QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Stella HAMILTON**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Cairns
FILE NO(s):	2016/3147
DELIVERED ON:	14 December 2018
DELIVERED AT:	Cairns
HEARING DATE(s):	18 May, 28 September & 18-19 October, 2018
FINDINGS OF:	Nerida Wilson, Northern Coroner
CATCHWORDS:	Aged Care, palliative care, euthanasia, dementia, suffocation, CCTV, privacy, consent, public interest intervenor, cause of death undetermined.

REPRESENTATION:

Counsel Assisting:	Ms M. Benn
Counsel for Ozcare:	Ms S. Williams (instructed by MacDonnells Lawyers)
Counsel for Dr House and Dr Adams:	Ms C. Steele (Ashurst Lawyers)
Counsel for Caroline Britton:	Mr W. Pennell (instructed by Firth Lawyers)
Aged & Disability Advocacy Australia:	Ms K. Williams Mr G. Rowe

Contents

1. The *Coroners Act 2003* provides at s. 45 that a coroner's written inquest findings must be given to the family of the person who died, each of the persons or organizations granted leave to appear at the inquest, and to various officials with responsibility for the subject matter of any recommendations. These are my findings in relation to the death of Stella Hamilton. They will be distributed in accordance with the requirements of the Act and posted on the website of the Coroners Court of Queensland.

The Inquest

2. Pre-Inquest Conferences were held in advance of the Inquest on 18 May 2018, and on 28 September 2018. A two day Inquest was held on 18 and 19 October 2018 in the Coroners Court of Queensland at Cairns.

3. The information and evidence relied upon by me to formulate these findings includes:

    i. The brief of evidence;
    ii. Oral evidence at Inquest;
    iii. Written submissions provided by:
        Counsel Assisting the Northern Coroner, Ms Benn
        Counsel appearing on behalf of Ozcare, Ms Williams
        Counsel appearing on behalf of Dr House and Dr Adams, Ms Steele
        Counsel appearing on behalf of Caroline Britton, Mr Pennell
        Public interest advocate: Aged and Disability Advocacy Australia

4. In all a total of 15 witnesses were called to give evidence.

5. Of the three Hamilton siblings only one, Caroline Britton, appeared with legal representation. Hamish and Fiona Hamilton did not engage legal representation. Caroline, Fiona and Hamish gave oral evidence at the Inquest, did not claim privilege and answered all questions asked of them.

6. I touch only on those matters/evidence I believe is necessary to understand the findings formulated by me without referring to all of the evidence available to me at Inquest.

Issues for Inquest

7. The issues for the Inquest were as follows:

    1. The findings required by section 45 (2) of the *Coroners Act 2003;* namely the identity of the deceased person, when, where and how she died and what caused her death

    2. Whether any persons contributed to the death of Stella Hamilton

    3. The adequacy of security procedures including monitoring the movement of residents and visitors in and around Ozcare Malanda Aged Care Facility

4. Whether recommendations can be made that relate to public health and safety and/or to prevent deaths from happening in similar circumstances in the future pursuant to s. 46 of the *Coroners Act 2003*.

Coroners Findings

8. A Coroner must not include in the findings[1] any statement that a person is, or may be:

   (a) guilty of an offence; or
   (b) civilly liable for something.

9. The focus of an inquest is to discover what happened, not to ascribe guilt or attribute blame or apportion liability.

10. The purpose of an inquest is to inform the family and the public of how the death occurred with a view to reducing the likelihood of similar deaths.

Standard of Proof

11. The standard of proof to be applied at coronial inquests is well set out by Freckleton and Ranson in their text *Death Investigation and the Coroner's Inquest*[2]

12. Coroners can only make findings on the basis of proof of the relevant facts on the balance of probabilities.

13. However, where the matters that are subject of the coroner's findings are very serious or approximate criminal conduct, the finding will be on the upper end of the balance of probabilities, in accordance with the scale postulated in *Briginshaw v Briginshaw*[3]*.* As Latham CJ put it*:*

> *There is no mathematical scale according to which degrees of certainty of intellectual conviction can be computed or valued. But there are differences in degree of certainty, which are real, and which can be intelligently stated, although it is impossible to draw precise lines, as upon a diagram, and to assign each case to a particular subdivision of certainty. No court should act upon mere suspicion, surmise or guesswork in any case. In a civil case, fair inference may justify a finding upon the basis of preponderance of probability. The standard of proof required by a cautious and responsible tribunal will naturally vary in accordance with the seriousness or importance of the issue.*[4]

Justice Dixon framed the test similarly:

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[1] Section 45 (5) *Coroners Act* 2003
[2] Freckleton, I. and Ranson,D. *Death Investigation and the Coroner's Inquest* 2006 p. 554
[3] (1938) 60 CLR 336; 12 ALJ 100; HCA 34
[4] (1938) 60 CLR 336, 343-4

The truth is that, when the law requires the proof of any fact, the tribunal must feel an actual persuasion of its occurrence or existence before it can be found….
The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding are considerations which must affect the answer to the question whether the issue has been proved to the reasonable satisfaction of the tribunal. In such matters 'reasonable satisfaction' should not be produced by inexact proofs, indefinite testimony, or indirect inferences.[5]

14. Coroners should be mindful of a deleterious effect that a finding of contribution to cause of death may have on a person's character, reputation and employment prospects, as well as the gravity of such a finding. While allegations of matters such as assault need to be proved only on the balance of probabilities before a coroner, their criminal nature is one of the factors to be taken into account in determining whether the requisite level of 'comfortable satisfaction' exists as to the matters alleged. 'Because of the gravity of the allegation, proof of the criminal act must be "clear, cogent and exact and when considering such proof, weight must be given to the presumption of innocence" The result is that the distinction is between the criminal and civil standards in such matters may not be of major consequence.[6]

15. The Inquest into the death of Stella Hamilton required an inquiry into whether any person contributed to the death of Stella Hamilton[7]. The serious nature of such inquiry requires a standard of proof at the upper end of the balance of probabilities.

16. A coroner must not include in any findings a statement that person is guilty of an offence (i.e. a criminal act), or civilly liable for something.[8]

17. I therefore heed that *proof of any allegations approximating criminal conduct must be clear, cogent and exact and when considering such proof, weight must be given to the presumption of innocence and that the result is that the distinction is between the criminal and civil standards in such matters may not be of major consequence*.[9]

Introduction and background issues

18. Mrs Stella Hamilton was born on 17 October 1943 and was 72 years when she died on 31 July 2016 at the Ozcare Malanda Aged Care Facility, North Queensland.

19. Mrs Hamilton was a dementia patient in the Palmerston wing. The Palmerston wing is a secure, specialised dementia wing with a number of bedrooms leading from common areas where residents gather to eat, watch television, participate in activities and talk with each other.

[5] (1938) 60 CLR 336, 361-2
[6] op. cit. p. 555
[7] Inquest issue 2
[8] s. 45 (5) *Coroners Act 2003*
[9] Freckleton and Ranson, op. cit. p.555

20. At the time of her death, Mrs Hamilton had been resident at the facility for almost seven months. She had previously lived full time with her eldest daughter, Caroline, and Caroline's husband and children near Ingham, North Queensland.

21. Around Christmas time 2015, Mrs Hamilton's adult children Caroline Britton, Fiona Hamilton and Hamish Hamilton determined their mother's care needs had increased and her medical needs and behaviours were such that her needs would be best served by the Ozcare facility where she had previously spent time in respite care in September 2015.

22. Mrs Hamilton's General Practitioner at Ozcare, Dr Diana House gave evidence of Mrs Hamilton's presenting comorbidities including severe dementia, cranial nerve pain, and profound iron deficiency resulting in anaemia. Mrs Hamilton was osteoporotic and she had experienced a number of falls. In keeping with her onset of dementia, Mrs Hamilton displayed signs of aggression and a lack of insight.

23. In consultation with her doctors, Mrs Hamilton's family determined that it would be too invasive and traumatic to impose any further medical interventions on their mother.

24. I was in no doubt after hearing the oral evidence of Caroline Britton, Hamish Hamilton and Fiona Hamilton that in the days leading up to their mother's death, they each became increasingly distressed as her pain levels increased. The daughters in particular took up conversations with the staff and treating doctors about how to best manage their mother's pain levels.

25. Days prior to her death Mrs Hamilton was placed on a syringe driver to administer her morphine.

26. By Saturday 30 July 2016, Caroline, Hamish and Fiona felt *that their mother's spirit had left her body*. Although breathing shallowly, she was not conscious. The medical progress notes confirmed that by the early morning of 31 July 2016, Mrs Hamilton was unconscious. She was noted to be comfortable in her bed, and that death was imminent.

27. The adult children requested, and had been granted, the opportunity by Ozcare to care for their mother 'round the clock' in her last days.

28. Caroline and Fiona took turns staying at Ozcare and slept on a mattress beside their mother on the floor for the 10 days prior to her death. They attended to her personal care needs including assisting her toileting, washing, dressing and bathing. The daughters monitored their mother's pain levels and advised staff when they felt more morphine was needed. The Ozcare progress notes reflect that the staff considered that both Fiona and Caroline had their mother's care needs appropriately in hand.

29. At the conclusion of the two day inquest, Caroline, at the invitation of the court, spoke about her mother and described her as a 'strong woman, an unbelievable nurse, an

incredible mother (and grandmother) who gave up everything to raise her three children'.

30. Caroline told the court that she and her siblings had bonded over their mother's illness and they wanted to ensure that she did not go to her death alone. Caroline told the court that her own children (the grandchildren) loved her mother. She told the court that from the first time her mother's illness had been diagnosed, some years prior, it became extremely upsetting to know their mother was going to pass away in such noticeable decline and with associated pain.

31. Caroline said she, Fiona, and Hamish, appreciated the time they were afforded with their mother by the Ozcare staff, and that they had received incredible support from the facility, and by some of the staff in particular. Caroline said that each of the three adult children had in their own way suffered from anxiety and depression as a result of their mother's illness and death and that they were shocked to find out how terribly ill she had been at the time of her death. (I took this reference to mean the autopsy conclusions that Mrs Hamilton was suffering undiagnosed necrotising bronchopneumonia at the time of her death, in addition to the known comorbidities).

The events prior to Mrs Hamilton's death

32. On Saturday night 30 July 2016, Caroline slept in Room 6 at her mother's side on a mattress on the floor.

33. Room 6 is a single occupancy room with a single size medical bed and ensuite facilities. The room can be accessed by two doors, one leading into the Palmerston wing corridor (the internal door). The second door is on the opposite side of the room and is described as a glass sliding door with security screen leading directly into an external courtyard.

34. EN Plowman checked on Mrs Hamilton at 6.30am on Sunday 31 July 2016 and saw Caroline asleep on the mattress next to her mother's bed. EN Plowman later saw Caroline at around 8.30am and asked if she needed anything.

35. Carer Heather Ward also checked on Mrs Hamilton around the same time and noted she was breathing shallowly and raspily, 'the death rattle'.[10]

36. At 8.52am, Caroline telephoned her sister Fiona[11] and asked Fiona to come into Ozcare so that she could leave to spend some time with her husband and children who were returning to Ingham later that afternoon.

37. Between 9.00am and 9.30am EN Plowman checked on Mrs Hamilton and noted that Caroline had rolled Mrs Hamilton onto her side in the bed.

[10] Exhibit C5 and oral evidence of Heather ward
[11] Exhibit C2.1 page 11 – Fiona's phone records

38. EN Plowman saw Hamish walk past the kitchen window (to enter room 6 from the courtyard) between 10am and 10.30am.[12]

39. Hamish delivered snacks to Caroline and they walked out of the facility together and saw Fiona in the carpark at approximately 11.00am.[13] Caroline gave Fiona a copy of Caroline's wedding DVD and suggested that Fiona play the DVD in the common room so that Fiona could remember their mother as she was in earlier times 'vibrant and beautiful'. Caroline and Hamish departed Ozcare at the same time and separately.

40. Fiona entered to her mother's room and kissed her mother. Her mother was unconscious but she could hear her breathing with the doona up to her neck.[14] Fiona then lay on the mattress between her mother's bed and the door leading to the outside courtyard for one or two minutes[15]. Fiona then went in search of remote controls for the DVD player in the common room, and she gave evidence that she had some difficultly locating the controls to the DVD player. In any event she was able to connect the equipment and she commenced playing the DVD of Caroline's wedding with assorted nurses, carers and residents gathering around to watch the DVD with Fiona. The DVD ran for approximately 16 minutes.[16]

Enrolled Nurse Plowman finds Mrs Hamilton deceased

41. EN Plowman[17] recalls that at the end of the DVD 'everyone was talking about Stella'. EN Plowman decided to quickly 'duck in and check on Stella' after the DVD.

42. At about 11.40am EN Plowman entered Stella's room via the corridor through the internal door. The door to Room 6 was closed (this was not unusual). EN Plowman gave evidence that she did not see any family members in the room, nor could she see Mrs Hamilton.

43. EN Plowman went to the glass sliding door leading to the courtyard and in her evidence stated *I looked outside to see if one or other of the family members had taken Mrs Hamilton outside in a fall out chair*. The sliding door was slightly open.[18] EN Plowman did not see anyone in the courtyard, she turned back into the room and looked again at the bed and noticed bumps under the doona. EN Plowman felt the doona and felt Mrs Hamilton's body under the doona.

44. EN Plowman observed that the head end of the bed was raised slightly, that the doona and sheet were covering Mrs Hamilton's face, and that the doona was not tucked in but was over Mrs Hamilton's head. She could not see Mrs Hamilton's head until she pulled back the sheet and doona.[19]

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[12] In oral evidence Hamish Hamilton said his reason for entering the facility via the courtyard was because of the (offensive) smell in the Palmerston wing. Exhibit B2 page 3
[13] Exhibit B2.1 page 7
[14] Exhibit B2.1 page 8
[15] Exhibit B2.1page 8
[16] Exhibit B2.1 page 8 – other accounts of the run time for the DVD are 30-45 minutes.
[17] Statement to Queensland police page 21
[18] Oral evidence of Nurse Plowman
[19] Exhibit B2.1 page 2

45. EN Plowman, in the first version of events she provided to the police on the evening Mrs Hamilton died, recalled that when she pulled back the blankets, Mrs Hamilton was lying on her back with her arms either by her side, or on her torso.

46. The investigating officers contacted EN Plowman after their interview with Fiona Hamilton on 1 August 2016 and asked her to confirm the position of Mrs Hamilton when she entered the room. EN Plowman told police she was incorrect initially as 'now she thinks about it, the deceased was located on her right side with pillow between her knees[20] and facing the slightly open glass sliding door'.[21]

47. Prior to any other person entering the room, EN Plowman pulled back the bedclothes covering Mrs Hamilton's face. EN Plowman could see that Mrs Hamilton was not breathing and she called for Nurse Anu who was the registered nurse on duty.

48. EN Plowman opened the internal door and was in the doorway as Fiona approached room 6. She gauged that Fiona could tell by the look on her (EN Plowman's) face that Fiona knew her mother had passed away.

49. EN Plowman's evidence is that Fiona entered into the room and said to EN Plowman, "*Hamish said that if we covered her head she would go quicker and she would*…". EN Plowman recalls Fiona trying to say the word '*asphyxiate*' at the end of the sentence but it didn't come out as asphyxiate. EN Plowman doesn't remember what word Fiona used, or the sound, she just knew that Fiona was trying to say asphyxiate.

50. EN Plowman was alarmed by Fiona's response as it was completely unprompted, and Fiona had not been advised that her mother had been found with bedclothes covering her head. Fiona later denied that she made the comment, when interviewed by police and in her oral evidence.

51. Nurse Anu attended and pronounced life extinct.

52. Fiona contacted Caroline and Hamish who returned to the facility. Mrs Hamilton was washed and prepared for the undertakers by her daughters, and then taken to the chapel. EN Plowman saw Fiona, Caroline and Hamish moving their mother from the room trying to get the bed through the door and 'she did not want to see them so she left the body with Nurse Anu and Leah to move'.[22]

53. On the evidence available at inquest, I am satisfied that the first time each of the adult children were informed by a third person that their mother was found with the bedclothes over her head was the following day, 1 August 2016, when participating in records of interview with police.

[20] Exhibit B2.1 page 3
[21] Exhibit B2.1 page 2
[22] Exhibit B2.1

54. There is no evidence that the management or staff informed Caroline, Fiona or Hamish on 31 July that Mrs Hamilton was located with bedclothes over her head. Each of the siblings gave evidence that they first became aware of the situation when informed by police during interviews on 1 August.

55. Within a short time of Mrs Hamilton being pronounced deceased, EN Plowman told Nurse Anu about the circumstances in which she had found Mrs Hamilton[23]. Nurse Anu reported the conversation to Daniel Robinson, the then Ozcare facility manager who was on site. EN Plowman later gave her version of events to Mr Robinson and he recorded that version in the progress notes which I will refer to later in these findings.

Autopsy Report

56. An autopsy was undertaken on the 4 August 2016 by Dr Nathan Milne, a senior Forensic Pathologist with Queensland Health at Forensic and Scientific Services, Brisbane, Queensland.

57. Dr Milne concluded as follows:

> 'The opinion as to the cause of death is based on the police and medical history, and a full post-mortem examination including associated testing. In my opinion, the cause of death is best considered as undetermined. Although this lady has significant natural disease capable of causing death, there are potentially suspicious circumstances surrounding the death.
>
> The most significant findings at autopsy were:
>
> - Advanced Alzheimer disease.
> - Necrotising bronchopneumonia.
> - Coronary atherosclerosis.
> - Cachexia.
> - Very high morphine concentration, in the context of palliative care.
>
> In the absence of any potentially suspicious circumstances, I would consider the most likely cause of death to be necrotising bronchopneumonia complicating Alzheimer disease and cachexia. Coronary atherosclerosis was of an extent that could have caused sudden death at any time, however, in the presence of severe acute bronchopneumonia, this is considered a less likely cause of death. The toxicology findings, including a very high morphine level, are consistent with administration of morphine in a palliative care context. It is generally accepted that in someone who is dying, the increasing need for drugs (such as morphine) to maintain comfort and dignity, will accelerate death.
>
> She was found with a sheet and doona over her head. It cannot be excluded

[23] Exhibit B2.1 page 03

that this had some contribution to death by causing a degree of suffocation. The clinical description of this lady prior to death includes being unconscious and breathing shallowly, which is consistent with impending death. Post-mortem examination showed significant bronchopneumonia to explain her limited breathing capacity. Someone in such a condition could potentially die at any time. Therefore, anything further limiting her ability to breathe, such as having bedding over her face, could potentially accelerate death. Smothering (by covering the nose/mouth) could also potentially be achieved without leaving any marks on the face or causing any internal injuries.'

58. The autopsy report was peer reviewed by Eminent Forensic Pathologist Associate Professor Alex Olumbe.

The Queensland police investigation

59. The Queensland police conducted an investigation into the death of Stella Hamilton.

60. On 1 August 2016, the investigating officer Senior Constable Milgate provided a Supplementary Form 1, Police Report of Death to a Coroner and concluded as follows;

> *Investigators believe that this sudden death is to be treated as suspicious due to comments made by the deceased's persons daughter Fiona and in particular, 'Hamish told me that if we covered her face that she would go quicker', and she attempted to use the word 'asphyxiation' in this sentence and the fact that the deceased was found by RN Plowman with the sheet and doona pulled well up over the deceased persons head which is highly unlikely to have been done by the deceased due to her poor state of health and the fact that no person observed the deceased conscious at all that morning. Investigations are continuing.*

61. The police obtained witness statements from:

- Jenny Plowman — Enrolled Nurse Ozcare
- Heather Ward — Carer Ozcare
- Gail Mazzer — Carer Ozcare
- Anu Kunjappan — Registered Nurse Ozcare
- Daniel Robinson — Manager, Clinical Care, Ozcare
- Dr Dianna House — Mrs Hamilton's treating doctor
- Dr Adams — assisted Dr House with treatment and care
- Julie Smee — Clinical Nurse Consultant

62. The police also conducted formal records of interview with Caroline, Fiona and Hamish on 1 August 2016.

The evidence of Enrolled Nurse Jenny Plowman

63. Nurse Jenny Plowman advised police she entered room 6 at about 11.40am, to check on Stella after watching the wedding DVD with Fiona and other residents and staff, and that she could not see her. She looked outside wondering if Caroline or Hamish

had taken Stella outside in her fall out chair as they had done this the day before. She could not see them in the courtyard. She then observed lumps under the doona on Mrs Hamilton's bed. She touched the lumps and felt Mrs Hamilton. She observed the bed sheet and doona were up over her head but not tucked in. She cannot recall how far up over the head they were but couldn't see Mrs Hamilton's head until she pulled back the sheets and doona. She observed Mrs Hamilton lying on her right side[24], facing the slightly open glass door with a pillow between her knees. No injuries were observed, she was not breathing and she called for Registered Nurse Anu to attend the room.

64. EN Plowman provided a version of events to Daniel Robinson the facility manager that afternoon[25] at around 5pm. Mr Robinson wrote up his notes of that conversation in the progress notes including that:

> *While walking to the room with Fiona, Fiona stated "Hamish said she would die quicker if we placed the covers over her face". Jenny found this alarming as it was completely unprompted and she had not been notified that this was how staff had found Stella.*
>
> *Mr Robinson concluded in his notes: Jenny was very unsettled and unable to complete the progress notes at the time of the event however has taken notes and will complete progress note entry tomorrow.*

Heather Ward - Carer

65. Heather Ward is a carer at Ozcare. She last saw Mrs Hamilton around 8.30am on Sunday 31 July 2016 in room 6. Caroline was present. Carer Ward noticed that Stella was unconscious, had shallow and raspy breathing and described the 'death rattle' which indicated she was not long before passing away. Carer Ward recalls thinking to herself, 'Stella is losing the battle to survive'. Carer Ward picked up Mrs Hamilton's arm, she noticed it was limp, there was no movement at all and she did not look like Stella anymore. She was warm to touch. The sheet and doona were up to her mid-chest and she was lying on her right side facing the glass exterior door. Caroline said to Carer Ward, *Mum's spirit has left but her body remains with us*. This is the last time that Carer Ward saw Caroline before her mother's death. Carer Ward saw Fiona soon after her mother's death and Fiona said to her, *I thought that if I played the DVD she would pass.*[26] Carer Ward was later in the room when Caroline re-entered the room when she returned to Ozcare after being informed by Fiona of her mother's death. Carer Ward saw Caroline put her hands in the air with delight and heard her say, *Yay.*[27] I accept the submissions on behalf of Caroline Britton that this gesture was borne of relief (that her mother would suffer no longer).

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[24] Her recollection in hindsight when confirmation sought by police about the position in bed
[25] Exhibit E1 page 33
[26] Carer Heather was not surprised by the comment and in oral evidence said it is something said in aged care homes quite often. She understood it to be a spiritual comment.
[27] Exhibit C5 para 14; and confirmed by Caroline in her oral evidence she said that because she was relieved.

Gail Mazzer - Carer

66. Around 9.15am on 31 July 2016, Carer Mazzer asked Caroline if Stella enjoyed her day outside yesterday and Caroline replied, *Yes she was rigid when we took her out but when we brought her back in at about 5.00pm she was like a floppy ragdoll. I think she died yesterday but she's still here.* When Carer Mazzer stuck her head in Stella's door later that morning she saw her in the 'foetal position' lying in the bed facing the glass door (to the courtyard) in the room.

67. Carer Mazzer was present when Caroline returned to room 6 after her mother's death and recalls her saying, *well mum, you're dead now*.[28] Again I accept that this response was an acknowledgement that her mother had been released from her pain.

Registered Nurse Anu Kunjappan (referred to as Nurse Anu)

68. Nurse Anu confirmed that Mrs Hamilton was receiving morphine hourly to assist with pain management. She was asked to attend room 6 by EN Plowman to confirm life extinct.[29] When Nurse Anu entered Mrs Hamilton's room she noticed that she was lying on her right side facing the glass door with a pillow beneath her head. Upon checking her vital signs, Nurse Anu declared life extinct at 11.45am. She described Mrs Hamilton's skin as warm to touch. She cannot recall the positioning of the bed linen.[30]

69. Nurse Anu recalls that EN Plowman told her, 'When I went into the room, I thought Stella was outside as I couldn't see her in the room and then I saw a lump beneath the doona, so I felt it and when I pulled the doona back it was Stella lying in the bed with the doona up over her head'.[31]

70. Nurse Anu later overheard a conversation between EN Plowman and Daniel Robinson, the manager of Clinical Services at Ozcare Malanda, and heard EN Plowman conveying to Mr Robinson that Fiona Hamilton said, *Hamish told us that if we left the doona over her head she would go quicker*.[32]

Dr Diana House – treating practitioner

71. Dr House is the visiting medical officer to the Ozcare Aged Care Facility in Malanda. She is a general practitioner on the Atherton Tablelands and attends the facility each Tuesday afternoon for general rounds. In cases of emergency she attends Ozcare out of those hours to review clients. She confirmed with police investigators that Mrs Hamilton did not have long to live and that pain relief and medication was administered by qualified nurses (under Dr House's supervision) at Ozcare.

[28] Exhibit C6.1 para 4 and oral evidence of Gail Mazzer. When put to Caroline in oral evidence she could not recall if she had said that.
[29] A registered nurse was required to declare life extinct
[30] B2.1 page 5
[31] Exhibit B2.1 page 5
[32] Exhibit B2.1 page 5

72. Dr House first consulted with Mrs Hamilton on 9 February 2016. Dr House described her condition then as poor but stable, and noted that Ms Hamilton had the following medical conditions.[33]

    a. Alzheimer's disease
    b. Depression
    c. Trigeminal Neuralgia (pain in her face)
    c. Severe iron deficiency
    d. Gastrointestinal tract blood loss
    e. Probable bowel cancer.

73. In June 2016, Dr House, during a review, noted a further drop in Mrs Hamilton's haemoglobin levels and a general deterioration. On 7 June 2016, Dr House and Mrs Hamilton's daughter, Caroline Britton[34] discussed that the family elected not to investigate a possible intestinal blood loss by procedures such as an endoscopy or colonoscopy due to the severity of her dementia and the fact that she did not have long to live.[35]

74. The plan was for Ms Hamilton to receive palliative care to manage pain if evident.[36]

75. From 7 June 2016 until 26 July 2016, the progress notes indicate that Mrs Hamilton continued to show signs of pain and was given morphine, midazalom and maxalon as required.

76. Dr House last saw Mrs Hamilton alive during her rounds at Ozcare on 26 July 2016, at which time she assessed her to be in significant pain. Dr House arranged for provision of a syringe driver to ensure the appropriate administration of Mrs Hamilton's medication, prescribing a combination of morphine, midazolam and haloperidol, with the intention of optimising patient dignity and comfort in the terminal phase of her life.

77. By Sunday 31 July 2016, Dr House was expecting Mrs Hamilton to pass away within 24 – 48 hours. She spoke with Ozcare nurses that morning by phone specifically about Mrs Hamilton's condition and medication. Dr House was advised at around 12 noon on that day that Mrs Hamilton was deceased.

Discussion about euthanasia between Caroline and Dr House Tuesday 26 July 2016

78. Dr House advised police that she recalled, and documented, in the Ozcare file, that on Tuesday 26 July 2016 she had a conversation with Caroline during rounds at Ozcare.

[33] Exhibit D1.1 para 10
[34] Caroline was also her mother's Enduring Power of Attorney
[35] B2.1 page 5
[36] Exhibit E1 page 5 and 6

79. On Tuesday 26 July 2016, Dr House was conducting her rounds of the Malanda facility with Clinical Nurse Consultant (CNC) Julie Smee. Fiona Hamilton and Caroline Britton were present.[37] During that consultation, Caroline asked if Dr House could give her mother the 'green dream'.[38]

80. At the commencement of her oral evidence at inquest, when asked if she wished to change or amend any part of her statement, Dr House said that her reference to the green dream should be changed to the 'blue needle'.[39] There was no challenge to the interchangeability of the phrases 'green dream' or the 'blue needle', I took both to be a euphemism for euthanasia. Dr House refers to the green dream when providing a statement to police and refers to the blue needle in the progress notes at Ozcare. Caroline and Fiona have only referred to the blue needle or the long blue needle.

81. Dr House was unsure what the blue needle was[40] but in oral evidence said she knew that she was being requested to euthanase Mrs Hamilton.

82. The Ozcare progress notes (written up by Dr House and dated 27.7.16) records as follows:

> *Both daughters present.*
> *Pt rapidly deteriorated today.*
> *Now essentially bed bound – sleeping*
> *V pale*
> *No haemetemesis*
> *Ankles edematous*
> *Family asking for blue needle – declined*
> *Discussion regarding palliative care*
> *Family keen for syringe driver*
> *Advised none available*
> *Compromise*
> *Butterfly inserted R ant abdo wall*
> *Bolus 10 mg morphine – 5 g midazolam administered*
> *Then hourly administration*
> *0.6 morphine 30g in 4.8 ml*
> *Midazolam 5 g solution saline*
> *Family appeared happy and accepting of above plan*
> *Please notify of issues with pain*
> *Presumed gastric carcinoma progressive G IT bleed*
> *Not for active interventions ie endoscopy / transfusions*

83. Dr House felt challenged and taken aback by the request.[41]

84. Dr House told Caroline and Fiona that she did not practice euthanasia and that she would provide palliative care. Dr House confirmed she would ensure that Mrs Hamilton was kept comfortable and her dignity optimised during the dying process by a combination of medication (later administered via syringe driver).

85. CN Julie Smee who was in and out of the room during the consult did not hear Caroline request the blue needle however she did hear Caroline ask if 24 hours' worth of

[37] Nurse Smee in her statement said that Hamish Hamilton was also present and conceded in her oral evidence that he may not have been. Hamish in his evidence said he had never met a doctor at the facility and Carolina and Fiona in their evidence said that Hamish was not present.
[38] Exhibit B2.1 page 6
[39] Reference to the 'blue needle' is found at page 17 of the progress notes Exhibit E.1
[40] In oral evidence Dr House recalls asking Caroline for clarification but cannot recall the exact response
[41] B2.1 Page 6

morphine to be left in the room after it was explained to her that a syringe driver was not available.[42] CN Julie Smee explained to Caroline she couldn't, and that it was too risky. Dr House in her oral evidence said that she was not privy to the request for 24 hours' worth of morphine.

8 6 . Caroline recalls the circumstances of the discussion on 26 July differently to that of Dr House and CN Julie Smee.

87. At inquest, Caroline did not recall specifically asking Dr House to give or administer the blue dream (or blue needle) but recalled mentioning it when she realised her mother was going to be dying soon. Caroline recalled that it led into a discussion about euthanasia with Dr House and it involved everyone's opinions including, that it was what her mother would have wanted. Fiona Hamilton said they discussed euthanasia throughout the process[43] but she doesn't recall it being specifically discussed with Dr House on 26 July.

88. Dr House was asked in oral evidence by Counsel for Caroline Britton if during this conversation on the 26 July, Caroline was expressing to Dr House what her mother's wishes were prior to her dementia. I clarified the question asked during inquest and understand the question as 'was Caroline trying to convey to Dr House her mother's wishes (euthanasia) prior to her losing capacity (should she ever get dementia)'.

89. Dr House indicated that was not her recollection of the conversation on 26 July.

90. In written submissions provided on Mrs Britton's her position at inquest on this point, is restated, that Caroline conveyed to Dr House a discussion her mother had with her and her siblings when they were teenagers about the 'long blue dream'.

91. Dr House is an experienced doctor working with the aged care sector and in her evidence said that as a GP, euthanasia was "*a discussion that comes up all the time… but not so confrontingly*".

92. I did not form an impression that Dr House would be rattled by a 'general discussion' about enthanasia with the family (as has been submitted by Caroline). On 26 July Dr House believed she was being asked to assist to bring on end of life. There was no challenge at inquest to the contemporaneity of the progress notes written up by Dr House which record: *Family asking for blue needle - declined*

93. Dr House received a phone call from Caroline on Thursday 28 July 2016 when she telephoned Dr House's surgery distressed by her mother's pain levels. Caroline requested an increase in the levels of medication.

94. CN Smee (at the request of Dr House) reviewed Mrs Hamilton's pain levels and medication and Nurse Smee adjusted the syringe driver accordingly.

95. Until such time as the syringe driver was in place the nurses were manually administering required doses every hour by a permanent subcutaneous needle[44] inserted into the right side of Mrs Hamilton's anterior abdominal wall.

[42] Oral evidence of Julie Smee and Exhibit C9 para 12
[43] of their mother dying
[44] A winged infusion set known as a butterfly

96. At approximately 10am on Sunday 31 July 2016, Dr House spoke with the duty nurse at Ozcare and was advised that Mrs Hamilton appeared comfortable and that no further additional doses of medication were required. The nurse advised that she expected Stella to die overnight and was content with the current management regime.

97. At midday Dr House was advised that Mrs Hamilton had been found deceased. At the time of conveying news of Mrs Hamilton's death, Dr House was not advised that Mrs Hamilton was located with the bedcovers over her head.

98. Dr House was informed at approximately 3.30pm on 31 July by Daniel Robinson that Mrs Hamilton had been located with the bedclothes covering her head. Dr House who was then in Cairns, immediately travelled to Ozcare Malanda to assess the situation and then contacted the (then) Northern Coroner, to report the death and her concerns surrounding the circumstances in which she was told Mrs Hamilton had been found.

99. Dr House presented as caring and genuinely invested in Mrs Hamilton's care.

100. Dr House was asked[45] if she believed the family had been involved in Mrs Hamilton's death and responded:

> *I don't know… but to be openly asked to euthanase and then for a patient to be found in these circumstances, you wonder.*
>
> *I was requested to euthanase Stella.*
>
> *I was shocked to be directly asked.*

101. With reference to the circumstances surrounding Mrs Hamilton's death Dr House responded:

102. *This has been incredibly traumatic for a lot of people and sadly a breach of trust. Once something like this happens it's very hard to trust a relative again and sadly means you have to set up even more safety nets to protect the patients, to protect the staff and to protect yourself. I feel very betrayed personally when I have a lady who is dying, and we were doing everything we could to make sure she had a dignified peaceful death and the outcome of this is really sad*.

103. When asked if it was possible that a resident of the dementia ward may have wandered in and pulled the bedcovers over Mrs Hamilton's head she replied, "*It is possible, but unlikely*".

104. Dr House informed the inquest that if in the future she was put in the same position by family, she would arrange for transfer of the resident to a hospital to ensure patient safety.

Julie Smee – Clinical Nurse

105. CN Smee is a clinical nurse at Ozcare, and she assists General Practitioner Dr Dianna House with rounds at the facility each Tuesday. CN Smee recalls a conversation on Tuesday 26 July 2016 when she was present during rounds with Dr House. At this time morphine was being manually administered hourly as there was

[45] By me during her oral evidence

no syringe driver available. When told a syringe driver was not yet available Caroline asked CN Smee if the nurses could leave 24 hours' worth of prescribed morphine in the room.[46] CN Smee advised she could not, and that it was too risky. Instead she arranged for 8 hours' worth of prescribed morphine to be placed in the safe in the clinical room, to be accessed only by nursing staff.

106. The following day a syringe driver became available at the Atherton Hospital and was thereafter used to administer morphine.

107. On Friday afternoon the 29th July 2016, CN Smee was outside the facility about to go home and she spoke to Hamish. She recalls him saying words to the effect, "This whole slow drip feed death is bull shit."

Records of interview with the Stella Hamilton's children

108. Each of Mrs Hamilton's adult children were interviewed separately by police on 1 August 2016.

Fiona Hamilton

109. Fiona denied, when questioned by police, that she had pulled the blankets up over her mother's head prior to leaving the room to watch the wedding DVD on 31 July 2016. Fiona further denied that upon entering her mother's room after her death she said words to the effect, 'Hamish said that if we covered her head she would go quicker or attempted to say the word asphyxiation'. She was emphatic and told police she would never have said that, or put the bedclothes over her mother's head, nor did she discuss putting bedclothes over her mother's head with Hamish.

110. Fiona did tell police that mum always used to say 'if I get alzheimer's give me the long blue dream… personally I could never do that'[47]

111. When asked again by police[48] if it was possible that she had made the comment to Jenny (Plowman) Fiona then responded:

> *If that's what nurse Jenny said it could very well be possible, I have no recollection of saying anything like that… I am not saying it's what I said at all, if nurse Jenny said that she obviously said that, you know I'm not disputing what she said I am not disputing what she's said I am disputing what I said to her. I have no understanding why I would say something like that apart from the fact it was mass distress.*
>
> *Fiona: so obviously someone's put the sheet over her head, someone's lifted the doona's and put doona's over her head haven't they*
>
> *Officer: look that's what nurse Plowman has told us*
>
> *Fiona: fucking hell*
>
> *Officer: honestly I don't know why she would – I would hope that she wouldn't be lying to us, she would have no reason to lie to police about this*

[46] Oral evidence of Julie Smee and exhibit C9 para 12
[47] Exhibit C2.1 page 33
[48] C2.1 page 32

Fiona: I have no reason to lie about this, why would I lie, why would I sit here and say I put a sheet over my mother because I wanted her to go quicker, why would I want that

Officer: look well if I was to speculate you may perhaps see your mum in pain..

Fiona: I saw mum in pain, I asked for extra morphine..

112. Fiona stated she would never harm her mother and wanted her to pass away when she was ready to pass away.

113. Fiona also told police that the internal door to her mother's room (from the corridor) was always unlocked and that anyone could have entered the room as residents walked around the facility all hours of the day and night.

114. Fiona told police that she was constantly trying to push residents out of the room and that one female resident was found laying in bed with her mother several times.

115. Fiona agreed that she did say that if she played the DVD she thought her mother would pass.

Hamish Hamilton

116. Hamish advised police that he felt his mother had been unconscious for days and that her spirit had left her body the previous day, Saturday 30 July 2016. When asked by police, *Did you kill your Mum?* he replied, *No, why would I do that. It's not my choice, it's the soul's journey, I'm all for euthanasia but it's illegal in this country. Watching your mum die just by increasing dosages of morphine is bull shit, it's no way to die and it's really cruel but that's the system we're under and that's something I can't change*.[49] He went on to say, *I did not do anything to pass mum on quicker, it's her decision not mine. I can't even push that thing in, have you seen your mum die… Please leave my home*.[50]

Caroline Britton

117. Caroline said that she'd arrived from her usual place of residence near Ingham ten days prior to her mother's death. She wanted to be with her mother as she knew she was ailing at a fast rate and that she and her sister Fiona took turns to stay with her mother overnight.

118. Caroline said that they took their mother for a walk in a fall out chair[51] on Saturday 30 July, and when they returned from the walk they could see that their mother's soul had left her body and that she could not move any of her body parts. Caroline said that overnight on the 30 July, her mother's breathing slowed and often went into stages of long periods without breathing at all, only to then gasp and the cycle would continue.

119. Caroline recalls Fiona arriving at the facility on Sunday at around 10.30am to take care of her mother and that Hamish arrived at the same time. Caroline's husband

[49] B2.1 page 9
[50] B2.1 page 10
[51] Special medical chair with wheels

suggested that it would be a nice gesture to leave the wedding DVD for Fiona to watch.

120. Caroline left Ozcare at around the same time as Hamish. She received a call at about 11.43am from Fiona saying that her mother had died. She then returned to Ozcare.

121. Caroline agreed that she had spoken to Dr House about the 'long blue dream' as her mother had often spoken about not wanting to die in an aged care facility.[52] Caroline agreed that the blue dream was a reference to euthanasia, but they (the family) knew it was illegal.

122. During the interview, the police advised Caroline that her mother was found with the bedcovers over her head. The police noted that Caroline seemed shocked by the news and conceded that her mother would not have been able to do that. Caroline conceded that along with the alleged comments by Fiona about Hamish suggesting that covering her head with bedclothes would hasten death, in conjunction with the 'blue needle' conversation, that things were a little odd. [53]

123. Caroline could not explain how the bedcovers came up over her mother, but she stated that people would come in to the room all the time, and she added that Hamish or Fiona would not have placed the sheets over their mother. Police have observed that Caroline appeared to be forthcoming and also emotional during the interview and they concluded that they thought she was telling the truth.[54]

Evidence at inquest by Investigating Officer Milgate

124. During the course of his oral evidence, Senior Constable Milgate advised the court that EN Plowman had told him during the investigation that she had become unsure about the exact location of the sheet/doona over Mrs Hamilton's body [55] and that her uncertainty was conveyed to him about two weeks after Mrs Hamilton's death. Officer Milgate recalls receiving that information at the same time as he was trying to arrange with Nurse Plowman to make a pretext call to Fiona, approximately two weeks or so after Mrs Hamilton died. (EN Plowman declined to participate in the pretext call).

125. Officer Milgate could not locate a record of that conversation in his notebook (or elsewhere). The relevant notes of that conversation were not produced.

126. EN Plowman in her oral evidence stated that the request by the police to enter in to a pretext conversation occurred within two days of Mrs Hamilton's death, and not within two weeks as was suggested by Officer Milgate.

127. EN Plowman said in evidence that at no time did she say that she had become uncertain about the exact location of the blankets on the day she discovered Mrs Hamilton.

[52] Exhibit B2.1 page 11
[53] Exhibit B2.1 page 11
[54] Exhibit B2.1 page 11
[55] Exhibit B2.2 page 1

128. The Supplementary Form 1 dated 3 August 2016 (three days after Mrs Hamilton's death) and prepared by Senior Constable Milgate[56] states that:

> "*Investigators are in the process of attempting to conduct a pre-text telephone call between Nurse Plowman and Fiona Hamilton*".

129. This timeframe confirms Nurse Plowmans recollection the pretext conversation within two days of Mrs Hamiltons death. That report does not record a reference to Nurse Plowman advising she had become uncertain about the position of the blankets.

130. I find that there is insufficient evidence EN Plowman provided a version of events approximately two weeks after Mrs Hamilton's death (or at anytime) that she had become uncertain about the exact location of the blankets.

131. The only deviation in EN Plowman's recollection of events was the position in which she initially found Mrs Hamilton (on her back), and in my view she has adequately accounted for that anomaly. In her oral evidence EN Plowman referred to the stress and strain of the events of 31 July, and to having had a couple of glasses of wine that evening prior to speaking with police for the first time, as impacting her recollection of the position of Mrs Hamilton's body. EN Plowman said she had been up since 4.30am on the day Mrs Hamilton died. She relayed her more accurate recollection of the positioning (on her right side) to police within three days of Mrs Hamilton's death.

132. In all other respects EN Plowman's evidence has remained consistent from the time of death on 31 July 2016 to the date of the inquest, 2 years and 3 months later.

133. Officer Milgate impressed me as a senior and experienced investigator. He could not locate a written reference to this very important conversation, and his recollection of the timeline in which he requested may be inaccurate. The lack of this notation or reference (to uncertainty about position of the bedclothes) was inconsistent with his otherwise precise record keeping for this investigation.

134. The inquest proceeded on the basis that Mrs Hamilton was located at the time of her death with bedclothes over the whole of her body including her head. That was not challenged.

Final police investigation report to Coroner 12 March 2017

135. On 12 March 2017, the Queensland police provided an updated investigation report by way of a Supplementary Form 1, Police Report a Death to a Coroner and concluded as follows;

> 'The investigating officer believes that all avenues of the investigation have been exhausted. The investigating officer is unable to prove that any suspicious behaviour contributed to or accelerated the death of Stella Hamilton for the following reasons:

[56] At page 2

Witness Nurse Jenny Plowman changed her initial version regarding the position of the body upon locating it, from lying flat on her back with hands on stomach to lying on her right side. Further, when questioned regarding the sheet / doona over the deceased's body, the witness had become unsure about the exact location. As a result the witness' version has become inconsistent and her credibility as a witness has weakened.

- The autopsy was unable to prove the cause of death and there were no signs of asphyxiation detected.
- The toxicology results revealed nothing unexpected considering the circumstances of the medical treatment received by the deceased.
- Over the last 5 days of the deceased person's life, Doctor Dianna House revealed that she was in close consultation with nursing staff due to the rapid deterioration of the deceased's condition and that by 31 July 2016 the doctor and the duty nurses expected Stella Hamilton to pass away within 24 hours, therefore the death was not unexpected.
- Telephone records of the deceased's children (Fiona, Hamish and Caroline) were retrieved and revealed nothing suspicious or unexpected.
- All three named persons (Fiona, Hamish and Caroline) participated in recorded interviews, no admissions were made, and no other information was provided causing concern or suggesting any unlawful acts were performed.

As a result the investigating officer believes that no offence can be proven and it is unlikely that an offence has occurred. The investigating officer believes this matter requires no further action and can be filed pending any further unexpected information coming to hand.'

Access to room 6

136. There was evidence throughout the inquest, from both family members and staff that it was not uncommon for residents of the Palmerston wing to wander into Room 6. This is not surprising as the Palmerston wing is a high dependency dementia unit. Fiona and Caroline specified items that disappeared from their mother's room as a result of other residents entering from time to time.

137. Some of the staff recall Caroline and Fiona advising them of missing personal items taken from their mother's room by residents, or themselves became aware of items being removed.

138. There was evidence of an occasion when a resident was located by a family member lying in the bed beside Mrs Hamilton. I understood no sinister motive was intended by the resident and that it was an unintended consequence of residing within an open dementia unit.

Pain levels experienced by Stella Hamilton and the impact on next of kin

139. Stella Hamilton was very very ill. The autopsy revealed a severe acute bronchopneumonia. That condition was undiagnosed prior to her death. The family, in consultation with the treating general practitioner chose not to pursue further medical interventions or diagnostic testing, so not to cause further pain and distress to their mother, taking into account she was unlikely to survive such interventions. They instead chose palliation as the most merciful ending to their mother's life.

140. Caroline, Fiona and Hamish loved their mother. Caroline and Fiona attended Ozcare in shifts, and 'around the clock' to tend to their mother and accompany her to her death.

141. The evidence bears out the emotional trauma as the adult children witnessed their mothers devastating and painful decline. The family interceded when they thought it necessary to ensure their mother's care and pain relief was optimised.

142. I accept the evidence of the family (corroborated also by progress notes) that Mrs Hamilton experienced severe pain, particularly in the days prior to the insertion of a syringe driver two days before death.

143. I include below a summary of the relevant Ozcare progress notes[57] for the week prior to her death, recording that Mrs Hamilton was complaining of pain, she was crying, grimacing, sitting on the side of the bed rocking, and unable to settle. I have no doubt these are manifestations of severe levels of pain. I have also read progress notes[58] (not included below) noting Mrs Hamilton rocking, sighing, sobbing, and curled up in the foetal position in pain.

Date	**Time**	**Morphine Administered**
23.07.2016	15:30	Complaining of abdominal pain, crying. PRN inj Morphine given (10mg) at 15:30.
23.07.2016	20:00	Looks to be in pain (abdominal) and unable to settle. Inj Morphine 1Omg and inj Midaz given at 20:00.
24.07.2016	10:15	...PRN 10mg of Morphine s/c and 7.5mg of Midazolam given at 08:00.... Observed as comfortable ATOR.
24.07.2016	14:30	Stella's daughter Fiona alerted me to check on Stella stating that her mouth was sore. Stella sitting on the side of the bed and rocking. Notified RN... PRN morphine and midaz given at 13:30hrs.

[57] Ozcare written submissions 12 November 2018 para 13
[58] Summarised at Annexure A & B Ozcare submissions 12 November 2018

24.07.2016	18:00	Stella showing strong signs of non-verbal pain re facial grimaces. Also stated pain at 17:40...RN John approved 10mg of Morphine sc and 7.5mg of Midazolam… administered at 17:45
24.07.2016	22:50	Stella showing signs at pain at 22:40... RN John approved 10mg of morphine sc and 7.5mg of Midazolam… administered injections at 22:45
25.07.2016	06:00	Reported by daughter to check on Stella for pain…. Possible pain but not restless...PRN 10mg Morphine sc given to promote comfort at 06:00. Awaiting effect.
25.07.2016	11:00	PRN Morphine 10mg given at 9:30 as per CN Julie Smee

The possibilities considered

144. I have considered the following:

Whether Mrs Hamilton somehow managed to cover herself and/or get herself into a position that caused her to become wholly covered.

145. This possibility was not raised at inquest. By then, Mrs Hamilton was non-responsive and unconscious. This scenario is unlikely if not improbable.

Whether either Hamish or Fiona Hamilton placed the bedclothes over their mothers head to hasten her death

146. Certainly the evidence bears out a family in great distress as they were witness to the slow and painful death of their mother, a family who generated a discussion around the topic of euthanasia with their mother's treating general practitioner five days prior to her death, and whose mother was located in a way that corresponded with Fiona's unsolicited comment, 'Hamish said that if we covered her head she would go quicker'.

147. Two days prior to his mother's death Hamish was found sobbing at his mother's bedside and he was comforted by Carer Ward. That same afternoon, CN Smee saw Hamish in the Ozcare carpark and he said*, this whole drip feed death is bullshit*.

148. Hamish was seen between 10am and 10.30am walking past the kitchen window to enter room 6 from the courtyard. Hamish is said to have left the facility on his own around 11am to meet a girl for a date.[59] There are no independent witnesses to his movements between that time and returning to the facility when contacted by Fiona shortly after his mother's passing.

149. Fiona was the last known person to see her mother prior to death. The internal door was closed while the DVD was playing. The sliding door to the courtyard was slightly open when EN Plowman discovered Mrs Hamilton under the bedclothes.

[59] Exhibit B2 page 4

150. There was opportunity for Fiona to cover her mother prior to exiting the room to play the DVD in the common room.

151. There was also opportunity for a person to enter through the sliding door from the courtyard. Hamish was known to use this entry as the preferred access to his mother's room. When asked at inquest why he entered the facility by the outside access, he indicated that he could not stand the smell in the Palmerston wing.

152. The first known person to re-enter the room was EN Plowman around 11.40am when she discovered Mrs Hamilton.

Whether a resident entered room 6 during period of time that the DVD was playing in the common room and placed the blanket over her head (perhaps believing she was dead).

153. It was not uncommon for residents to 'wander' including into Mrs Hamilton's room. There is a freedom of movement within the Palmerston wing. The internal door was not locked. Caroline and Fiona in particular gave several examples of residents coming in to room 6. To a certain extent staff conceded entry to the room by other residents did occur. I could not dismiss the possibility that a resident of the facility entered and exited Mrs Hamilton's room without detection during the period of time the DVD was playing outside in the common room. Whilst the common room is only a short distance from the entrance to Mrs Hamilton's room there is no direct line of sight

Hindsight bias

154. If one were to line up the circumstantial evidence in this matter and conclude that Fiona and Hamish Hamilton had both motive and opportunity to place the bedclothes over their mother's face so as to expedite her death and release her from her (and their) suffering, and that one or other intentionally placed the bedcovers over their mother so as to expedite her death, would in my view be to err.

155. Whilst the circumstances in which Mrs Hamilton was found, that is wholly covered by bedclothes, the discussion with Dr House about euthanasia, and the comment made by Fiona after her mother's death, seem at first to lead to an outcome that might seem obvious, I have considered that an assessment of only that evidence, (the evidence that fits that outcome) excludes other significant evidence and factors including:

- There are no witnesses to the event.
- Mrs Hamilton was at the brink of death.
- No suspicions or concerns were indicated by the Forensic Pathologist at autopsy and a cause of death nominated as 'undetermined' as the forensic pathologist could not include, or exclude, suffocation as a cause of death due to the circumstances.
- All three siblings participated in a record of interview and no admissions were made by Caroline, Fiona or Hamish.

- All three siblings gave evidence at inquest, no admissions were made or evidence adduced that gave any additional weight to the possibility that one or more of them were implicated in placing the bedclothes over their mother.
- A thorough police investigation concluded that it was unlikely an offence had occurred

156. I am mindful of the possibility of error when looking retrospectively with such scrutiny, that there is a real possibility of cherry picking the evidence to make it fit circumstances that seem to be compelling and obvious.

> *Confirmation bias is a common heuristic whereby people give undue emphasis to evidence that validates or supports their existing beliefs and expectations and excuse or explain away information that does not. People in all walks of life fall into this error and to harshly criticise …… for doing so would involve the making of a similar mistake: namely, critiquing their conduct with hindsight bias.* [60]

Conclusions and findings

157. I find that on Tuesday 26 July 2016, Caroline Hamilton spoke with Dr House at Ozcare during routine weekly rounds and that during the conversation:

a) Caroline generated a direct conversation about the long blue dream
b) The term blue needle (or blue dream or green dream) was a euphemism for euthanasia
c) Dr House believed she was being requested to euthanase Mrs Hamilton.

158. I am satisfied on the balance of probabilities, that EN Plowman:

a) entered Mrs Hamilton's room in the Palmerston wing at 11.40pm on 31 July 2016
b) located Mrs Hamilton under the bedclothes covering the whole of her body including her head
c) turned down the bedclothes and saw that Mrs Hamilton was deceased.

159. I am satisfied that no other person was present in the room at this time.

160. I find that Fiona Hamilton shortly thereafter entered room 6 and EN Plowman heard her say, 'Hamish said that if we covered her head she would go quicker'.

161. I find that a person other than Mrs Hamilton intentionally placed the bedcovers over Mrs Hamilton's head.

162. There is insufficient evidence before me to identify the person who placed the bedcovers over Mrs Hamilton's head. [61]

163. I cannot determine if the bedclothes were placed over Mrs Hamilton's head before or after her last breath.

[60] Findings of Inquest into the death of Ronald Brockel (19 April 2013, BARNES, M State Coroner)
[61] On the balance of probabilities in accord with the test in *Briginshaw*

164. If the bedclothes were intentionally placed over Mrs Hamilton's head after her last breath there would be no causal connection between that act and her demise.

165. I cannot determine if Mrs Hamilton's death was caused by, or expedited, as a result of the bedclothes covering Mrs Hamilton's face, thereby limiting her ability to breathe and/or causing her to suffocate.

166. I cannot find on the evidence if Mrs Hamilton died from either:

a) natural causes prior to being covered by the bedclothes, or;
b) natural causes after being covered by the bedclothes or;
c) suffocation as a result of her face being covered by bedclothes.

167. But for the circumstances in which Mrs Hamilton was found, the forensic pathologist would have determined the cause of death as necrotising bronchopneumonia complicating Alzheimer disease and cachexia.

168. The forensic pathologist concluded that anything further limiting Mrs Hamilton's ability to breathe such as having bedding over her face could potentially accelerate death and that smothering could potentially be achieved without leaving any marks on the face or causing any internal injuries.

169. I find that Stella Hamilton died at Ozcare Malanda on 31 July 2016 and that her cause of death is **undetermined.**

Findings required by s. 45

Identity of the deceased – Stella Hamilton

How she died – Stella Hamilton was a resident of the Ozcare Aged Care Facility at Malanda. She was suffering advanced and necrotising bronchopneumonia complicating alzheimers disease and coronary atherosclerosis. She was at the very end stage of her life and receiving palliative care. On the day of her death she was unconscious and death was imminent. She was located deceased in her bed with bedclothes covering the entirety of her body including her head, such that she could not at first be seen. I find that a person other than the deceased placed the bedclothes over her head I cannot determine if Mrs Hamilton was deceased prior to the bedclothes being placed over her head or if she died from suffocation as a result of the bedclothes being placed over her head.

Place of death – Ozcare, 5183 Turnball Rd, Malanda. Queensland 4885

Date of death – 31 July 2016

Cause of death – undetermined

Additional issues explored at inquest

The adequacy of security procedures including monitoring the movement of residents and visitors in and around Ozcare Malanda aged care facility

170. Ozcare Malanda aged care facility has to comply with a number of statutory and regulatory bodies and the principles/charters created within, including but not limited to:

    a. *Aged Care Act* 1997 (Cth);
    b. *Quality of Care Principles 2014* (Cth);
    c. The Accreditation Standards (Cth);
    d. *User Rights Principles* 2014 (Cth); and
    e. Charter of Care Recipients' Rights and responsibilities – Residential Care (Cth).

171. When considering monitoring their residents and visitors Ozcare Malanda has to comply with, including but not limited to

    a. *The Privacy Act* 1988 (Cth); and
    b. Australian Privacy Principles (APPs).[62]

a) Ozcare Malanda aged care facility does not have a formal visitation policy, however, has the following in place:

    a. Staff Code of Conduct;
    b. Elder Abuse training, policy and checklist;
    c. Compulsory reporting of elder abuse;
    d. Specialised training 'privacy and dignity';
    e. A 'Key to me' form for residents that is privy to staff; and
    f. Mandatory yearly training with respect to security and safety.

172. When asked by Counsel for the Ozcare Malanda facility what they would do in certain situations relating to patients wandering or if they had concerns with an unknown visitor, staff were able to recite what they did in particular situations and their responses were in accordance with Ozcare policies and procedures.

173. It became apparent during the inquest that managing residents with dementia who are known for wandering is a difficult task and that the staff of Ozcare Malanda were knowledgeable on the topic and well trained in this regard. It was also apparent that it is beneficial for the resident's health to wander to some extent.

[62] Contained in Schedule 1 of the *Privacy Act 1988 (Cth)*

174. Ozcare Malanda was re-accredited in March 2015[63] and in March 2018.[64] Ozcare Malanda have not at any time been sanctioned under the Aged Care Act.[65]

175. There is no prescriptive way for Ozcare Malanda to operate or meet with the accreditation standards.[66] Ms Tracey Rees, the State Director for Queensland and Western Australia for the Australian Aged Care Quality Agency provided an email to the Office of the Northern Coroner on 6 April 2018. A summary of the salient sections of her email are as follows:[67]

:

- The Quality of Care Principles are explicit about the flexibility services have, to determine how they operate their business of providing care and services to care recipients;
- The agency expects that a service would have systems and processes in place to meet their regulatory responsibilities about the physical environment and safe systems, that management is actively working to ensure a safe and comfortable environment consistent with care recipient needs; and
- CCTV cameras are currently not a legislated requirement in aged care services.

Public Interest Intervenor – Aged and Disability Advocacy Australia (ADAA)

176. The ADAA were invited to observe the Inquest and make written submissions in accord with s 36 *Coroners Act* 2003.

177. It is useful to place into these findings the whole of the submission received.

> 'Primarily, there is the fundamental issue of Aged Care Services regulated by the Commonwealth Aged Care Act 1997, with associated Commonwealth regulatory bodies with Coronial investigations being a state based process. This results in less familiarity between these systems.
>
> As outlined in par. 74 of the Counsel Assisting submissions witnesses were examined about their views on CCTV in these three areas:
>
> a. Entry and exit points to facility
> b. Entry and exit points to residents' rooms
> c. Inside residents' rooms.
>
> Use of CCTV footage is not regular industry practice in the aged care sector, however, it is undergoing consideration at a national and state level.
>
> In September, an aged care worker was charged with assault following CCTV footage of alleged assaults. It is reported that the family installed CCTV cameras in an elderly gentlemen's room.

[63] Exhibit C11 page 23
[64] Exhibit C11 page 75.
[65] Exhibit C6 para 26
[66] Exhibit F1 page 1
[67] Ibid

Exhibit H1 from Office of the Australian Information Commissioner (OAIC) summarises the privacy obligations relevant to the use of CCTV in aged care. These include:

a. Collection of solicited personal information
b. Notification of the collection of personal information
c. Security of personal information.

The OAIC also raise the possibility of State laws that may impact upon the use of CCTV footage.

This is relevant in Queensland.

Queensland Criminal Code 1899, (the Code) sections 227A and B, creates a misdemeanour for the observations, visual recordings and distribution of these recordings, in a situation whereby a reasonable adult expects privacy.

The subsequent s227C, excuses a variety of professionals such as Police, mental health, disability worker, parole officers. This occurs, particularly, when a person is subject to lawful custody or a supervision order (which may be made in Queensland, another State or Commonwealth).

Any change in utilisation of CCTV needs to be included in an amendment to s 227C of the Code. Clearly, living in an aged care facility in circumstances similar to Stella Hamilton is not within the current purview of this section.

The other issue surrounding use of CCTV, arguably everywhere else apart from entrances and exits of aged care facilities, concerns the issue of consent.

Obviously, adults can provide consent for themselves, whilst they have capacity to make their decisions.

It may well be the situation, particularly in locked areas such as where Stella Hamilton resided that many of the residents would have been unable to provide this consent for themselves due to impaired capacity.

Legislation, whether State or Commonwealth needs to be clear as to who can consent to CCTV monitoring, when the relevant privacy considerations are met.

a. This may include the attorney or guardian (State based legal frameworks).
b. Otherwise, it may be a representative under Commonwealth law. A previous Australian Law Reform Commission Inquiry into "Equality, Capacity and Disability in Commonwealth Laws (DP 81) made recommendations for clarifying and defining the decision-making role in relation to aged care

The discussion around use of CCTV is beneficial for consumers of aged care services and their families and decision makers.

There are currently legislative barriers in Queensland for the use of CCTV, which would involve amendment to the Queensland Criminal Code.

Many of the relevant privacy issues raised by OAIC can be addressed by facility policy and practice, signage and consent.

Clarification of who can consent according to State and Commonwealth laws would also provide certainty for both facility providers and families alike.

Referral of these key issues to the newly constituted Royal Commission into Aged Care Quality and Safety along with referral to the soon to be established Aged Care Quality and Safety Commission would also be highly beneficial.'

Recommendations in accordance with s.46

178. Section 46 of the Coroners Act 2003 provided that a Coroner may, whenever appropriate, comment on anything connected with a death investigated at an inquest relates to:

    a. Public Health and safety; or
    b. The administration of justice; or
    c. Ways to prevent deaths from happening in similar circumstances in the future.

179. Most witnesses who attended the inquest were asked for their views on the use of CCTV footage in a facility such as Ozcare Malanda. They were asked about their views on CCTV footage:

    a. At entry and exit points of the facility;
    b. At entry and exit points of resident's rooms; and
    c. Inside the residents rooms.

180. There were different views across the different groups of witnesses that being; Ms Hamilton's children, the Ozcare Malanda nursing and carer staff and the Ozcare management.

181. Ms Hamilton's daughter Caroline Britton said that if there was CCTV footage 'we wouldn't be here right now' she went on to say there would have been a full view of her room and the common room, she said her and her sister's line of questioning from the Police was accusatory towards them and felt that if there was [CCTV footage] it would have answered the questions straight away.

182. Ms Hamilton's daughter Fiona Hamilton was asked for her view regarding CCTV footage and she said that she believed her mother had no privacy and dignity left anymore and would have loved to have CCTV in her mother's room as it protects the resident and the staff.

183. Ms Hamilton's son Hamish Hamilton was asked of his views regarding CCTV footage and commented that it would help clarify what really happened but he had seen the reports about privacy issues but thought that it would be a great help to monitor the residents and staff.

184. Fiona Hamilton provided written submissions wherein she stated (CCTV) is an instrument in aiding and protecting those who no longer have the ability to protect themselves.

185. The staff from Ozcare who were questioned about CCTV were comfortable with having cameras on the entry and exit points of the facility but they were not comfortable with having them on the entry and exit points of the resident's rooms as this would impede their privacy. One staff member pointed out that residents can become incontinent in the hallways and that filming that and the clean-up was not something that should be on film. The staff were not comfortable with having cameras in the resident's room, because of the intrusion on the privacy of residents.

186. Detective Senior Constable Kyle Milgate was asked if CCTV footage would have assisted his investigation. His response was that it would have definitely helped. He had received versions (of events) and it would corroborate those versions and give a timeline.

187. I do not intend to make recommendations in respect of implementation of CCTV at the Ozcare facility, noting it would require a whole of industry approach and the will of various legislatures, regulators and industry providers. There are broader considerations that are beyond the scope of this inquest.

188. The Letters Patent relevant to the scope of inquiry set for the Royal Commission into Aged Care Quality and Safety provides terms of reference that will most appropriately deal with issues of privacy and safety in aged care settings.

189. I acknowledge the assistance of Counsel assisting the Northern Coroner Ms Benn throughout the investigation and inquest.

190. In conclusion I offer my sincerest condolences to Caroline, Fiona and Hamish and their wider family for the loss of their much loved mother.

191. I direct that a copy of these findings be provided to:

- Caroline Britton
- Fiona Hamilton
- Hamish Hamilton
- Ozcare Malanda
- Ozcare Queensland
- Dr Diana House
- Dr Jessica Adams
- Det Senior Constable Kyle Milgate
- Queensland Police Service

- The Aged Care Quality and Safety Commission

192. I further direct that a copy of these findings be provided to the Royal Commission into Aged Care Quality and Safety.

193. I close the inquest.

Nerida Wilson
Northern Coroner
14 December 2018