IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: 2008 / 4028

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of Anthony Travaglini

Delivered On:	3 July 2015
Delivered At:	65 Kavanagh Street Southbank 3006
Hearing Dates:	25 February 2013, 28 February 201, 19 April 2013, 25 April 2013, 18 April 2013, 27-29 May 2013
Findings of:	PETER WHITE, CORONER
Representation:	Dr P Halley on the instructions of Minter Ellison Lawyers on behalf of Eastern Health
Police Coronial Support Unit:	Leading Senior Constable K Ramsey

I, PETER WHITE, Coroner having investigated the death of Anthony Travaglini

AND having held an inquest in relation to this death on 25 and 28 February, April 19, 25, 28 and May 27, 28 and 29, 2013 at Melbourne,

FIND that the identity of the deceased was Anthony Travaglini, born on 21 January 1968, and the death occurred on 8 September 2009 at Upton House High Dependency Unit, (HDU), Box Hill Hospital, in the State of Victoria,

FROM: 1 (a) Drug toxicity in a man with asthma (undiagnosed) and sleep apnoea[1]

in the following circumstances:

BACKGROUND

1. Anthony Travaglini (Anthony) was 40 years of age at the time of his death. His medical history included schizoaffective disorder as well as drug and alcohol abuse. I also note that he had lost two fingers in an accident while working as a butcher.
2. Anthony had been through multiple admissions to various psychiatric services, including previous admissions to Upton House, at Box Hill Hospital. He was also treated as an

---

[1] On the morning of 25 February 2013, the Court heard submissions from Counsel for Eastern Health concerning an objection to the taking of evidence from a former employee, psychiatric registrar, Dr Tom Eimany. Dr Eimany's statement of evidence had been extracted from a longer statement relating to an investigation of an unrelated death, which statement had been provided to the Court by another Coroner. I then reviewed the one paragraph, which paragraph was supplied to Eastern Health. The paragraph in question (contained in the broader statement), was as follows.

"with regard to the death of Anthony Travaglini, is it acceptable for management (of Upton House), to stop staff from contacting the family after that? Or threateningly tell staff,
'we all agree that no one would have done anything differently', during a clinical presentation without letting any one else speak."

Counsel argued that as Dr Eimany was not directly involved with the care provided to Mr Travaglini that he had no relevant evidence to give. Counsel also advised that he had been taken by surprise and that he would need an adjournment to take instructions and to prepare to cross-examine Dr Eimany as to whether these words were said. Dr Eimany had been summonsed to attend and was briefly examined and confirmed that he was present and heard these particular words used by Dr Jose Segal, who at the time was Principal Consultant Psychiatrist with Eastern Health, see transcript page 292.
Following discussion with Counsel it was determined to proceed to hear evidence of other witnesses as earlier planned, and to use the material provided by Dr Eimany as a basis for the questioning of relevant witnesses,- but not as evidence of the truth of the content, or as proof that Dr Segal had used such words, (this absent any further application to re-call Dr Eimany). See Transcript 25 February at pages 7-9 and 22. I note here that Dr Segal later denied that such words were used by him at a Root Cause Analysis meeting, but did not deny that they may have been used during a morbidity and mortality meeting. See transcript at page 310.
Following a further request by the Court and after hearing from Counsel and the interested parties, the Court additionally ruled in favour of Eastern Health's submission that the Court was not entitled as of right to view preparatory statements made by Eastern Health Staff, at the request of in house counsel. The judgement prepared in respect of this particular objection, dated 28 February 2013 is set out on the Courts website.

outpatient in the Koonung centre. Eastern Health was the corporate entity representing Upton House and the Koonung centre.

3. Anthony also had a history of a condition described by his treating specialist Dr K Detering as,

   'severe sleep apnoea',

   for which he had been treated with the continuing use of a nasal CPAP mask. He had been reviewed for this condition by Dr Detering at the Austin and Repatriation Medical Centre, through sleep studies carried out in November 2000. See report of Dr Detering dated 2 August 2013, which report has been added to the exhibits list, with clinical records attached, at exhibit 12.[2]

4. On August 25, 2008, Anthony was admitted as an involuntary patient to the inpatient psychiatric unit, Banksia ward, through the Southern Health Crisis Assessment and Treatment team. He was admitted to Banksia, because there was no bed space at Upton House, (where he had previously been admitted for treatment).

5. Dr Paul Daffy, Consultant Psychiatrist at Banksia reviewed and recommended Anthony for treatment as an involuntary patient. On the following day 26 August 2008, Dr Prasad Pratange also reviewed Anthony and upheld the recommendation that he receive involuntary treatment.

6. During his admission at the Banksia, Anthony was seen to be very disturbed and to require sedative medication and periods of seclusion. He also developed paranoid delusions and became aggressive and violent. He was prescribed oral risperdone and diazepam together with olananzapine, to promote sedation.

7. On the following day 27 August, he was prescribed intramuscular Resperidal Consta and at 8.15 pm he was administered 75 mg of zuclopenthixol acetate. At 4.05 pm on 1 September 2008, he was also administered 75 mg of zuclopenthixol and 2 mg of benztropine.[3]

8. At approximately 5.30 pm on the 2 September 2008, Anthony was transferred from Dandenong Hospital to Upton House, at Box Hill Hospital. The Psychiatric registrar on Duty at Box Hill Hospital was Dr Malmalabaduge Fernando.

---

[2] See Dr Detering's statement at exhibit 12.

[3] See footnote 12. Iwas unable to locate, in the medical record which came from Banksia, evidence that the first of these doses was administered.

Dr M Fernando[4]

9. At approximately 5.30 pm on September 2, 2008, Dr Fernando admitted Anthony to High Dependency Unit (HDU), Upton House. He remained an involuntary patient under section 12 of the *Mental Health Act 1986* at the time of admission.

10. Dr Fernando found that he was,

    '*grossly thought disordered, psychotic, and had significant risk issues to himself, his family, staff and other patients due to his delusional beliefs*'.[5]

11. Dr Fernando diagnosed a relapse of his schizoaffective disorder with manic psychotic features in the context of medication non-compliance and substance misuse. She determined to continue his respiridone prescription. Anthony was continued as an involuntary patient, and he remained threatening and unstable.[6] Her physical examination of Anthony revealed no abnormality, other than obesity, (105kg).

12. The treatment notes indicate that he became increasingly irritable and threatening and was given PRN Olanzapine 10mg and Diazepam 10mg orally. Seclusion started at 6.55 pm. He remained agitated and was banging on the door. Dr Fernando's next contact with Anthony came at 11 pm that evening when he was given a seclusion review after which he was ordered to be secluded due to threatening behaviour. Later he was found lying on the floor of a seclusion room, having collapsed and vomited with brown colour vomitus. This matter was recorded by Dr Fernando,

    '*for the treating team for follow up of the condition and his regular oral medication was given*'.[7]

13. Dr Fernando next saw Anthony at 9am on 7 September , 2008 when she saw him in the HDU. (Anthony by this stage, had been removed from the seclusion room, as it was required to accommodate a second patient, who had apparently caused significant damage to the seclusion unit he was previously occupying). [8]

---

[4] Dr Fernando was employed as a medical officer at Eastern Health Mental Health Services, from January 2, 2007.

[5] See Dr Fernando's statement at exhibit 4 page 2.

[6] In this regard see particularly the evidence of shift leader Nurse McKeown set out below, who tried unsuccessfully to seek out and have Anthony transferred to another unit where a seclusion room was available.

[7] Exhibit 4, page 3.

[8] The time of this consultation was not recorded in the clinical notes. See also exhibit 4 page 3.

14. Anthony presented as grossly thought disordered, with paranoia and grandiose delusions. He denied self-harming thoughts or the intention to harm others at this time.

15. His risk issues remained the same and Dr Fernando recommended HDU management for the rest of the day. At 11.30 pm, the same day, nursing staff rang Dr Fernando because Anthony was becoming more difficult to manage,

'acting impulsively psychotic, irritable and threatening',

and because the one available HDU seclusion room was already occupied. Instructions were given over the phone, about his ongoing management,

'with prescribed medication of Olanzapine 10mg or oral Chlorpromazine 100mg, or PRN to be given whenever needed'.[9]

16. Dr Fernando arrived at the Unit at 11.45 pm to review Anthony directly. She found him to be highly agitated with no inclination to follow directions as he paced up and down in the HDU with speech increasing in time and volume. She also noted that his respiratory rate and blood pressure were reduced from that measured between the 3 and 7 September 2008. She considered this level of deviation to be normal human variation and did not direct nursing staff to undertake specific monitoring.[10] She later discussed her findings with on call Consultant Dr S Joshua[11], in the context of not having a seclusion bed available for him at Upton House. She further referred to the medication chart and read out to Dr Joshua the total doses of Acuphase injection (Zuclopenthixil acetate), provided to him over the previous two weeks, to that time. She informed Dr Joshua of the dates of the doses given in Banksia ward (75 mg x 2) and the last dose 100mg IM, given on 5 September at Upton House.[12]

17. Dr Joshua instructed that Anthony was to be given Acuphase 125 mg stat, with Benztropine of 2mg by injection for faster sedation, together with an extra dose of Chlorpromazine 100mg orally, and a mood stabiliser sodium valpoate. Dr Fernando remained present while Anthony was given the medication and remained present as he walked around the ward while still distressed and agitated.

---

[9] Ibid.

[10] See Dr Fernando's discussion of this matter at transcript page 164-65. See also exhibit 2(c), the frequent observation chart, which suggests that specific monitoring did take place at 1.30 and 2.30 am on 8 September 2008, with a continuing low blood pressure and respiration recorded at those times.

[11] Dr Joshua a consultant psychiatrist took over on call duties from Dr Antony on the 7 September, which was over the weekend. The registrar on duty was a Dr Afrah Mazhar.

[12] See exhibit 6 page 3 Dr Joshua, and exhibit 4 page 2 Dr Fernando. See also footnote 3 above.

18. I note here that at this time neither Dr Fernando, nor Dr Joshua, were aware of Anthony's past significant illnesses, which included sleep apnoea. I also note that at this time they further discussed the possibility of transferring Anthony out of Upton House and of swapping him for a patient at Maroondah Hospital HDU.

19. Anthony did not settle and was seen walking around the ward after snatching short periods of sleep. Dr Fernando examined Anthony again at 1.30 am,

    'with the assistance of nursing staff and with his cooperation'.

20. At the same time nursing staff especially the shift leader RPN McKeown, made calls to on call manager for Eastern Health Mr Wood and the Ward Manager, Ms Bagulho, independently seeking to make arrangements to transfer Anthony to a facility with a seclusion room. Dr Fernando later took a call from Mr Wood in which the difficulties with Anthony, were discussed.

21. Later, Dr Joshua called the ward for a further update from Dr Fernando. The possibility of an arrangement to be made for Anthony's transfer out of the Unit, was not raised in that discussion. I further note that it was evident from his testimony, that RPN McKeown, felt a level of frustration, arising out of the requirement that he needed to get consultant-to-consultant agreement, before his plan to transfer Anthony away from Upton House, could be affected).

22. Dr Fernando again reviewed Anthony and recorded her findings, this before leaving the unit at 2.45am.

23. She returned to the unit at 8.30 am the following day and learnt that Anthony had died.[13]

Dr George Anthony

24. On 4 September 2008, the consultant psychiatrist Dr George Anthony, reviewed Anthony at Upton House. He also diagnosed a relapse of his schizoaffective disorder and prescribed 200 mg sodium valproate (a mood stabiliser), in addition to his continuing respiridone.

Dr Caroline Fairhall

25. On 5 September 2008, Anthony was reviewed by Dr Fairhall, a psychiatric registrar. She noted that Anthony was becoming increasingly paranoid and threatening towards other

[13] Ibid page 4.

patients and staff. He had impaired insight and did not believe he was suffering from mental illness.

26. After consultation with Dr Anthony, Dr Fairhall prescribed 100mg zuclopenthixol and 2mg colnazepam intramuscularly. His sodium valproate was increased to 500g bd with benztropine as required and clonazepam 2mg intramuscularly as immediate treatment. Benztropine was chartered as a PRN medication, should Anthony experience extra-pyramidal side effects from antipsychotic medication[14].

27. He was to be reviewed daily over the weekend.

RPN John McKeown[15]

28. RPN McKeown, spent much of the evening of 7 September 2008 in the HDU. '*Anthony was highly agitated and paranoid and concerned that someone was trying to kill him'*. He had been in the HDU since his arrival from the Banksia Unit on 2 September 2008.

29. There were two seclusion rooms but neither were available to house Anthony and RPN McKeown spoke at length to the on call manager regarding the possibility of having him transferred to another hospital.

30. Three code greys had to be called as Anthony's behaviour continued to escalate. After consultation with Dr Fernando he was given a further dose of Acuphase 125mg and Benztrapine 2mg IMI at 0.45 am on 8 September.

31. He was checked at regular 15-minute intervals as per the high dependency unit's protocol. See exhibit 7(a) which details the record of 15-minute observations made of Anthony and purports to show that he was asleep and breathing through the night.[16] The two nurses in HDU that night were Tony Brady, and Gerry McMahon whose statement was also part of the Court's brief. See also the Frequent Observation Chart at exhibit 2(c)

32. According to RPN McKoewn staffing in the HDU was adequate for five patients, and the 15 minute observations involved checking breath and checking pulse, but not engaging in a conversation.[17] Mr McKoewn further testified that the level of checking was appropriate and

[14] Exhibit 3 page 1.
[15] RPN McKeown is a retired psychiatric nurse who was the shift leader in charge at Upton House on the night 7 September 2008.
[16] I note that the observation record exhibit 7(a) suggests that he was awake until 1am, and asleep thereafter.
[17] See transcript 228-29

that the suggestion put by Anthony's sister that she had heard that his door was kept closed and that he was only checked visually through a window to the door was not correct.

33. However, I note here that he later testified that,

'Otherwise, yes it would be closed but the nurses have actually if they are unsure they have to go in and look.'[18]

34. RPN McKoewn further explained that Anthony was snoring during the night and that he was restless, moving his position within the bed. He also stated that he was familiar with the condition sleep apnoea, but not aware that Anthony suffered from it.[19] Anthony was not observed to have difficulty breathing and that his snoring was regular rather than broken by occasions when he appeared not to be breathing.[20]

35. In answer to question raised in a letter to the Coroner by a Ms Collins, RPN McKoewn agreed that the medication provided to Anthony was intended to sedate him.[21] He further disagreed that other patients had tried to get nursing staff to stop sedating Anthony,

'having regard to the level of medication he was receiving.'[22] Further allegations concerning Anthony being *'floppy'* and being *'dragged back to his room by staff'*, were also firmly denied.

36. At approximately 6.30 am, RPN McKoewn heard a noise, which caused him to go into Anthony's room, where he was discovered not to be not breathing, and without a measurable pulse.

8 SEPTEMBER 2008

37. Late in the evening of 7 September 2008, Dr Fernando was called by nursing staff, to review Anthony. Following discussion with Dr Joshua and on his advice she ordered administration of 125mg zucopenthixol intramuscularly, 100 mg chorpromazine orally and 2 mg cogentic intramuscularly, and a mood stabiliser.

---

[18] Transcript page 228.
[19] Transcript page 231. I note that RPN McKoewn was aware that Anthony's early clinical records were missing and that if he had been aware of his history of apnoea that, *'Anthony probably would have been specialled.'*
It is also the case that at transcript page 239 Mr McKoewn (later) stated that he was not aware that there were missing volumes of clinical notes. And that, *'The only reading we would probably do would be in the recent admission entries by the Doctors, which in itself is quite substantial,'* Transcript page 240.
[20] Transcript page 230.
[21] See Marked for Identification provisional exhibit 5, and discussion at transcript page 185, where the documents (nil) evidentiary value is discussed.
[22] Transcript page 233-34

38. At 12.45 am, nursing staff administered the medication.

39. Anthony remained in his bed-room and was checked every 15 minutes.

40. At 1.30 am, Nurse Gerard McMahon noted he was snoring audibly.

41. At 1.30 am and 2.30 am notes on the Frequent Observation Chart, exhibit 2(c), reveal that Anthony's made, '*nil complaint*', but that his blood pressure and respiration rate were reduced from recordings made on the previous day.

42. At 6.30 am, Charge Nurse John McKewan checked Anthony. He was sleeping and breathing. At 6.40 am on 8 September 2008, Nurse Gerard McMahon found Anthony unresponsive. He was unable to be resuscitated.

CAUSE OF DEATH

Dr Michael Bourke

43. Dr Bourke, the forensic pathologist who performed the autopsy, formed the opinion that the cause of death was,

    '*combined drug toxicity in a man with asthma*'.

44. Toxicological analysis detected therapeutic levels of valproic acid, diazepam, olanzapine and risperidone. Chlorpromazine was present at the concentration of 0.3mh/L where therapeutic levels range up to 0.08mg/L following a single dose. Dr Bourke was additionally examined about the post-mortem finding of 63 nanograms per ml of zuclopenthixol, and whether that finding indicated an over prescription of the drug. His view was that the (somewhat elevated) post mortem reading could not be relied as indicating over prescription because of redistribution through the body after death, and that the antemortem test, which revealed a level of 24 nanograms per ml zuclopenthixol,-was within the range he would expect to see in a patient suffering from a severe psychosis. His further evidence was that zuclopenthixol is not a drug which is routinely monitored in a clinical setting.[23]

45. In a supplementary report dated 15 February 2013, Dr Bourke acknowledged that Anthony had no clinical history of asthma but confirmed his view that the microscopic examination of Anthony's lungs revealed pathological changes indicative of acute and chronic asthma.[24] In oral testimony Dr Bourke further also confirmed this opinion notwithstanding that the asthma condition had never been identified during life, and also offered that given his

[23] Transcript page 264-65.
[24] See exhibit 8(a)

history of sleep apnoea, this was also a factor contributing to Anthony's death. In these circumstances his opinion, which I adopt, was that Anthony had died because of,

'combined drug toxicity in a man with asthma and sleep apnoea'.[25]

46. In further testimony Dr Bourke was questioned about the mechanism of death and was asked whether Anthony might have died as a consequence of prolonged QT interval, rather than respiratory depression, *'in a man with asthma and sleep apnoea'*. His opinion was that the mechanism of respiratory depression leading to death was more likely than prolonged QT interval.[26] His further view was that there was no evidence of excessive dosage of medication when asthma and sleep apnoea, were taken out of the clinical equation.[27]

'So in this man-another person, and I am sure these drugs are given all the time, and in the normal sequence of events they settle down and do well. But in this man at that time, everything came together to cause his death.'

It was not in dispute, that the prescription of both the benzodiazepine and the zuclopenthixol, in the circumstances of a history of sleep apnoea, was excessive.

'We except that in the knowledge of Anthony having sleep apnoea, that really the drug regime ... was excessive, ... they were all therapeutic doses, but they were given in no knowledge of sleep apnoea.'[28]

Dr Peter Norrie[29]

47. In his expert opinion report dated 7 February 2013, Dr Norrie stated that the clinical management of Anthony was appropriate in the context of his agitated behaviour,

'and that there was every effort to balance the treatment against the risks'.[30]

48. In oral evidence he further stated that,

---

[25] Transcript page 253
[26] Transcript page 263.
[27] Dr Bourke deferred those with expertise in toxicology and also stated, that, *'it didn't leap out at me that the drugs were excessive'.*
[28] See statement of Counsel at Transcript page 267-68. See also the statement of Dr Maura Sportano De Silver, Consultant Psychiatrist at the Banksia Unit, (Exhibit 11, within Brief at page 6), who noted that Anthony's history included 'Obstructive Sleep Apnoea requiring CPAP'.
[29] Dr Peter Norrie is the Chief Psychiatrist in the Australian Capital Territory and provided an expert opinion in respect of the care provided in this case.
[30] See exhibit 9 at page 2-3, where Dr Norrie states that in his opinion there was a balanced and careful consideration of a (medication) plan by Dr Stephen Joshua and Dr Sherine Fernando in the early hours of 8 September 2008. *'It has to be acknowledged that the management of acute agitation is not a perfect science but a balance of risk'.*

'*without being aware of the diagnosis* (of sleep apnoea) *the increasing doses* (particularly of sedation) *are very reasonable*'.[31]

He was then further questioned about Anthony's ongoing condition of sleep apnoea and agreed that it was relevant information and that had staff been aware, it would have impacted the choice of medications, particularly the use of benzodiazepine drugs that were provided. He further explained that benzodiazepines in particular have an increased risk of respiratory depression.

'*You would not ideally want to combine a risk of respiratory depression with sleep apnoea*'.[32]

RESPONSE

Dr Jose Segal[33]

49. Dr J Segal testified that the use of Zuclopenthixol in combination with other medications primarily benzodiazipines, has been reviewed with Eastern Health having published guidelines concerning that matter. These are found in 'Objectfile', which is an Eastern Health intranet resource open to all clinical and nursing staff. The protocol set out within exhibit 10, speaks of the different environments in which Zuclopenthixol (Acuphase) should be employed and the dangers of combining its use with the use of benzodiazepines, with maximum daily recommended doses, together with other suggested alerts and precautions.

50. I also note that the protocol signed off on by Dr Segal, directs that the use of combination Acuphase and benzodiazepine medication, should only occur in accord with these maximum daily dosages, and under the direction of a Consultant Psychiatrist.

51. Dr Segal gave additional evidence about the anticipated impact of the new Mental Health Act, and the movement towards a,

'*recovery focus, ... this is a paradigm shift, it is a philosophy shift in terms of provision of care to patient's with mental illness. This philosophy puts the patients support networks; family, carers , identified others, in the forefront of the provision of care*'.

52. Dr Segal further testified as to the new *'Family and Carer Contact'*, document, which is now included on each new CBF patient file.

---

[31] Transcript page 274.
[32] See transcript page 274
[33] See footnote 1.

FINDINGS

53. Anthony Travaglini had a history of schizoaffective disorder with previous admissions to various psychiatric services including Upton House, Box Hill Hospital. His clinical file notes were contained in six files, only the last of which, was reviewed by his treating Doctors following his admission to Upton House on September 2, 2008. Significantly, this last file was also commenced without a summary or alert in respect of his earlier medical history.

54. During the period of his admission until his death on September 8, Anthony exhibited a high level of agitation, paranoia and threatening behaviour towards himself, towards other patients housed within the HDU and to psychiatric carers employed within the unit. The conditions for both staff and fellow patients within the HDU over this six-day period were consistently difficult and challenging.

55. Anthony's presentation was determined to require the prescription of both anti psychotic and sedative medication including zuclopenthixol and benzodiazepine sedation. I also find that there was a strong feeling among senior nursing staff that his threatening conduct was such that arrangements should be made for his transfer to another unit, where a seclusion unit might have been used to seek to control the threatening behaviour aspects of his presentation. The evidence does not establish that Dr Fernando and Dr Joshua responded to this concern.[34]

56. I note the levels of zuclopenthixol medication provided and the maximum levels recommended. Having regard to the opinion evidence of Dr Norrie and Dr Bourke, I find that the evidence does not establish that Anthony was given excessive doses of zuclopenthixol, or other anti-psychotic medication and that there is no evidence per se, of an excessive prescription of sedation. I further accept the evidence of Dr Norrie concerning his observations as to the high level of care taken by Dr Fernando and Dr Joshua, in the early hours of 8 September 2008, to formulate what they then believed was an appropriate plan for his ongoing care.

57. It is also clear however that the provision of these levels of sedative medication was inappropriate given Anthony's history of sleep apnoea, about which history his treating

[34] See discussion at transcript page 171-75.

clinicians remained un-informed.[35] The record of that history diagnosed by a sleep specialist in August 2003, was available, but a systems failure concerning the collection and presentation of that record meant that clinicians at Upton House did not have access to it, during and following what was to be Anthony's final admission some five years later.

58. Additionally I note that the one volume of clinical history made available to Upton House clinicians had no document alert, which might have otherwise informed clinicians of the history set out in earlier volumes, and of the potential threat created by that history.[36] It is also relevant that at that time there was no system in place for the electronic recording of such information.[37]

59. In this regard, I also observe that the (unexplained) absence of an alert sheet in the last volume might reasonably have encouraged both clinical staff to proceed with greater rigour than actually occurred in this instance. I find then that initially there was an acceptance that missing clinical files would not become available and following this, a failure to seek to locate and review all relevant files.

60. Later in the absence of the full clinical history and alert sheet, I find that although Anthony's sister, Lucy Mizzi had made herself available to staff, that the various personnel concerned, failed to seek an additional medical history from her, or from other family member's.[38]

61. I further find that had either of these initiatives been adopted, that such an approach would have permitted a better and more informed treatment and care and given Anthony and his family, a significantly improved chance of a favourable outcome.[39]

.....

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

The family of Anthony Travaglini

The Chief Medical Officer Eastern Health

---

[35] See a concession to this effect in the evidence of Dr Antony at transcript page 89, Dr Fernando at transcript page 180 and Dr Joshua at transcript page 213. See also f/n 15 above, which confirms that his history of sleep apnoea had been recorded in earlier clinical notes.

[36] See exhibit 8(b) and footnote 2 above. See also discussion at transcript page 215 concerning the absence of the alert sheet from the one latest clinical file available to clinicians and nursing staff at Upton House

[37] See discussion of earlier Eastern Health record systems by Dr Segal at transcript page 305.
Such material would now be expected to be included in the electronic patient filing system, which requires the maintenance of an alert sheet, with relevant reports also scanned into the system, (known as a CBF).

[38] Lucy Mizzi testified as to her background, which included working for 15 years as a nurse at the Austin Hospital and to her concern for her brother and of her availability to clinicians and others concerning his welfare. See also her evidence at transcript page 46 concerning Anthony's history of sleep apnoea and Dr Segal's response set out at 52 above.

[39] See concluding remarks of Counsel for Eastern Health on these issues at transcript page 314.

The Senior Consultant Upton House, Box Hill Hospital

The Chief Psychiatrist in the State Of Victoria

Dr J Segal

Dr S Joshua

Dr M Fernando

RPN J McKeown, retired.

Signature:

PETER WHITE
CORONER
Date: 3/7/15