of recorded information in the RFC notes, the extent of the information concerning Ms Smith's condition provided to Dr Allison. Dr Allison's notes were not available due to the length of time since Ms Smith's death. I have no reason to consider that Dr Allison was provided with information by nursing staff that indicated an acute medical condition requiring transfer to hospital. On this basis I cannot say that it was unreasonable for Dr Allison to prescribe Ms Smith standard antibiotics, pending full clinical review to take place on the Monday morning, in less than 2 days.

Dr John Davis is the current principal of GP Assist, a different entity than GP Assist (Tasmania). At the time of Ms Smith's death Dr Davis worked as a consultant with GP Assist (Tasmania). In an affidavit for the inquest, Dr Davis provided information regarding the GP Assist service. He stated that the model of care whereby a general practitioner provides care and advice to a patient over the telephone is not unusual in general practice. He stated that prior to the establishment of the GP Assist, telephone consultancy for medical advice would have been commonplace throughout Tasmania during after-hours periods. He also stated that this model is used in European centres.

Dr Davis provided evidence that the GP Assist service is designed to provide initial assessment of patients during the after-hours period. He said that Dr Allison, who responded to the call in respect of Ms Smith, was an experienced practitioner who had worked with the service for a significant length of time. He said that it was a common practice for the consulting doctor at GP Assist to say that if the patient deteriorated, did not improve or if staff were otherwise concerned then they should call back. He noted that it was also an option for the GP Assist doctor to visit patients in Hobart if there was a high degree of concern about the well-being of the patient communicated to the doctor. He further stated that "invariably the efficacy of the GP Assist consultations and the reliability of them to properly treat the patient at any given time was highly dependent on the accuracy and timeliness of information provided by the nurses".

I accept this statement by Dr Davis. In the case of Ms Smith I do not find that the advice and treatment provided by GP Assist formed any causative part of the circumstances of her death. Dr Ratnagobal returned to duties on the morning of 10 August and was required to assess Miss Smith's clinical condition afresh on the basis of an examination of her and upon all of the other relevant information.

Notwithstanding the unequivocal comments of Dr Bell, I am hesitant to criticise the use of telephone medical services such as GP Assist to treat psycho-geriatric patients, as it was apparent from the evidence that the issue is a complex one and GP Assist was not an interested party at inquest. Further, in 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 need for a physical assessment and examination, there is potential for the use of the service to mask the seriousness of the medical case.

The main issue emerging at inquest was the necessity for clear and accurate transfer of information to the doctor at GP Assist and the necessity for the RFC nursing staff to carefully document the information provided and advice given. The GP Assist service is still routinely used by RFC in after-hours periods. RFC should therefore give consideration to developing (or reviewing) procedures relating to the provision and recording of information by nursing staff to GP Assist, necessary to ensure an accurate diagnosis and to inform further medical decisions.

Further, it is unclear on the Chart for escalation of care as to when the GP Assist service may be appropriately utilised. For example, it would not seem appropriate for use in the case of the nominated Tier 1 and Tier 2 acute situations that require either an emergency response or urgent medical review. However, it may be appropriate for use in the non-acute Tier 3 and Tier 4 situations. The Chart does not make such distinction.

Summary

The findings pursuant to Section 28 (1) of the Coroners Act 1995 are:

(a) The identity of the deceased is Molly Jessie Smith;
(b) Ms Smith died in the circumstances set out above;
(c) Ms Smith died as a result of pyelonephritis and pneumonia; and
(d) Ms Smith died on 16 August 2009 at Royal Hobart Hospital.

Comments on care pursuant to section 28(5) of the Coroner's Act

There was a failure by Dr Ratnagobal to diagnose Ms Smith with an infectious illness and to transfer her to the RHH between 8 and 13 August 2009 for treatment. This treatment may have prevented her death. To a lesser degree, there was also too long a delay by nursing staff to take action to transfer Ms Smith to the RHH.

In relation to Ms Smith's care generally, Dr Bell provided evidence that, in the two years before her death, standard management of her diabetes did not occur. He stated that Ms Smith was reviewed in the RHH diabetic clinic in 2007 but there is no evidence of further attendances at this clinic. He also noted that the diabetic treatment sheet for over one year showed evidence of uncontrolled diabetes and that the medical record from the RFC provides no specific evidence of screening for diabetic complications. The evidence did not indicate that any lack of standard diabetic management contributed to her death.

The care and treatment of Ms Smith by the state over a period of 53 years was generally appropriate. However, I observe that at a time shortly after it became apprarent that she would reside permanently in state-run facilities, a formal guardian should have been appointed to make decisions on her behalf. The guardianship should have endured for the whole period until her death. Although she was recorded as being a "voluntary" patient, it is doubtful that Ms Smith ever had the ability to provide informed consent. She did not have the capacity to understand important facts, risks and benefits nor to properly communicate choices in respect of any important decision affecting her. It is likely that she did not understand the procedures for seeking discharge and the likely consequence of such request.

The *Mental Health Act 1996* and it successor operates upon the desirability of voluntary admission over involuntary admission for many good reasons, including achieving the best therapeutic outcomes for patients. However, it has been recognised that there are reasons against voluntary admission, particularly where capacity for informed consent is doubtful. These include: the potential for patient coercion and abuse, fewer opportunities for discharge, the patient's lack of access to legal advice, a lack of legal process or determination; and the patient is not free to leave. (see *Donald H. Stone, The Benefits of Voluntary Inpatient Psychiatric Hospitalization: Myth or Reality, 9 B.U. Pub. Int. L.J. 25, 52 (1999); Karna Halverson, Voluntary Admission and Treatment of Incompetent Persons with a Mental Illness, 32 Wm. Mitchell L. Rev. 161, 188 (2005)).*

Likewise, the decisions made in respect of Ms Smith as a “voluntary” patient were unchecked, not scrutinised by a legal guardian and not subject to the formal processes of the law or amenable to challenge. I also comment, in particular, that a guardianship order in favour of Mrs Parton should clearly have been considered and made prior to the proposal to relocate Ms Smith to RFC. Mrs Parton could therefore have been involved in the decision on behalf of Ms Smith and provided her consent if she agreed with the decision. It was inappropriate to relocate Ms Smith to RFC without a decision made by a formal guardian under the applicable guardianship legislation or an order under the *Mental Health Act* 1996.

Notwithstanding the lack of a legal guardian for the vast proportion of her care, Ms Smith was provided by the state with as good a quality of life as could have been achieved for her. Over a lengthy period of time very significant efforts and resources were devoted to managing her severe mental health and complex physical conditions. The dedication and tolerance of all those who treated and cared for Ms Smith over many years is to be commended. In particular, the care and friendship of Mrs Parton greatly enhanced the quality of Ms Smith’s life.

Recommendations

I **recommend** that RFC modify the Adult Observation and Response Chart to incorporate clear instructions regarding appropriate instances for invoking the use of the GP Assist service during after-hours periods, such instructions being referenced to acute/non-acute presentations and/or Tiers 1-4 on the Chart.

I **recommend** that RFC provides ongoing training of nurses in managing acute medical conditions including procedures for liaison with consultants or medical officers, recording of escalation in patients’ conditions, use of the GP Assist service, and training in the use of the Chart.

I **recommend** that RFC conduct a review of its procedures for supervision of medical practitioners holding conditional registrations requiring supervision, including the selection and training of the proposed supervisor and the recording and retention of all documentation relating to the supervision.

I **recommend** that RFC implement a written policy and system to ensure that persons admitted to RFC who are incapable of giving informed consent to their admission, residency and/or treatment at RFC are identified and only admitted, treated and/or continue residence

with the substitute consent of a legal guardian appointed pursuant to part 4 of the *Guardianship and Administration Act 1995,* or pursuant to a power or order under the *Mental Health Act 2013.*

Conclusion

In concluding, I express my appreciation to all counsel who appeared at the inquest. I particularly thank counsel assisting, Ms Sandra Taglieri, for her high quality work. I also express my gratitude to Constable Kathryn Luck, Coroner's Associate, in assisting with the organisation of the inquest.

Dated: 17 November 2017 at Hobart in Tasmania.

Olivia McTaggart
Coroner