OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Raleigh HOY**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Ipswich
FILE NO(s):	COR 52/07(8)
DELIVERED ON:	5 May 2009
DELIVERED AT:	Ipswich
HEARING DATE(s):	30th January, 2008, 18th September, 2008 and 26th September, 2008
FINDINGS OF:	Ms D MacCallum, Coroner
CATCHWORDS:	CORONERS: Inquest – the management of Tarampa After Care Centre; the accreditation of Level 3 facilities; the medical treatment of the deceased; and the link between Clozapine (Clozaril) and cardiomyopathy

REPRESENTATION:

Sgt K Carmont	appearing to assist the Coroner
Mr A Luchich	appearing on behalf of Dr Piaggio and Dr James
Mr M Fairclough	appearing on behalf of M & Mrs A Sherlock, owners of Tarampa After Care Centre
Mrs S Hoy	Mother of the deceased

CORONERS FINDINGS AND DECISION

The ***Coroners Act 2003*** provides in s45 that when an inquest is held into a death, the coroners written findings must be given to the family of the deceased person and to each of the persons or organisations granted leave to appear at the Inquest. These are my findings in relation to the death of Raleigh Hoy. They will be distributed in accordance with the requirements of the Act.

CORONER'S JURISDICTION

A coroner has jurisdiction to inquire into the cause and circumstances of a reportable death. Where possible the coroner is required to find:

- Whether death in fact happened;
- The identity of the deceased;
- When, where and how the death occurred; and
- What was the cause of death.

An Inquest is not a trial between opposing parties but an inquiry into the death. The focus is on discovering what happened, not on ascribing guilt, attributing blame or apportioning liability. The purpose is to inform the family and the public of how the death occurred and if relevant, recommending ways to reduce the likelihood of similar deaths. As a result, the Act authorises a coroner to make preventive recommendations concerning public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances. However, a coroner must not include in the findings any comments or recommendations, or statements that a person is or maybe guilty of an offence or express an opinion on any civil liability.

ADMISSIBILITY OF EVIDENCE AND THE STANDARD OF PROOF

Proceedings in a coroner's court are not bound by the rules of evidence because s37 of the Act provides that the court "*may inform itself in any way it considers appropriate".* That does not mean that any piece of evidence, however unreliable or irrelevant will be admitted and acted upon. It simply enables the coroner greater scope to receive information that may not be admissible in other proceedings and to have regard to its provenance when determining what weight should be given to the information.

A coroner should apply the civil standard of proof, namely the balance of probabilities but the approach referred to as the *Briginshaw* sliding scale is applicable. This means that the more significant the issue to be determined, the more serious the allegation or the more inherently unlikely an occurrence, the clearer and more persuasive the evidence should be.

A coroner is obliged to comply with natural justice and to act judicially. This means that no findings adverse to the interest of any party may be made without that party first being given an opportunity to make submissions against findings that might be damaging to the reputation of any individual or organisation.

BACKGROUND

Mr Hoy had a long and complex history of mental illness. The diagnosis prior to his death was that he had autistic spectrum disorder and schizophrenia and had been on significant medication for these conditions for some years. At the time of his death he was taking the following medications:

Clozaril three times per day;
Lithicarb twice per day;
Valpro 3 times per day;
Fefol once per day;
Probitor once per day.

In January, 2005 he was transferred to the Tarampa After Care Centre in Tarampa and remained there until his death on the 6th January, 2007. His mother requested an Inquest based on the medications he was prescribed and her concerns, probably fuelled by a comment in the autopsy report, that these medications led to the death of her son.

Prior to residing at Tarampa, Mr Hoy had lived at Kia Ora Lodge at Sandgate since about February 2000. In August 2004 he was given a notice of eviction due to his increased needs and inappropriate behaviour. A letter dated 28th January 2005 from the Sandgate Community Mental Health Services refers to this notice but also refers to the hostel closing at which time Mr Hoy was hospitalised pending relocation.

TARAMPA AFTER CARE

Tarampa After Care is a Level 3 accommodation facility accredited pursuant to the ***Residential Services (Accreditation) Act 2002***. Such facilities need to comply with 38 standards. Of these 22 relate to accommodation requirements, 6 relate to food standards and 22 relate to personal care services. A level 3 residential is one which provides three levels of service. These are accommodation, food service and personal care service. A level 1 residential provides only accommodation, level 2 provides accommodation and a food service and level 3 provides the additional service related to personal care assistance. Accreditation can be for 1 year or up to 3 years. The provider's accreditation is reviewed at the expiration of the period for which accreditation has been granted.

Upon registration a Level 3 facility is subject to at least monthly visits from the Community Visitor Program which is established under the Guardianship and Administration Tribunal. The purpose of these visits is to ensure that residents are appropriately dressed, that aspects of personal hygiene are being attended to, whether residents have access to outings/social events, whether basic freedoms (such as freedom of movement about the premises) are being infringed, the manner and recording of the distribution of medications, a check on food service delivery, whether the residents have any complaints and whether the premises are being appropriately maintained.

Mr Haralampo, who is the Manager of the Residential Services Accreditation Branch of Compliance, provided evidence as to the requirements of

accreditation. It is probably fair to say that the regulations are cast in broad terms and that to some extent aspects of the evaluation are determined by Mr Haralampo or the occupant of his position from time to time. The initial registration is essentially done on a self assessment provided by the service provider with no apparent independent checks. Further once accreditation is applied for and whilst there is an initial visit to observe procedures it seems that once accreditation is granted, there is a fair degree of self regulation involved, although with the overriding observations of the Community Visitor.

Interestingly Mr Haralampo when asked how a determination was made as to an appropriate staffing ratio stated that during the accreditation process a number of residents are spoken to for the purpose of ascertaining their views on the operation of the facility. Further it seems some arbitrary number such as the square root of the number of residents is used to determine a cross section of the residents. It becomes immediately obvious that there is a flaw in this approach as it presupposes that all residents are capable of speaking for themselves. Whilst Mr Haralampo stated that in cases where a person was unable to speak for him/herself an approach would be made to the next of kin or the Adult Guardian. That again presupposes that the resident has a family in regular contact or that the Adult Guardian has meaningful information about the level and standard of the resident's care.

If I correctly understand Mr Haralampo's evidence the Act and Regulations were brought into effect partly in response to the closure of residential facilities as a consequence of the 60 Minutes report about residents of mental institutions being bathed in kerosene and also as a consequence of the disastrous fires in Sandgate and Childers. The legislation was introduced with a view to keeping as many residences as possible open but with putting some regulatory procedures in place. This is undoubtedly the rationale for keeping the regulations broad in their terms. It is probably fair to say that the legislation remains a "work in progress".

Mr & Mrs A Sherlock were at the time of Mr Hoy's death and at the time of the Inquest the owner/operators of the Tarampa After Care Centre. Mr Sherlock gave evidence about the procedures in place at the time of Mr Hoy's death. He said that the residence provides accommodation for up to 55 residents although at the time of Mr Hoy's death there were about 50 people living there. It seems that only Mr Hoy and one other resident, who had a stroke related disability, required full personal care. The other residents required varying levels of assistance.

The facility had, in consultation with and at the instigation of Dr Piaggio, Psychiatrist, introduced a communications book for the purpose of noting medical related concerns and this was available to both, Dr Piaggio and Dr James, the GP treating Mr Hoy. Dr Piaggio had frequent recourse to this book but it seems it was less useful to Dr James. I am unsure after the evidence whether Dr James chose to disregard it or was unaware of it.

The book was a single bound volume with alphabetical tabs relating to each resident. The only downside seems to be that the book was from time to time

sent with the residents when they were going to medical appointments at Mental Health/Dr Piaggio. Therefore any comments or concerns, which occurred in the absence of the book, would have to be entered after its return. There are obvious difficulties if the person making the observation had gone for the day or even remembered to note it up upon its return. Perhaps this is something that the operators could look at to determine if the notes, relevant to the resident, could be copied and sent without the book having to leave. Dr Piaggio also said that he used it for the purpose of including comments, some for the benefit of the operators and some for the benefit of the resident's GP.

Mr Sherlock also gave evidence of the staffing levels. Essentially there is one staff member in attendance 24 hours per day on a shift or roster basis. During the day there may be additional staff as Mr & Mrs Sherlock are there during business hours but after hours and on weekends the role falls to one person. This person is expected to monitor the residents and to ensure they are all in bed at lights out, that meals are served, medications handed out, that the building is secure and to be available to assist if anyone gets into trouble during the evening or if there is some other emergency.

Mr Sherlock says that the residence is treated as the home of the occupants so they are expected, where possible, to assist in the general maintenance of the facility. He specifically mentioned assisting in the kitchen with serving and cleaning up but I am unaware of what arrangements are made for cleaning the premises, laundry etc.

The staff does not have any specialist training in dealing with mental health issues and it seems only a very low level of first aid training. Although Mr Sherlock argues that the facility provides accommodation only for people who have a level of self sufficiency that is not an entirely accurate picture. It was clear from his evidence that at the time of Mr Hoy's residency there were at least two people who needed assistance with showering and toileting, he also mentioned an occupant who had alcohol related dementia.

Whilst the staff hand out the medications which have been pre packaged in Webster packs there does not seem to be any accurate accounting there for. For example if a resident receives his tablets but is not seen to consume them the system seems to be inadequate for getting this information to the medical providers. I accept that there is no power to force the taking of medication but I would have thought this was an issue with potentially serious consequences. If, for example, there is a person who is required to take medication which is "life saving" then I might have thought that some attempt would be made to advise the doctor of this or to follow up with the patient to attempt to get him/her to comply. Equally the failure to take psychotic type medication can have serious consequences.

Mr Sherlock did say that checks were done of the rooms to make sure that medications were not being stored but that is not the complete answer. The medications may be getting passed onto other residents, being flushed down toilets and/or being disposed of in a number of other ways. This is an issue which needs to be addressed.

Ms Gloria Lomax was the staff member on duty on the day of Mr Hoy's death. She says that she was responsible for serving dinner to the four early diners and giving them their medications. She said that she had to fetch Raleigh from his room and as he sat she heard him say that he was having trouble breathing. She asked if he had asthma to which he replied "no". He sat down and she handed him his medication. He then stood up and went towards his room. After she completed her tasks she went to his room and again asked him how he was and he again relied that he was unable to breathe. She says that she went back to the kitchen to get her mobile phone and asked one of the other residents, a person by the name of Ken, to come and assist her. She says that as they walked towards the room she phoned "000". When they arrived at the room she says that Ken checked on Raleigh and said he thought that Raleigh was no longer breathing. She says that Ken took the phone from her and informed the "000" operator that the ambulance was needed immediately. Upon arrival it seems that the ambulance determined that Mr Hoy was already deceased and so the police were informed.

Mr Raymond John Howe is the Chief Executive Officer of the Purple Heart First Aid Training. His organisation was responsible for the training of Ms Lomax whilst at Tarampa After Care Centre. His organisation runs senior first aid courses and CPR training. This is an accredited training organisation through the Department of Employment and Training. The course undertaken by her was only for CPR competency. It is basic in nature and it seems limited to the basic techniques but with a rider that the trainee's safety is paramount. It does not seem that it determines how well the trainee will respond in a stressful situation or in fact if they would or could respond at all. It seems as though Ms Lomax did panic and did not even attempt CPR.

FAMILY CONCERNS

At the outset Mrs Hoy was concerned that her son had been over medicated. She stated that she was not aware he was epileptic and did not think that such medication was necessary. Further she believes the drugs prescribed were dangerous and in particular *Clozaril (Clozapine)* was the one she was most concerned about. It was her view that Clozapine was the cause of his death because of its association with cardiomyopathy. She also expressed concern that there was no contact with her or any other member of his family as to his commencement on Clozapine.

She also expressed some concern about the facilities at Tarampa After Care stating that her son had sufficient funds, which were administered by the Public Trustee to provide better accommodation. She stated that he was required to share a room.

She also made some references to what she perceived as mistakes in the autopsy report, namely comments about her son having grey hair and that he was uncircumcised. However on my reading of the report I did not form the view that the Pathologist had said anything which was incorrect. He referred to Mr Hoy as showing signs of "*early greying*" and that the penis "*appears uncircumcised*".

ISSUES FOR THE CORONER

Apart from the findings required pursuant to the Act the issues which have arisen are:

(a) the management of Tarampa After Care Centre;
(b) the accreditation of Level 3 facilities;
(c) the medical treatment of the deceased; and
(d) the link between Clozapine(Clozaril) and cardiomyopathy.

(a) Management of Tarampa After Care Centre

As previously noted Mr Hoy was a resident of the above centre and had been for a period of about 2 years prior to his death. He was placed there at the request of the Sandgate Community Mental Health Service because of a change in residential arrangements in Sandgate.

There are many positives about the Centre. It appears to have a pleasant aspect for the residents in a attractive rural setting. It has a number of facilities such as a pool, tennis court and picnic area for the use of the residents. The photos show premises which appear clean and well appointed and with grounds which also appear well maintained. Further it seems that appropriate practices were implemented for the delivery of medications although I will have some comment about the following up of those practices. I also note that Dr Piaggio commented favourably about the commencement of the communications book although again I have commented previously about some potential improvement in the use of that book.

On the negative side it is my observation that there is perhaps insufficient staff or at least staff with appropriate training and appropriate personality to deal with persons who have disabilities of varying kinds. At the outset I acknowledge that this Centre is ***not*** a nursing home but it is clear that it does provide accommodation for people with varying levels of disability and varying behavioural challenges. That being the case I would think that as a starting point it should ensure:

(a) That it employs staff competent to deal with varying and challenging behaviours/disabilities;
(b) employs sufficient staff to ensure that if an emergency arises then there is sufficient staff to ensure the emergency is properly handled and that the remaining residents are not compromised as to safety or needs;
(c) have staff competent in first aid and CPR techniques; and
(d) ensure that panic/alert buttons or phones are at close intervals about the premises to ensure speedy contact with emergency services.

What seems to have been one of the failures in this incident was that:

(a) Ms Lomax was the only person on duty responsible for the handing out of medications, serving of meals and to handle any emergency which may arise;
(b) Ms Lomax was not really suited to deal with an emergency and did not even attempt CPR although she had training in that regard;

(c) There was no panic/alert button close by which could either have been accessed by a staff member OR a resident if the need arose;
(d) Some time was lost in Ms Lomax continuing to serve the meals before attending to Mr Hoy;
(e) Further time was lost in having to return for her phone to contact the ambulance.

Had there been at least another staff member that person could have immediately gone with Mr Hoy to his room and monitored his situation. In her initial report of the incident Ms Lomax stated that she had to return to the kitchen area for her phone before she was able to contact the ambulance but she said in evidence that she had taken the phone with her. In this latter regard I did not believe her and consider that the statement made immediately after the incident and in the absence of any reasonable explanation for the change, was the correct version of events. This means that further precious time was lost. Again if there had been a phone or other panic/alert button in close proximity she could have called for that help without having to leave Mr Hoy. Indeed had she remained with him she may have been able to commence CPR immediately he stopped breathing.

By saying the above I do not wish to suggest that the outcome for Mr Hoy would have been any different than it was. I mention it only in the hope that the Centre may review its practices. I note that Mr Sherlock stated that the residents were encouraged to regard the Centre as their home and to assist in the operations within their respective capabilities. That being the case another suggestion might be to appoint an appropriate resident or residents who would provide assistance in emergency situations whether by taking over service of meals, accompanying a staff member who might be going to check on an ill resident and to act as “runner” to phone for emergency services or to provide whatever additional assistance required.

The next issue which is of some concern is the distribution of medications. The Centre has an appropriate procedure with “Webster packs” for each individual and arranges for that medication to be given out in accordance with the directions. This clearly provides a service to the residents and is to be commended. However the issue is what happens if the resident refuses or forgets to take the medications. I note that the current practice is for the sheets to be noted as to whether it was received and taken or whether it was received but not observed to have been taken. Mr Sherlock “suggested” that if the medication was not observed to have been taken then it was reported to the Doctor. However this seems to have been only noted in the communications book and it is fairly clear the Dr James in particular has little recourse to that book.

The issue of medication not taken may be a potentially serious problem. Firstly it could result in death or serious medical complications. Secondly if the medication was “saved” it could be potentially lethal if consumed in one large dose. Thirdly it could result in those with mental health issues being adversely affected if the medication is not maintained at appropriate levels thus posing a risk to themselves and/or others.

There would also seem to be an issue where the Centre could have noted on the resident's record whether the taking of the medication was essential. If there was a failure to do so then perhaps immediate contact should be made with the doctor. I accept that the Centre is not in a position to force residents to take the medication but having regard to the difficulties of some of those residents then it might be precautionary to have some arrangement for medical advice to be sought immediately or as soon as practicable.

(b) Level 3 Accreditation

This is the one area with which I have found some difficulty. What has caused some concern is that this accreditation is obviously intended to ensure some regulation of facilities which provide accommodation to those persons who are not highly functional, who are probably vulnerable and who have limited social and economic resources. It has to envisage people with physical and mental disabilities who may not require nursing home care but who are obviously unable to care for themselves without some level of assistance. For that reason alone there needs to be some more work done on the guidelines.

In a well run organisation self regulation is the preferable method of proceeding as it does not put in place a number of regulations which are unnecessary for every residence and which may impose an unreasonable financial impost for the type of service provided. I accept that Mr & Mrs Sherlock would be prepared to provide assistance and change as necessary. However in the general sense closer observation and/or regulation of similar facilities may be necessary.

Undoubtedly the Community Visitor fulfils a vital role in the enforcement of the regulations but I am of the view that the regulatory body also needs to be more proactive. I have mentioned above some matters in respect of the Tarampa After Care Centre which I thought were both good and bad in respect of the operation thereof.

Those matters which should be part of the regulation are as follows:

(a) The employment of sufficient and appropriately trained staff to ensure the comfort and safety of residents;
(b) Ensures that all staff employed in a Level 3 facility are trained and competent in both first aid and CPR;
(c) Ensures that medications are appropriately stored and distributed;
(d) Ensures that procedures are in place for advising doctors etc if the medications are not apparently taken;
(e) Ensures the appropriate training of staff in the particular facility is such that they are aware of emergency procedures and the whereabouts of emergency equipment;
(f) Depending on the size of the facility and type of residents whether the employment of a registered nurse is required to maintain accreditation; and

(g) The installation of an emergency phone in close proximity to each of the residences and/or panic/alert buttons.

There may well be other issues which need to be addressed and which I have not foreseen, directed as this Inquest is to the facts of this matter.

(c) Medical Treatment of Raleigh Hoy

Mr Hoy was being treated by Dr James for his day to day medical ailments and by Dr Piaggio for the issues associated with his mental health.

Dr James it is fair to say is a medical practitioner of the old school. He had a somewhat robust attitude to Mr Hoy and noted that it was difficult to get appropriate information from him. It seemed that on a lot of the occasions when he saw him he considered that he was rambling and largely incoherent.

Dr James had been seeing Mr Hoy since 2005 when he first came to live at Tarampa. Unfortunately Dr James seems to have had no knowledge of the "Communications Book" which the Centre had established for the very purpose of keeping the medical practitioners apprised of the day to day issues with the residents. It also seems that Dr James continued to prescribe medications (e.g. Valpro) because that is what Mr Hoy was on when he first came to Tarampa. One might reasonably wonder why there wasn't regular checking as to whether this medication was still required.

Dr James said that his mental health was an issue for the Mental Health Unit but he continued prescribing a drug which he believed related to that mental health issue. It also seems that Dr James claims that he was unaware of the other medications he was on or which were prescribed by the mental health unit, other than those which were prescribed when he came to live at Tarampa. Again this is an area I might have thought was essential particularly when some drugs can have adverse effects when prescribed together.

Dr Piaggio, was his treating Psychiatrist, and had first consulted with Mr Hoy on 22nd June, 2007. At the time he accepted that the previous diagnosis of autistic spectrum disorder and schizophrenia was correct. He advises that Clozaril/Clozapine was, at the time of Mr Hoy's death, the "gold standard" for treatment resistant schizophrenia. Dr Piaggio also advised that although Valrpo (Epilim) is usually used in the treatment of epilepsy, in Mr Hoy's case it was prescribed "*because it acts as a mood stabiliser and an adjunct in the treatment of patients with schizophrenia, particularly those who are acting out and are aggressive"*.

In June, 2006 Mr Hoy had been hospitalised because he had become aggressive and hypo manic. He was admitted to the Ipswich Mental Health Unit from the emergency department and remained an inpatient until 7th July, 2006. During this time he was treated by Dr Richardson and at the time of discharge he was prescribed a trial of Lithium twice per day. This trial was discussed with Dr Piaggio. Dr Piaggio again advised that this was an "adjunctive therapy" to manage Mr Hoy's aggression and hypomania. He did

not think that a combined treatment of clozapine, valproic acid and lithium was contraindicated.

It was Dr Piaggio who instigated the "Communication Book" at Tarampa. His entries indicate that at least some were directed to Dr James to make certain checks and have tests performed. However without Dr James being prepared to be co-operative in the use of this book it had limited value unless the staff ensured that Dr Piaggio's requests were passed on. In at least one circumstance Dr Piaggio had requested blood tests in respect of the lithium levels and was never provided with any results and did not know if they had in fact been performed, nor in fact did he contact Dr James about same.

Dr Piaggio also states that whilst on this type of medication regular blood tests are done to determine that the drugs remain within therapeutic limits. In addition patients on Clozaril were required to undergo an ECG, a chest X-ray and an Echocardiogram on a 2 to 3 year basis. Mr Hoy had last had a chest X-ray and ECG when admitted to hospital in June, 2006 with results that were not concerning. He was due to have the echocardiogram in late January, 2007. However the practice has now changed and such tests are performed every 18 months to 2 years.

Dr Piaggio says that it was and remains his practice to provide copies of the results of any blood tests he orders to be sent to the GP. I also note that one of the concerning factors of Clozaril is diarrhoea. This was another matter Dr James had been asked to follow up with an endoscopy. However Dr Piaggio was not overly concerned when there was no result provided, assuming that either the problem had been temporary or that Dr James was awaiting an appointment through the public health system for the endoscopy to be performed.

Whilst I have some reservations about the treatment provided by Dr James I would not suggest he was negligent or dangerous. Dr James is a practitioner of some 50 years experience. He may not have shown interest in the "Communications Book" but I cannot say that he did anything or failed to do anything which would be a cause for concern. I understand that since Mr Hoy's death Dr James has had more contact with Dr Piaggio and has attended some lectures given by Dr Piaggio. I think this demonstrates some expanding of his attitude.

Dr Piaggio presented as a practitioner of considerable experience and expertise who was well acquainted with his speciality. He seemed to have a caring attitude to Mr Hoy and had suggested some additional steps to be taken to assist with his comfort. Having regard to the likely demands of his practice within the Mental Health system it would be overly strict to criticise him for not following up on some issues and in fact he had every right to assume that a fellow professional was doing that which had been asked of him. He shows some proactive responses to the types of patient he deals with and also to assist organisations such as Tarampa in their care of such persons.

(d) Link between Clozapine (Clozaril) and cardiomyopathy

In the autopsy report Dr Nathan Milne reported that there was a raised concentration of Clozapine at 2.2 mg/kg. The reported fatal range of Clozapine is between 1.2 – 13 mg/kg so this reading was in the lower range. Dr Milne considers that cardiomyopathy is the cause of Mr Hoy's death and that some of the known causes of this condition include, alcohol, toxins and drugs, including clozapine. He was therefore of the view that it was *"Possible Clozapine caused or contributed to his cardiomyopathy".* Although there was a potentially fatal concentration of Clozapine in the blood he was not of the view that this was the likely cause of death due to that concentration being "*towards the lower end of the potentially fatal range and death is less likely to occur in long term users of the drug".*

Associate Professor Lindsay Brown provided a report to Messrs Blake Dawson Waldron which has been admitted as Exhibit 23 in these proceedings. Essentially and assuming I am correctly interpreting Professor Brown's findings he substantially agrees with Dr Milne's comments. In particular he stated as follows:

> *"While the measured clozapine concentration of 2. 2 mg/kg cannot be excluded as the cause of death, this seems unlikely given the reported post-mortem redistribution of this drug together with the therapeutic plasma concentrations reported over the previous three years for Mr Hoy."*

Overall I have come to the conclusion that whilst there is clear documented research which indicates the link between cardiomyopathy and the use of clozapine there is nothing in the evidence before me which would satisfy me that it has caused the condition in Mr Hoy.

FINDINGS PURSUANT TO s 45

I am required to find as far as possible who the deceased was, when and where he died, what caused the death and how he came by his death. I have dealt above with the circumstances of Mr Hoy's death. Given the evidence before me I have no reason to depart from the finding made by Dr Milne as to the cause of death. As a result of considering all of the material contained in the exhibits and the evidence given by the witnesses I am able to make the following findings:

(a) The identity of the deceased was Raleigh Hoy***;***
(b) Mr Hoy died on 6th January, 2007 ;
(c) Mr Hoy died at Tarampa After Care Centre, 449 Lowood-Minden Road, Tarampa;
(d) The cause of death was dilated cardiomyopathy.

RECOMMENDATIONS PURSUANT TO s46

I do not propose to repeat some of the comments I made particularly under the heading of ***"Level 3 Accreditation".*** It is a complicated area and one which this Inquest only touched on in a peripheral sense but perhaps some of

my comments may be taken to the appropriate department for a more detailed consideration into any improvements in the system.

Perhaps these proceedings have not answered all of Mrs Hoy's concerns and those of the other members of Mr Hoy's family. I extend to them all my sympathy at the passing of their loved son and brother.

I now declare this Inquest closed.

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D.M. MacCALLUM
CORONER
IPSWICH
5 May 2009