IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2016 005017

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
*Section 67 of the **Coroners Act 2008***

Inquest into the death of KENNETH JAMES STEPHENS

Delivered on:	23 February 2018
Delivered at:	Coroners Court of Victoria at Bendigo 71 Pall Mall, Bendigo
Hearing dates:	23 February 2018
Findings of:	Coroner Peter Charles WHITE
Assisting the Coroner:	Acting Sergeant Sonia Reed, Police Coronial Support Unit

I, PETER CHARLES WHITE, Coroner,
having investigated the death of KENNETH JAMES STEPHENS
and having held an inquest in relation to this death on 23 February 2018
in the Coroners Court of Victoria at Bendigo
find that the identity of the deceased was KENNETH JAMES STEPHENS
and that the death occurred on 21 October 2016
at the Echuca-Serpentine Road, Serpentine, Victoria 3517
from:

I (a) UNASCERTAINED

in the following circumstances:

1. Kenneth Stephens [known as 'Boon' but hereinafter referred to as 'Mr Stephens'] was a 51-year old single man who lived alone, but not far from his twin brother Rodney [hereinafter referred to as 'Rodney Stephens'] and his wife, in Leitchville. Mr Stephens and his brother were dairy farmers, although Kenneth Stephens was not working full time proximate to his death. Mr Stephens had a medical history that included moderate chronic schizophrenia, heavy cannabis use, tobacco smoking and excess alcohol consumption.

Mr Stephens' Psychiatric History

2. Mr Stephens had a documented psychiatric history from 1995 when he received involuntary psychiatric treatment as an inpatient at Bendigo Healthcare's Alexander Bayne Centre [ABC]. At that time, he was diagnosed with drug-induced psychosis and responded to the introduction of antipsychotic medications. However, upon discharge he was noted to be non-compliant with medications and continue to use cannabis and alcohol at high levels. Mr Stephens was very well supported by his family and, following further admissions and community treatment he was cared for in the private system for close to 20 years. At various times he had been diagnosed with schizophrenia[1] and depression.
3. In 2016, Mr Stephens was admitted to ABC on four occasions, namely, 27 May to 6 June, 9 to 30 June, 15 July to 18 August and 21-31 August 2016. His presentations were characterised by paranoid thoughts about his food and drink being poisoned, excessive consumption of milk and vomiting in an effort to expel 'poisons' and a belief he was going to die.

[1] Schizophrenia refers to a group of disorders characterised by positive psychotic symptoms at some stage of illness, where mania and major depression are not prominent or persistent features, and where negative and cognitive symptoms are likely to be prominent and associated with varying degrees of disability. Comorbidity is extremely common. In the paranoid type, paranoid delusions are prominent.

4. Mr Stephens' diagnosis in August 2016 was schizoaffective disorder.[2] He was treated with paliperidone[3] 75mgs depot injection monthly, sodium valproate[4] 1500mgs daily, with clonazepam[5] 0.5mgs and zopiclone[6] 7.5mgs at night as required to aid sleep. Mr Stephens was discharged from inpatient treatment subject to a Community Treatment Order [CTO] under the *Mental Health Act* 2014 [MH Act].

5. Echuca Community Mental Health Service [ECMHS] provided intensive support between and after Mr Stephens' psychiatric admissions. Mr Stephens and/or his brother were contacted on a daily basis by ECMHS to ensure that he was compliant with his medication regime, did not exhibit any early warning signs of deteriorating mental health and to make arrangement for administration of his depot injection. In addition to these contacts, after his final admission ECMHS completed four home visits, two face-to-face assessments by a registrar and consultant psychiatrist and two formal multidisciplinary team reviews of Mr Stephens' progress.

6. Indeed, after that final admission, which had occurred in the context of the recent death of his mother, Mr Stephens' condition had improved sufficiently to enable him to return to work on the dairy farm, play lawn bowls, drive his car and go to the local pub on occasion. He also reported sleeping well and cooking for himself and appeared to maintain an adequate diet.

7. On 26 September 2016, Mr Stephens received a depot injection of paliperidone, administered by his general practitioner, Dr Rana, at the Ochre Health Medical Centre in Cohuna. Dr Rana noted that Mr Stephens appeared well and reported taking his medications.

Circumstances Proximate to Death

8. On 13 October 2016, Rodney Stephens contacted ECMHS to raise concerns that his brother was not sleeping given that he had attended the dairy unusually early. ECHMS contacted Mr Stephens who was willing to engage, calm and gave an explanation for his early appearance at

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[2] Schizoaffective disorder is a combination of two mental illnesses – schizophrenia and a mood disorder. The main types of mood disorder include bipolar disorder (characterised by manic episodes or an alternation of manic and depressive episodes) and unipolar (characterised by depressive episodes). Diagnosis can be difficult because the symptoms of schizoaffective disorder are so similar to that of schizophrenia and bipolar disorder. A diagnosis of schizoaffective disorder requires compliance with the diagnostic criteria from the International Classification of Disease diagnostic codes schizophrenia [ICD F20.0-20.3] and mood (affective) disorder codes [ICD F30, F31 and F32].

[3] An antipsychotic available in oral or slow-release depot injection.

[4] An anticonvulsant used to treat seizures, mania in people with bipolar disorder and to prevent migraines.

[5] Long-acting benzodiazepine used as a preventative for individuals diagnosed with epilepsy and in palliative care which can also be used for its sedating effects to treat anxiety where other treatments have been ineffective.

[6] Zopiclone is used in the treatment of insomnia.

the dairy. A call was made to Rodney Stephens the following day who confirmed that his brother appeared to be his usual self and had reported good sleep.

9. On 17 October 2016, Rodney Stephens reported to ECMHS that his brother had been at lawn bowls all day, an account Mr Stephens later confirmed.

10. On 18 October 2016, Rodney Stephens contacted ECMHS stating that his brother was laughing a lot and had been away from home for most of the previous day. ECMHS clinician Leanne McCallum contacted Mr Stephens who appeared stable, reporting that he been to a female friend's home for lunch. He denied drug use but said he had drunk between four and six beers.

11. Ms McCallum completed a home visit at which she found Mr Stephens to be stable, with no change to his mental state assessment. Rodney Stephens reported that his brother had been good that day, however, Mr Stephens volunteered that he was non-compliant with sodium valproate because, in his view, he did not need it. An appointment for a review with consultant psychiatrist Dr Thomas was arranged for 24 October 2016.

12. On 19 October 2016, at Rodney Stephens' request, an ECMHS contacted Mr Stephens about his upcoming appointment. Mr Stephens remained agreeable to the appointment with Dr Thomas and in order to save him the trouble of attending additional appointment with his general practitioner, ECMHS offered to administer his depot injection the same day.

13. On 20 October 2016 Rodney Stephens contacted ECMHS because his brother had attended the dairy early again and this time also appeared subdued. Mr Stephens later reported to an ECMHS clinician that he felt good, had been out on his motorcycle and played bowls, and did not need the sodium valproate as his mood was normal.

14. At about 10.30am, Mr Stephens drove to his brother's home. Rodney Stephens was not there but tradesmen Joel McGillivray and Michael McGlone were present and observed him dressed for lawn bowls and appearing somewhat run down. Mr Stephens accessed a large container of fresh milk and drank a large amount of it before also consuming sugar and a large amount of water. He vomited several times before leaving the address by car for his friend Robert Nott's home, situated a little further up the road.[7] Mr McGlone telephoned Rodney Stephens to inform him that his brother appeared unwell.

15. At about 11am Rodney Stephens contacted ECMHS to inform clinicians of the situation.

16. By about 1pm, Senior Constable Sean Closter of Cohuna Police, who was performing divisional van duties in the Cohuna/Leitchville area, had heard about Mr Stephens' apparent

[7] Coronial brief of evidence, Statements of Michael McGlone, Joel McGillivray and Robert Nott.

ill-health. He attended Rodney Stephens' home where the two men discussed Mr Stephens' condition and that ECMHS had been informed and were due to attend. SC Closter obtained the contact details of ECMHS clinicians.[8]

17. SC Closter spoke with an ECMHS clinician who advised that on the basis of the report received from Rodney Stephens about his brother's unusual behaviour, the mental health service would arrange for his status under the MH Act to be varied. Psychiatrist Dr Thomas had already been contacted and ECMHS clinicians would attend to convey Mr Stephens to the ABC. SC Closter was asked if he would attend as a precautionary measure and, upon securing the approval of his supervising sergeant, agreed to do so.[9]

18. Dr Thomas varied Mr Stephens' CTO to an inpatient treatment order [ITO] under the MH Act.[10]

19. At about 2.10pm, SC Closter arrived at Mr Nott's home to find ECMHS clinicians already in attendance. Mr Stephens was standing near a fence with a florid complexion and bloodshot eyes and the pants of his lawn bowls uniform appeared to be wet. When asked how he was feeling, Mr Stephens replied that he was okay – not in pain – but that he had been vomiting and incontinent of faeces. He said he did not want to go to hospital.[11]

20. Mr Stephens continued to drink water and vomit intermittently. Though he appeared tense, he interacted to a limited degree with the ECMHS clinicians, who told him that he did not look well and should be seen by a doctor. Mr Stephens reiterated that he did not want medical attention.[12]

21. At about 2.15pm, one of the ECMHS clinicians telephoned for an ambulance and explained Mr Stephens' circumstances and condition.[13] All present continued to engage Mr Stephens in conversation and reassure him about being medically reviewed. He remained lucid and resistant to medical care, continued to vomit and lose control of his bowels and became increasingly unsteady on his feet.

22. A little before 3pm, Mr Stephens experienced a seizure of between 30 and 60 seconds duration. The emergency services were contacted again and an update of his condition provided. SC Closter requested information as to when the ambulance would arrive via police

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[8] Coronial Brief of Evidence, Statement of SC Closter.

[9] Ibid.

[10] Coronial Brief of Evidence, Exhibit 3.

[11] Coronial Brief of Evidence, Statement of SC Closter.

[12] Ibid.

[13] Ibid and Coronial Brief of Evidence, Statement of David Natoli.

communications and was informed that the ambulance was 'just down the road'.[14] A short time later he was informed that the Cohuna ambulance had been cancelled and another had been dispatched from Kerang.[15]

23. At about 3.50pm, the Kerang ambulance arrived at the scene. About 15 minutes later, Mr Stephens experienced another seizure, this one lasting between 30 and 60 seconds and rendering him unconscious for about ten minutes. After he had regained consciousness and his vital observations were satisfactory, the ambulance departed with Mr Stephens aboard bound for the hospital in Bendigo.[16]

24. At about 5.12pm, *en route* to Serpentine where the Kerang ambulance crew was to rendezvous with a Mobile Intensive Care Ambulance [MICA] paramedic from Bendigo, Mr Stephens suffered a further seizure, followed by respiratory and cardiac arrest. Cardio-pulmonary resuscitation [CPR] was commenced and continued until after the MICA unit arrived to assist but Mr Stephens could not be revived. He was pronounced dead at 5.42pm on 21 October 2016.[17]

Coronial Investigation

25. Mr Stephens' death was reportable as he was a *person placed in custody or care*[18] by virtue of, upon variation of his CTO, being an involuntary psychiatric patient as defined by the *Mental Health Act* 2004 [MH Act], at the time of his death. This is one of the ways in which the *Coroners Act* 2008 [the Act] recognises that people in the control, care or custody of the State are vulnerable, and affords them the protection of the independent scrutiny and accountability of a coronial investigation.

26. As an additional protection, until the insertion of section 52(3A) into the Act in November 2014, all deaths of people placed in custody or care required a mandatory inquest. Now, the Coroner is no longer required to hold an inquest if satisfied that the death was due to natural causes but must publish Findings made concerning natural causes deaths of people in custody

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[14] Coronial Brief of Evidence, Statement of SC Closter.

[15] Coronial Brief of Evidence, Statement of SC Closter.

[16] Coronial Brief of Evidence, Statement of David Natoli.

[17] Ibid.

[18] See section 3 of the Act for the definition of a "person placed in custody or care". Mr Stephens' death was also 'unexpected' another indicia of reportability pursuant to the *Coroners Act* 2008.

or care.[19] Of course, the Act preserves a discretionary power to hold an inquest in relation to any death a coroner is investigating.[20]

27. This was a mandatory or statutorily prescribed inquest as Mr Stephens was a person placed in custody or care and the circumstances of his death are such that I am unable to make any findings as to the medical cause of death.

28. This finding draws on the totality of the material the product of the coronial investigation of Mr Stephens' death, and in particular, the inquest brief compiled by Detective Senior Constable Andrew Heazlewood of Bendigo Crime Investigation Unit. The brief, together with the inquest transcript, will remain on the coronial file. In writing this finding, I do not purport to summarise all of the available evidence, but refer to it only in such detail as appears warranted by its forensic significance and the interests of narrative clarity.

Forensic and Medical Investigation

29. As part of his investigation, DSC Heazlewood attended and searched Mr Stephens' home where he found several empty beer stubbies on the dining table and a large number of sodium valproate blister packs, some used and others unused. He then attended Mr Nott's home in order to examine Mr Stephens' car in which he located beer bottles in the front passenger foot well.[21]

30. Forensic Pathologist Dr Victoria Francis of the Victorian Institute of Forensic Medicine reviewed the circumstances of the death as reported by police to the coroner, available medical records and post-mortem CT scans of the whole body and performed an autopsy. Among Dr Francis' anatomical findings were an enlarged heart (cardiomegaly) with moderate single vessel coronary artery atherosclerosis and mild myocardial fibrosis, emphysematous lungs with bilateral pleural adhesions and mild to moderate hepatic steatosis. There was haemorrhage over the sternal body and posterior oesophagus with patchy alveolar haemorrhage, findings often seen in the setting of CPR.[22]

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[19] Section 73(1B). Section 52(3B) outlines the circumstances in which a coroner may consider a death to be due to natural causes.

[20] Section 52(1) provides that a coroner may hold an inquest into any death that the coroner is investigating.

[21] Coronial Brief of Evidence, Statement of DSC Andrew Heazlewood.

[22] Coronial Brief of Evidence, Report of Dr Victoria Francis.

31. Post-mortem toxicology detected hydroxyrisperidone, a metabolite of risperidone, at levels consistent with therapeutic use. No sodium valproate was detected, nor any other commonly encountered drugs, poisons or alcohol.[23]
32. Dr Francis advised that the cause of Mr Stephens' death was unascertained.[24]
33. The pathologist opined that the most likely event leading to death was the sudden onset of a cardiac arrhythmia, which is characterised by a sudden disruption to the conducting system of the heart. The risk of developing disease that may cause an arrhythmia increase with age, though may be triggered by more obvious pathological processes such as coronary atherosclerosis, hypertension, or cardiomyopathies.[25]
34. Dr Francis observed that people with schizophrenia have an increased risk of death (thought to be almost twice the risk of the general population). While a natural disease process may be identifiable in some people, a proportion of these deaths have no identifiable medical or toxicological cause. It is possible in these cases that death may be due to altered autonomic physiology, and possible interactions with psychotropic medications.[26]
35. Dr Francis commented that the significance of the sodium valproate packs found at Mr Stephens' home was uncertain given no trace of the drug was found in toxicological analysis. However, the pathologist noted that sodium valproate should be taken in tapering doses when commencing and ceasing the medication, with possible symptoms of withdrawal including anxiety, confusion, headache and seizures. Although the effects of withdrawal are more likely to be severe if cessation is abrupt, she noted that there was little clinical evidence of withdrawal effects in non-epileptic patients.[27]

Review of Mr Stephens' Mental Health Management

36. At my request, the Mental Health Investigator of the Court's Coroners Prevention Unit [CPU][28] reviewed the available evidence and provided advice about the adequacy of Mr Stephens' mental health management by ECMHS. The CPU advised:

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[23] Coronial Brief of Evidence, Toxicology Report authorised by Natalia George.

[24] Coronial Brief of Evidence, Report of Dr Victoria Francis.

[25] Ibid.

[26] Coronial Brief of Evidence, Report of Dr Victoria Francis.

[27] Ibid.

[28] The Coroners Prevention Unit [CPU] was established in 2008 to strengthen the prevention role of the Coroner. CPU assists the Coroner to formulate prevention recommendations and comments, and monitors and evaluates their effectiveness once published. The clinical divisions of the CPU – the Health and Medical Investigation Team and Mental Health Investigators are staffed by practising physicians and nurses who are independent of the health professionals or institutions involved in a particular investigation. They assist the Coroner's investigation of deaths

a. The care provided by ECMHS was of a high standard. The thoroughness of the assessment planning, engagement with Mr Stephens and his brother was frequent and meaningful. Its response to changes in Mr Stephens' presentation as reported by either of the Stephens brothers was timely and appropriate.
b. The frequency of psychiatric reviews, multidisciplinary reviews and lead clinician reviews was intensive and reflected the assessment of Mr Stephens' mental state and any corroborative history provided by Rodney Stephens.
c. The cause of Mr Stephens' death is unascertained and Dr Francis proposed a number of scenarios that may have culminated in his death. According to his brother, Mr Stephens had been drinking up to a dozen stubbies of beer nightly proximate to his death. Combined with his non-compliance with clonazepam and sodium valproate and his history of rapid decline, it is not unreasonable to consider Mr Stephens' behaviours – drinking large amounts of milk and water, eating sugar and forced vomiting – were linked to his mental state. Indeed, his medical records document similar behaviours in connection with previous episodes of inpatient care. The impact of consuming large amounts of milk water and sugar and repeated vomiting over a period of hours on his physical haemostasis is unknown.

Review by Ambulance Victoria

37. In response to a complaint from Bendigo Hospital about the initial delay in attending Mr Stephens, Ambulance Victoria [AV] conducted a clinical review of the case.[29] AV MICA paramedic and Clinical Review Specialist David Natoli, provided me with a statement detailing the circumstances of ambulance attendance on Mr Stephens on 21 October 2016 and the AV review. Mr Natoli advised as follows:
    a. From the information received during the initial call for an ambulance at 2.17pm,[30] it is considered that categorisation of case as 'Code 3 – not urgent' was appropriate.

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occurring in a healthcare setting by evaluating the clinical management and care provided and identifying areas of improvement such that similar deaths may be avoided in the future. CPU's skilled researchers and investigators contribute to prevention issues not arising in the health care setting.

[29] Coronial Brief of Evidence, Statement of David Natoli.

[30] Mr Stephens had been described by the caller as a client reclassified as an involuntary psychiatric patient who appeared physically unwell with faecal incontinence, vomiting and a swollen face but conscious and communicative.

b. The case was transferred to AV's Referral Service which further triages non-urgent cases to determine the most appropriate resource to respond. The applicable guideline was followed when the call taker categorised the case as 'unable to triage' due to information provided that the patient may be non-compliant,[31] and putting the case on hold for 30 minutes between 2.19pm and 2.42pm.

c. It was appropriate for the Cohuna ambulance to be dispatched to the case (at 2.42pm) as it was the nearest available ambulance at about 10 kilometres [km] from Leitchville. In accordance with protocol, the Advanced Life Support [ALS] paramedic contacted the Ambulance Community Officer [ACO][32] but the ACO was unavailable.

d. When the Cohuna paramedical advised the dispatcher while *en route* at 2.46pm that he was responding alone, he was asked to stand by and the ambulance ultimately cancelled. This decision was appropriate because AV policies require two AV crew members to transport an involuntary mental health patient to hospital and at the time of the request, Mr Stephens' condition was not time-critical nor were there any clinical issues requiring the urgent attention of a paramedic.[33]

e. At 3pm, when the Cohuna ambulance was cancelled, there were no nearby units available to attend Mr Stephens and so the dispatcher referred the case to a Communications Support Paramedic [CSP] for a solution. The CSP initially requested an ambulance from Echuca to attend but none were unavailable and so the Kerang ambulance, nearly 40 kilometres away, was dispatched at 3.04pm and *en route* within minutes on a 'Code 2' (urgent) basis.

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[31] Mr Stephens was reportedly refusing to answer questions relayed through a mental health worker.

[32] Cohuna branch is staffed by two ALS paramedics who work shifts as single officers. Each paramedic works eight days on and six days off and are available on an 'on call' basis after hours. Paramedics are supported by a small number of Ambulance Community Officers [ACOs] who are first responders employed by AV on a casual basis to provide advanced first aid in remote communities where the case load is low and the ambulance branch is not staffed full time. ACOs have life-saving skills, which they develop and maintain annually.

[33] Mr Natoli also advised that consideration was given to whether the Cohuna paramedic ought to have continued on to the address. However, it was though that such a response would have meant that the Cohuna ambulance would have had to wait for the Kerang ambulance because the former would not have been able to transport the Mr Stephens alone; this would not have been an efficient use of resources. He also noted that at the time the Cohuna ambulance was cancelled it would be seen in the distance from the Leitchville address. Although this was most unfortunate, the police member on scene was advised by the dispatcher why the ambulance was cancelled. Consideration was also given to whether the Cohuna ambulance could have been recalled to Mr Stephens at 3.43pm when he was reportedly experiencing a seizure. At that time, the Kerang ambulance was closer than the Cohuna ambulance and arriving some nine minutes later.

f. Following a further 000 call at 3.43pm indicating that Mr Stephens was experiencing a 'major seizure' and that an ambulance was required urgently, the Kerang ambulance was informed and proceeded to the scene with 'lights and sirens', a 'Code 1' response, arriving at the scene at 3.52pm.

g. On arrival of the ambulance, Mr Stephens was alert and responsive but experienced a further seizure at 4.05pm after which he remained unconscious for about ten minutes. During the time he was unresponsive, a paramedic contacted AV to discuss options for transporting Mr Stephens to hospital including by AV helicopter or a rendezvous with a MICA paramedic.

h. By 4.20pm Mr Stephens had regained consciousness and his vital observations were satisfactory such that the Kerang crew advised air ambulance that a helicopter was not required and they would rendezvous with another ALS crew or MICA on their way to Bendigo. Simultaneously, the CSP requested dispatch of an ambulance from Bendigo (Epsom) to meet the Kerang ambulance at Serpentine, which is situated 76km from Leitchville and about 125km from Bendigo.

i. At 5.11pm, the Kerang crew asked for the Epsom ambulance to attend on a 'Code 1' basis as Mr Stephens had suffered a further seizure before going into respiratory and then cardiac arrest. CPR was underway as the Kerang ambulance drew within 6 km of Serpentine. The Epsom crew arrived at Serpentine to assist resuscitative efforts at about 5.35pm. CPR was ceased at 5.42pm, Mr Stephens having been asystolic since 5.12pm without any change to his condition.

j. The review found the paramedics acted with a high regard to Mr Stephens' condition and safety and identified no concerns with the clinical care provided.

k. AV engaged in an open disclosure meeting with Mr Stephens' family in November 2016 and met with the ECMHS staff who had been with Mr Stephens in Leitchville on 21 October 2016.[34]

Conclusions

38. The standard of proof for coronial findings of fact is the civil standard of proof, on the balance of probabilities, with the *Briginshaw* gloss or explication.[35] Having applied the applicable

[34] Coronial Brief of Evidence, David Natoli.

standard to the available evidence I am satisfied that Mr Stephens, late of Hornsby Road, Leitchville, died on 21 October 2016 on the Echuca-Serpentine Road, Serpentine and that despite a full autopsy, his cause of death was unascertained.

39. I am satisfied by the available evidence, including the context of the services existing in the region, that Ambulance Victoria's response to the call for an ambulance for Mr Stephens on 21 October 2016 were reasonable in the circumstances.

Pursuant to section 73(1B) of the *Coroners Act* 2008, I order that this Finding be published on the Internet in accordance with the rules.

I direct that a copy of this finding be provided to the following:

Mr Rodney Stephens

Ambulance Victoria

Office of the Chief Psychiatrist

A/Prof Phillip Tune, Psychiatric Services, Bendigo Health

DSC Andrew Heazlewood, Bendigo CIU

Signature:

PETER CHARLES WHITE
CORONER
Date: 23/2/2018

Coroners Court of Victoria

[35] *Briginshaw v Briginshaw (1938) 60 C.L.R. 336 esp at 362-363.* "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 issues had 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…"