



# MAGISTRATES COURT *of* TASMANIA

## CORONIAL DIVISION

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### **Record of Investigation into Death (Without Inquest)**

*Coroners Act 1995  
Coroners Rules 2006  
Rule 11*

I, Olivia McTaggart, Coroner, having investigated the death of Feryne Gaylene Hunter

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

- a) The identity of the deceased is Feryne Gaylene Hunter;
- b) Mrs Hunter died in the circumstances set out in this finding;
- c) The cause of death was airway obstruction due to an aspiration event occluding a permanent tracheostomy; and
- d) Mrs Hunter died between 12 and 13 September 2017 at Glenorchy, Tasmania.

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Mrs Hunter's death. The evidence includes an opinion of the forensic pathologist who conducted the autopsy, the Police Report of Death for the Coroner, life extinct and identification affidavits, Ambulance Tasmania documentation and policies, affidavits of attending Ambulance Tasmania paramedics and police officers, records of the Hobart District Nursing Service, hospital and general practitioner records and reports, affidavit of Mrs Hunter's neighbour, records relating to Mrs Hunter's Red Cross medical alarm and information from Mrs Hunter's daughter.

Mrs Feryne Gaylene Hunter was born on 17 January 1942 in Hobart and was aged 75 years at the time of death. She was widowed and lived by herself at her home in Glenorchy. Mrs Hunter has three adult children: Helen Maria Poke, Wayne Patrick Poke and David Stuart Poke – all of whom live interstate. Her usual occupation throughout her life was that of a beauty consultant. She was retired at the time of her death.

The medical records in evidence in this investigation revealed that in 2007, whilst living in Victoria, Mrs Hunter underwent a tracheostomy following a severe respiratory tract infection which caused subglottic stenosis (narrowing of the airway below the vocal cords and above the trachea). She had a permanent tracheostomy fitted as a result. Her medical records also indicate that she had a history of asthma, gastro-oesophageal reflux disease, hyperlipidaemia and hypertension. Her conditions, particularly her subglottic stenosis and tracheostomy, were monitored and treated by her general practitioners who prescribed her medication and referred her to specialists when necessary. The records indicate that Mrs Hunter had a

number of falls in the months before her death, possibly related to blackouts, which were to be investigated by a geriatrician in November 2017.

Mrs Hunter is recorded as having had extensive ongoing medical care in respect of her throat and tracheostomy at the Royal Hobart Hospital (RHH). On 6 September 2017, about a week before her death, she underwent debulking and diathermy procedures on her throat. The reason for this was the persistent coughing up of clots through the tracheostomy. Even after the treatment, she was recorded as having coughed up clots.

Mrs Hunter had also been receiving assistance and care from the Hobart District Nursing Service (“the district nurses”). The district nurses visited her three times per week (Monday, Wednesday, and Friday) in the six years before her death for tracheostomy care. She was also visited by community support workers on the same days for domestic assistance. The nursing and carer’s notes in the several months before her death record that Mrs Hunter was coughing up clots and sputum and suffering tracheostomy blockages. She was given advice by the nurses to be admitted to hospital or see her general practitioner when appropriate.

On Monday 11 September 2017 Mrs Hunter was feeling unwell and stayed in bed. She was visited by a nurse who attended as usual at Mrs Hunter’s address. The nursing notes record that Mrs Hunter was tired and had tracheostomy blockages, the last being the previous evening. The nurse noted that Mrs Hunter was not as bright and chatty as usual and did not want to see her general practitioner. However, she told the nurse that she would call for an ambulance or use her Red Cross alarm if she became unwell. In the early afternoon, the nurse returned to check on Mrs Hunter’s condition and saw that she was having trouble breathing and was unable to talk.

At 1.56pm on 11 September the nurse called Ambulance Tasmania to attend to Mrs Hunter. Ambulance Tasmania paramedics attended seven minutes later. The paramedics recorded Mrs Hunter as alert, orientated, breathing normally but with a slightly elevated temperature. Mrs Hunter refused to be transported to hospital but accepted the advice of paramedics to make an appointment with her general practitioner the following day due to the possibility of an early chest infection.

The attending paramedics noted in the records that: *“patient refused hospital transport, which was voluntary, she was informed of risks associated with non-transport, the refusal was relevant to the current complaint, she had capacity to refuse and was given appropriate to discharge advice.”*

As I will discuss below, the paramedics on this occasion acted correctly and in accordance with procedure.

On Tuesday 12 September 2017 Mrs Hunter remained at her home. She did not visit her usual general practitioner and it is unknown if she had any visitors.

At approximately 9.45pm that evening, three police officers arrived at Mrs Hunter's address after responding to a 000 "no-voice" call. The call was made from a mobile phone which was registered in the name of Zeke Anthony Kendrick. Due to a clerical error by his telecommunications company, Mr Kendrick's mobile phone number had been registered to Mrs Hunter's address of 9 Madeline Court and not Mr Kendrick's correct address of 6 Madeline Court. Subsequent investigation revealed that Mr Kendrick did in fact call 000 but terminated the call without speaking as he decided that he no longer required assistance. Mr Kendrick, in his affidavit for the investigation, said that he was aware that an elderly lady lived across the road at 9 Madeline Court but it seems that he did not know her name and did not interact with her. Mr Kendrick had no knowledge of Mrs Hunter's health and his 000 phone call was not related to her.

The police officers could not raise any person by knocking at the door of 9 Madeline Court. However, through a partially opened front window, they saw Mrs Hunter seated in a hunched position on the stairs, breathing very heavily and apparently in a poor medical state. They formed the view that she needed help.

The officers therefore opened the window to its fullest extent which allowed one officer to climb into the residence and let the other officers in using the key to the front door. Constable Nikayla Roach spoke with Mrs Hunter who informed her that she did not call 000 and that she did not know anyone named Zeke Kendrick. It was apparent to the officers that Mrs Hunter was unhappy with the police presence in her house. Concerned by Mrs Hunter's shortness of breath and physical state, the officers tasked Ambulance Tasmania to attend the address at 10.06pm.

At 10.13pm Ambulance Tasmania paramedics arrived at Mrs Hunter's address in response to the police call. Paramedic Natasha Jones and intern-paramedic Anna-Rose Cook were advised by the police officers of their observations. Ms Jones and Ms Cook, who made affidavits for the investigation, said that they attempted to assess Mrs Hunter but she refused consent to do so on multiple occasions. In her affidavit, Constable Roach also confirmed that Mrs Hunter told the paramedics that she did not need their help as she was "fine".

Ms Jones and Ms Cook conducted a Glasgow Coma Scale (GCS) test based only upon visual assessment, with a resulting score of 15. They recorded in their notes that Mrs Hunter was conscious and alert, denied chest and other pain and denied shortness of breath. Their notes also record that Mrs Hunter told them that her breathing pattern was normal for her.

Both paramedics noted that Mrs Hunter's speech was clear and continuous and that she was calm and quiet. After questioning her about her medical state, they were satisfied that Mrs Hunter had capacity to refuse an assessment.

In their written report made shortly after the incident, the paramedics recorded Mrs Hunter as saying "*I want you all to go away and leave me alone*". I accept that Mrs Hunter did use those words and find that she was adamant in refusing assessment, treatment or conveyance to hospital. The paramedics advised her that she could contact either police or ambulance if she needed help. The police officers and paramedics then left Mrs Hunter's address, all of the view that there was no further assistance they could give.

The evidence indicates that Mrs Hunter made her way to the bedroom at some subsequent point and went to bed. This act was unwitnessed.

At 8.40am on Wednesday 13 September 2017 Ms Chivers attended her normal scheduled appointment to care for Mrs Hunter. She could not raise her at the door but saw through the window that Mrs Hunter was lying in bed. She then entered the house through the open back door and approached Mrs Hunter in bed. She noted that Mrs Hunter was cold to the touch and she felt no breath coming from her mouth. Ms Chivers then called her supervisor who sent out a registered nurse to the address. Ambulance Tasmania paramedics were also called. They attended and confirmed that Mrs Hunter was deceased.

Police officers, including a forensics officer, attended to examine the scene and commenced a coronial investigation into Mrs Hunter's death. Mrs Hunter was conveyed to the RHH mortuary after being formally identified by Ms Chivers at the scene.

On 14 September 2017 Dr Christopher Lawrence, State Forensic Pathologist, examined Mrs Hunter's body externally (including using a CT scan) and considered her medical records. Dr Lawrence concluded that Mrs Hunter died as a consequence of airway obstruction due to aspiration occluding a permanent tracheostomy due to tracheal stenosis following oesophageal procedure.

He noted that other significant conditions contributing to her death included asthma and hypertension. In his report Dr Lawrence stated that the CT scan of Mrs Hunter revealed an airway obstruction which appeared to be the cause of Mrs Hunter's death. Dr Lawrence stated that *"it appears likely that she has regurgitated food and this has then lodged in the tracheostomy and in the airway below the tracheostomy which does not have a balloon and she has succumbed to the airway obstruction"*. He also observed on the CT scan an obvious hiatus hernia (a type of hernia where the stomach slips through the diaphragm into the middle compartment of the chest).

He reported that this hernia was associated with an increased risk of aspiration of stomach contents from the oropharynx or gastrointestinal tract into the larynx and lower respiratory tract. I accept Dr Lawrence's conclusion as to cause of death.

### **Issues in the Investigation**

Mrs Hunter's daughter, Ms Helen Poke, raised concerns regarding her mother's death and the care provided by the Hobart District Nursing Service and Ambulance Tasmania which I will now address. Ms Poke questioned why her mother was left alone by ambulance and police personnel on the evening of 12 September when she did not have the physical capacity to care for herself. Further, Ms Poke questioned the sufficiency of the nursing care and intervention, given that, in her view, there was a deterioration in Mrs Hunter's cognition prior to her death.

#### *District Nursing Service*

I have had regard to the comprehensive nursing and care records provided from the Hobart District Nursing Service. The records are comprehensive and clearly show that the nurses and carers were conscientious in monitoring Mrs Hunter's condition, caring for her tracheostomy and emphasising the need for her to use her medical alarm or a 000 call if she had breathing difficulties if unwell. The nurses were also vigilant in ensuring that Mrs Hunter had organised appropriate specialist, general practitioner and other appointments. All entries in the nursing records indicate that Mrs Hunter was of sound mind, spoke coherently and responsively to the nurses and carers who visited, understood her condition and how to contact emergency care. There are two nursing entries on 5 and 11 April 2017 indicating that the attending nurse believed Mrs Hunter was muddled or confused at that time. This observation seems to coincide with her suffering some blackouts. Subsequently there is no record of any issues with her cognitive state, capacity to make medical decisions and seek appropriate help.

The medical treatment and care of Mrs Hunter was subject to a review by Dr A J Bell, coronial medical consultant. Dr Bell identified no issues with the nursing care provided to Mrs Hunter. I find that the nurses were diligent and provided good care.

#### *Ambulance Tasmania*

Ambulance Tasmania Acting Chief Executive, Mr Garry White, provided a report at my request which reviewed the attendance and actions of the paramedics who attended Mrs Hunter's address. Mr White also supplied a copy of the applicable *Ambulance Tasmania Refusal of Treatment / Transport Policy* ("the Policy"). The Policy is intended to provide guidance to paramedics concerning the proper and lawful approach where patients refuse treatment at the scene and/or transport to further medical treatment or assessment.

The Policy correctly provides that: "*every adult person with capacity has the right to make decisions regarding healthcare, including the decision to reject that which is recommended by the person's health provider. The right of choice is not limited to decisions that others, including family members and health providers may regard as sensible or even rational*". This principle has long been part of the common law which recognises that every human being of adult years and sound mind has a right to determine what shall be done with his or her own body.<sup>1</sup> The authorities hold that where a patient is competent, their consent, or lack thereof, must be followed even if it means they will die.<sup>2</sup> Further, an adult is presumed to have the capacity to consent to, or to refuse, medical treatment unless and until that presumption is rebutted.<sup>3</sup>

In the situation faced by the paramedics attending to Mrs Hunter on both 11 September and 12 September, the Policy required them to ensure that several assessment criteria, known as "VIRCA" are addressed before accepting the patient's refusal of assessment, treatment and / or transport. The acronym "VIRCA" assists the paramedic to assess the following: that the refusal is voluntary and informed; that it is relevant to the treatment; that the patient has capacity; and that advice is given regarding alternative pathways for follow-up treatment. The Policy further provides that, once the patient is deemed to have capacity and refuses treatment, a record of the advice given and the patient's decision must be clearly documented in the "PCR" (I assume meaning the electronic patient care record).

In the case of the paramedics attending on 11 September, the paramedics were clearly alert to the requirement to apply the VIRCA assessment and, as discussed above, correctly reported in

<sup>1</sup> *Schloendorff v Society of New York Hospital* (1914) 211 NY 125 at 129.

<sup>2</sup> *Re B* [2002] 2 All ER 449 at 20.

<sup>3</sup> *Re MB (Medical Treatment)* [1997] 2 FLR 426 at 30.

the patient care record against each of the criteria. Additionally, the notes in the record disclosed that Mrs Hunter was “alert and orientated”. Their actions in leaving without treating or transporting her were appropriate and in accordance with the Policy.

In the case of the paramedics attending the following day, 12 September, there was also no grounds to lawfully do anything other than they did. They were presented with a situation whereby Mrs Hunter persistently refused to be clinically assessed and was able to coherently communicate those wishes to them. There was no other information to indicate that she did not have capacity to make decisions in respect of her care and, correctly, she told them she did not initiate the call to police or ambulance. On the evidence, the best medical care was to transport Mrs Hunter to hospital for treatment. However, in light of her refusal of assessment and treatment, this course would not have been lawful.

In relation to the recording of the VIRCA assessment, the paramedics attending on 12 September should have more expansively recorded the relevant criteria in the patient care record. Their notes in the electronic record do not indicate that they informed Mrs Hunter of the risks or possible consequences of the decision to reject ambulance treatment or transport. The notes also do not indicate that they gave her advice regarding alternative treatment, although the evidence is clear that they told her to call the ambulance again if she required help.

Even though the documentation, in my view, should have been more comprehensive, the overwhelming evidence of the two paramedics and three police officers attending the premises was that Mrs Hunter did not wish to have any intervention no matter what advice was given to her. No other action could have been taken by them to change that course.

### **Comments and Recommendations**

There was nothing that could reasonably have been done by the nurses, carers, paramedics or police officers that could have prevented Mrs Hunter’s death. All acted appropriately and, to the extent possible, in her best interests. I cannot speculate why Mrs Hunter did not wish to accept medical treatment on the two successive days before her death, but I am satisfied that she had the ability to call for assistance when she required it.

Ambulance Tasmania, in its consideration of this matter, identified that the Refusal of Treatment / Transport Policy provides limited advice as to how paramedics are to manage situations such as those relating to Mrs Hunter’s refusal of treatment on 11 and 12 September. I agree that this is the case. Although both sets of paramedics acted appropriately and in

accordance with law, the Policy is confusing, particularly in relation to the area of consent and diminished capacity. This did not apply in Mrs Hunter's case, although priority should be given to reviewing and rewriting the Policy, with appropriate legal advice, to give simple and clear guidance on how paramedics are to deal with issues relating to capacity, consent and refusal of treatment.

I **recommend** that Ambulance Tasmania rewrite the Refusal of Treatment / Transport Policy.

I convey my sincere condolences to the family and loved ones of Mrs Hunter.

**Dated:** 15 May 2020 at Hobart Coroner's Court in the State of Tasmania.

**Olivia McTaggart**  
**Coroner**