IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2012 004996

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
*Section 67 of the **Coroners Act 2008***

I, PARESA ANTONIADIS SPANOS, Coroner,

having investigated the death of HUNTER JOSEPH STEWART
without holding an inquest:
find that the identity of the deceased was HUNTER JOSEPH STEWART
born on 17 April 1985
and that the death occurred on or about 24 November 2012
at Room 46, 9 Roden Street, West Melbourne, Victoria
from:

I (a) COMBINED DRUG TOXICITY (HEROIN, METHADONE, DIAZEPAM AND AMPHETAMINES)

Pursuant to section 67(1) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances**:

1. Mr Stewart was the 27-year old youngest son of Jane and Leigh Stewart and the brother of Joshua. He was raised in Camberwell in a close and supportive family and was educated nearby. Mr Stewart is remembered by his family as a warm and compassionate young man with a strong sense of justice.[1]

2. Mr Stewart had a history of major depressive disorder and alcohol dependence. He self-reported regular cannabis and alcohol use commencing in adolescence and heavy alcohol consumption after 16 years of age.[2] He had a long history of help-seeking behaviours, both with and without the assistance of his parents, and had attempted or attended numerous alcohol detoxification and rehabilitation programs with some short-term success, commencing in 2004 and with increasing in frequency in the last 18 months of his life.[3]

3. Mr Stewart's alcohol dependence had a detrimental impact on many aspects of his life. At times when intoxicated he would behave aggressively towards his parents, making demands for money and damaging property. Although they remained supportive of their son and continued to encourage him

[1] Coronial Brief of Evidence, Correspondence received from Mr and Mrs Stewart, undated.
[2] Coronial Brief of Evidence, Statement of Dr P. Chopra.
[3] Ibid and Coronial Brief of Evidence, Correspondence received from Mr and Mrs Stewart, 6 February -10 April 2013.

to address his alcoholism, Mr and Mrs Stewart sought and were granted Intervention Orders in November 2010, and again in June 2012 for 12 months, in terms prohibiting their son from engaging the above-mentioned behaviours and attending the family home having consumed alcohol.[4] Mr Stewart allegedly breached the 2012 Order a fortnight after it was granted.[5]

4. On 17 October 2012, Mr Stewart was arrested in Camberwell for public drunkenness and lodged in the police cells at Moorabbin as none were available in the local area. Sgt Cooper, concerned that Mr Stewart would resume drinking alcohol upon release from custody (as he said he intended to) made enquiries on his behalf for suitable accommodation but was unsuccessful. After six hours in custody (and still highly intoxicated), Mr Stewart started banging his hand on the cell door and threatened to bang his head against it until he was released. Sgt Cooper was concerned that Mr Stewart would carry out his threat to harm himself and so arranged for Mr Stewart to be escorted to St Vincent's Hospital [St Vincent's] for a psychiatric assessment.[6]

Psychiatric Admission

5. In the early morning of 18 October 2012, Mr Stewart was assessed by the Crisis Assessment and Treatment Team based in the St Vincent's Hospital emergency department, as presenting with persistent lowered mood and suicidal ideation. He was reviewed by the Addiction Medicine Unit [AMU] and commenced on naltrexone, vigabatrin, thiamine and diazepam for treatment of alcohol withdrawal before being admitted to St Vincent's Acute Inpatient Service [AIS] as a voluntary psychiatric patient.[7]

6. Whilst a patient of AIS between 18 October and 14 November 2012, Mr Stewart was under the care of consultant psychiatrist, Dr Prem Chopra. Dr Chopra led the psychiatric treatment team consisting of two psychiatric registrars and a medical officer and co-ordinated Mr Stewart's care with allied specialists, Dr Lloyd-Jones of the AMU, and clinical psychologist, Joyce Lee, in addition to making referrals for pastoral care and social work support.[8]

7. Mr Stewart was reviewed frequently by Dr Chopra at AIS. During Dr Chopra's first assessment, Mr Stewart described a history of pharmacological and cognitive behavioural therapy treatment for depression since adolescence. He reported current isolation from friends, difficulty maintaining employment, insomnia and feelings of emotional confusion, lowered mood and suicidality. Mr Stewart reported lengthy, increasing alcohol dependence and that drinking temporarily made him feel happy and prevented from acting in response to suicidal ideation.[9]

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[4] Coronial Brief of Evidence, Correspondence received from Mr and Mrs Stewart, undated.
[5] Coronial Brief of Evidence, Statements of A/Snr/Sgt. D. Cooper and Dr P. Chopra.
[6] Coronial Brief of Evidence, Statement of A/Snr/Sgt D. Cooper.
[7] Coronial Brief of Evidence, Statement of Dr P. Chopra.
[8] Coronial Brief of Evidence, Statement of Dr P. Chopra.
[9] Coronial Brief of Evidence, Statement of Dr P. Chopra.

8. Over the course of the admission, Mr Stewart's mood improved but he remained impulsive. He was involved in a physical altercation with a co-patient and absconded from AIS several times in order to access and consume alcohol, including methylated spirits.

9. Initial incidents on 25 and 26 October 2012 were managed in the least restrictive manner possible, in accordance with the prevailing mental health service delivery paradigm, by Mr Stewart signing a behavioural contract. The contract restricted his leave from the ward and provided for review of his (voluntary) status under the *Mental Health Act* 1986 [MH Act]. Following an incident in which he consumed a large amount of alcohol-based hand sanitiser secreted in his room, Mr Stewart was recommended as an involuntary patient and transferred to the locked Extra Care Unit [ECU] between 28 and 29 October 2012.[10]

10. On 29 October 2012, Mr Stewart's parents and brother attended AIS and participated in a family meeting. They provided a collateral account of Mr Stewart's anxiety, depression and increasing alcohol consumption and the Intervention Order prompted by aggressive outbursts. Dr Chopra supported Mr and Mrs Stewart's decision not to permit their son to return home, noting the importance of Mr Stewart accepting responsibility for his actions and addressing his alcoholism.[11]

11. As Mr Stewart would require alternative accommodation upon his discharge from AIS, a social worker sought a placement at Salvation Army Flagstaff Crisis Accommodation [Flagstaff]. He was also placed on the waiting list for admission to a residential detoxification program at Windana Drug and Alcohol Recovery Centre [Windana].[12]

12. On 31 October 2012, Mr Stewart presented as depressed and frustrated, expressing themes of hopelessness, helplessness and self-loathing but no suicidal intent. Dr Chopra observed that Mr Stewart's symptoms were consistent with Major Depressive Disorder and comorbid Alcohol Dependence and although he did not meet the diagnostic criteria for Bipolar Disorder, he demonstrated Cluster B personality traits with significant instability of mood and behaviour, and so was commenced on quetiapine ("Seroquel", a mood stabiliser).[13]

13. Mr Stewart remained engaged in treatment with good insight into his illness. He expressed some motivation to continue to address his depression and pattern of alcohol dependence, observing that both seemed linked to internalised frustration and intense self-criticism.[14]

14. On 6 November 2012, Mr Stewart disclosed childhood sexual abuse to psychologist, Ms Lee. He confirmed the allegation when reviewed the following day by Dr Chopra, indicating that he did not want his family to be informed. He reported having previously discussed his experience of sexual abuse with a treating doctor. Although Mr Stewart acknowledged a connection between past events and his current feelings of instability of his sense of self, he denied any current intrusive thoughts

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[10] Ibid.
[11] Ibid.
[12] Mr Stewart's AIS medical records.
[13] Coronial Brief of Evidence, Statement of Dr P. Chopra.
[14] Ibid.

relating to the alleged abuse and stated that he wished to focus on his future as that chapter in his life was closed. He was encouraged to continue to talk to treating clinicians about his experiences if he felt comfortable doing so.[15]

15. Mr Stewart consumed alcohol while on leave from AIS on 8 November 2012, and upon his return, was nursed overnight as an involuntary patient in ECU. On review by Dr Chopra the following morning, Mr Stewart stated that his alcohol use had been triggered by his disclosure of sexual abuse but expressed positive goals and continued to deny suicidal ideation.[16]

16. On 10 November 2012, Mr Stewart absconded from AIS and was returned by police in an intoxicated state. He remained in ECU as an involuntary patient until 12 November 2012 when he presented as more settled and was returned to the open ward. On review, Mr Stewart expressed some anxiety about an upcoming court appearance in relation to an alleged breach of Intervention Order but remained future focused and without suicidal ideation, expressing an intention to seek drug and alcohol rehabilitation.[17]

17. Discharge planning occurred throughout Mr Stewart's AIS admission. His accommodation at Flagstaff would be supported by an allocated caseworker and access to carers, outreach services, a co-located nurse and a daily meals service.[18] Mr Stewart was referred to Inner West Continuing Care Team [IWCCT][19] for psychiatric follow-up and encouraged to seek follow up with a general practitioner.[20] He was also due to enter residential rehabilitation at Windana on 27 November 2012.

18. On 14 November 2012 accommodation became available at Flagstaff. Mr Stewart was reviewed twice by Dr Chopra prior to discharge from AIS. During the first review, just before midday, Mr Stewart was positive about seeking drug and alcohol rehabilitation notwithstanding some anxiety about discharge and his capacity to abstain from consuming alcohol.[21]

19. A second review was prompted when Dr Chopra received a telephone call from Mrs Stewart who reported that her son had called her threatening suicide if his demand for financial support was not met. When reviewed again at 2.30pm, Mr Stewart acknowledged his mother's account of the telephone call, stating that he had threatened to harm himself in an attempt to have his needs met. He denied suicidal thoughts or plans and continued to be future focussed.[22]

20. Mr Stewart was discharged that afternoon with a two-week supply of prescribed medications venlafaxine (an antidepressant), quetiapine, naltrexone, baclofen and thiamine, and 20 diazepam tablets.[23]

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[15] Ibid.
[16] Ibid.
[17] Ibid.
[18] Coronial Brief of Evidence, Statement of K. Hecker.
[19] Part of NorthWestern Mental Health's [NWMH] Inner West Area Mental Health Service [IWMHS].
[20] St Vincent's/AIS Discharge Summary.
[21] Coronial Brief of Evidence, Statement of Dr P. Chopra.
[22] Ibid.
[23] St Vincent's/AIS Discharge Summary.

Accommodation at Flagstaff and Events Proximate to Death

21. Mr Stewart failed to attend an intake meeting with Flagstaff staff on the morning of 15 November 2012. When staff attended to check his wellbeing twice during the day he was not present and so arranged for evening staff to make a further attempt to see him. Around 8pm, staff recorded locating Mr Stewart and conducting a risk assessment; he was slightly intoxicated but otherwise well.[24]

22. Mr Stewart's non-attendance at the intake meeting delayed development of a formal case plan and much of the support provided to him at Flagstaff focussed on his immediate presenting needs. Mr Stewart was offered referrals for psychological counselling and drug health services that he declined, but accepted assistance to engage with Centrelink.[25]

23. On 20 November 2012, Mr Stewart consulted Dr Joseph Chow at Melbourne Central Medical & Dental, reporting recent use of heroin, ice and marijuana (after years of abstinence) following the accidental deaths of his partner and son a month earlier and requesting methadone (opioid replacement therapy). Mr Stewart reported that he was being prescribed Efexor (venlafaxine) for depression.[26]

24. Dr Chow offered to refer Mr Stewart for psychological counselling but the offer was declined. The general practitioner obtained a permit to treat Mr Stewart with methadone, prescribing a starting dose of 40mg per day, increasing by 10mg daily to a maintenance dose of 60mg. Mr Stewart was advised to return for review after one week, or sooner if he experienced any problems.[27] His first methadone dose was administered at Priceline Pharmacy in Melbourne Central at 10.30am.[28]

25. Flagstaff staff observed that Mr Stewart appeared in a lower mood and were told that he had commenced methadone for the first time that day. A request for a welfare check formed part of the handover to the afternoon shift. Staff noted that at about 9.15pm Mr Stewart was eating a late meal and was engaging with other residents and caseworkers and appeared well.[29]

26. Methadone was administered to Mr Stewart on 21, 22 and 23 November 2012.[30]

27. Whilst a resident at Flagstaff, Mr Stewart socialised with Richard Whelan with whom he had been at school. Mr Whelan recalled that Mr Stewart had reported recent use of heroin but had never seen him take the drug. He witnessed Mr Stewart drinking alcohol, smoking 'ice' and being injected with amphetamines by others with his consent. Mr Whelan reportedly last spoke to Mr Stewart on the afternoon of 23 November 2012 when Mr Stewart complained of feeling tired, having not slept for most of the previous week.[31]

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[24] Coronial Brief of Evidence, Statement of K. Hecker.
[25] Ibid.
[26] Coronial Brief of Evidence, Statement of Dr J. Chow.
[27] Ibid.
[28] Mr Stewart's Priceline Pharmacy – Melbourne Central records of methadone dispensed.
[29] Coronial Brief of Evidence, Statement of K. Hecker.
[30] Mr Stewart's Priceline Pharmacy – Melbourne Central records of methadone dispensed.
[31] Coronial Brief of Evidence, Statement of R. Whelan.

28. At about 7pm on 23 November 2012, an afterhours support worker at Flagstaff observed Mr Stewart walk into the building through the reception area.[32]

29. At about 2pm on 24 November 2012, a cleaner knocked on Mr Stewart's door and receiving no response, used his swipe card to enter the room. He observed Mr Stewart lying face-down on the floor beside his bed, fully clothed, and apparently deceased. The emergency services were called and attending paramedics confirmed that Mr Stewart was deceased.[33]

Investigations

30. Victoria Police attended the scene and observed that there were no signs of a disturbance in Mr Stewart's room. During a search of the premises, police found a quantity of cash, medications prescribed to Mr Stewart, two small bags believed to contain cannabis and 10 empty alcohol bottles.[34] The coronial brief on which this finding is based was later prepared by Detective Senior Constable Toby Dernelley of Melbourne Criminal Investigation Unit.

31. Senior Forensic Pathologist, Dr Noel Woodford of the Victorian Institute of Forensic Medicine [VIFM], reviewed the circumstances of the death as reported by police to the coroner, post-mortem computer assisted tomography scanning of the whole body [PMCT] and performed an external examination of Mr Stewart's body. Among Dr Woodford's anatomical findings were no evidence of recent injury or natural disease of a type likely to have caused or contributed to death, aspiration of gastric contents, small pleural effusions and punctate haemorrhage in distribution of coronary arteries.[35]

32. Routine post-mortem toxicological analysis detected morphine, 6-monoacetylmorphine (a heroin specific metabolite) and codeine, all consistent with the recent use of heroin, amphetamines, methadone, diazepam, venlafaxine (and their metabolites), temazepam, oxazepam, and paracetamol.[36]

33. Dr Woodford noted that toxicology indicated recent use of heroin, methadone, diazepam and amphetamines and that opiates (heroin and methadone) may combine with benzodiazepines (like diazepam) to induce profound central nervous system and respiratory centre depression. Subsequent hypoxaemia (low blood oxygen saturations) may predispose to the development of cardiac rhythm disturbance, particularly with concomitant use of stimulants like amphetamines.[37]

34. Dr Woodford attributed the cause of Mr Stewart's death to combined drug toxicity (heroin, methadone, diazepam and amphetamines).[38]

35. During the investigation into Mr Stewart's death, the Court received detailed correspondence from Mr Stewart's parents in which they raised many concerns about their son's clinical management, including

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[32] Coronial Brief of Evidence, Statement of C. Hudson.
[33] Coronial Brief of Evidence, Statement of R. Isaac.
[34] Coronial Brief of Evidence, Statement of S/C J. Keily.
[35] Coronial brief of Evidence, Medical Examination Report of Dr N. Woodford.
[36] Ibid.
[37] Ibid.
[38] Ibid.

his management by AIS and following discharge. I have not made an appraisal of the merit of all of the matters raised by Mr and Mrs Stewart as I do not consider that all fall within the reasonable scope of the coronial investigation of their son's death.

36. My investigation was limited to those matters that did appear to be sufficiently proximate and causally relevant to Mr Stewart's death, and which are broadly encompassed within the following areas: clinical management at AIS (including medications, communications with family, discharge planning, discharge and transfer of care), accommodation options and methadone prescription.[39]

37. At my request, the Coroners Prevention Unit [CPU][40] examined all available materials[41] and provided advice about the adequacy of the care and management Mr Stewart received. The CPU advised:

    a. Mr Stewart's treatment for both mental health and substance addiction was voluntary. The MH Act limits the circumstances in which an individual may be compelled to participate in psychiatric treatment to those individuals who meet specific criteria for involuntary treatment. There is no evidence that Mr Stewart met those criteria, except for brief periods when he was transferred to ECU. Moreover, alcohol dependence is not a psychiatric disorder treated within the mental health paradigm, but an addiction treated by addiction-specific services.

    b. The medications prescribed to Mr Stewart were within clinical practice guidelines and he was provided information about their use, including the safe use of anti-craving medications naltrexone and baclofen during a family meeting on 29 October 2012, at a review by NEXUS[42] and at discharge. Mr Stewart was not naive to drug and alcohol withdrawal services, the majority of which include harm minimisation education as part of the program.

    c. Mr Stewart reported childhood sexual abuse to AIS clinicians, having made previous disclosures of the alleged abuse to other clinicians and deciding not to make a report to police. He maintained this position whilst an AIS inpatient, during reviews with a psychologist and consultant psychiatrist, and specifically asked that the disclosure not be revealed to his family. The AIS staff response to Mr Stewart's disclosure of childhood sexual assault was appropriate.

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[39] These areas of concern are those identified by me, the CPU and causal/proximate issues identified by Mr Stewart's parents. Other areas of concern to Mr and Mrs Stewart, in particular their concerns about the perceived detrimental impact of medical confidentiality on their son's management, have been addressed in correspondence.

[40] The 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. It is staffed by expert investigators, practising physicians and nurses who are independent of the health professionals or institutions involved. They assist the Coroner's investigation of deaths occurring in a healthcare setting by evaluating the clinical management and care provided and identifying areas of improvement so that similar deaths may be avoided in the future.

[41] Including the coronial brief of evidence, Mr Stewart's medical, Medicare and Pharmaceutical Benefits Scheme records, and additional statements and materials provided to the investigation at the request of the CPU.

[42] A concurrent mental illness and substance abuse advisory service.

d. Although an Intervention Order was in place between Mr Stewart and his parents, they were invited to participate in family meetings and telephone AIS to speak to staff. The medical record indicates that Mr Stewart's parents were involved in decision-making to the extent their son allowed and that family education provided by AIS staff was appropriate in the context of their role in Mr Stewart's care after his discharge.

e. Mental state examinations, risk assessments, multiple medical and allied health reviews and clinical psychologist counselling all document no evidence that Mr Stewart was psychotic or suicidal in the last week of his admission to St Vincent's. The decision to discharge Mr Stewart from AIS on 14 November 2012 was therefore clinically appropriate.[43]

f. The choice of Flagstaff as a discharge destination was also appropriate. Mr Stewart was homeless and so the only available accommodation was at one of the few Victorian crisis accommodation facilities.[44] Residents stay at Flagstaff voluntarily and are required, as Mr Stewart was, to sign the rules of the facility, including not engaging in illegal activities and not bringing alcohol, illicit substances or non-prescribed medications onto the premises. While it is not clear to what degree these aspects of the contract are monitored or enforced, residents may still have access to alcohol or illicit substances off the premises.

g. While Flagstaff is not a clinical or medical service, its staff provide support and appropriate referrals, particularly to the in-reach support services and housing providers. Flagstaff staff met with Mr Stewart on admission and on seven other occasions, when he refused counselling and drug health appointments. The level of engagement from Flagstaff staff was appropriate.

h. The AIS discharge plan included a referral to IWCCT for case management support with relapse prevention and facilitation of Mr Stewart's move from Flagstaff to Windana. The referral was transmitted by fax on 14 November 2012 and followed up by a telephone call between Dr Ang of AIS and Ms Tang of IWCCT. On 16 November 2012, IWCCT records document that the referral was declined on the basis that Mr Stewart's primary presenting issue was alcohol use and support could be provided by Flagstaff staff, and a telephone message left at Flagstaff to that effect. Although IWCCT claims that AIS would have been informed that the referral had been declined, there is no record at either IWCCT or AIS of

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[43] Notwithstanding that acute psychiatric units do not have the capacity to hold patients who are homeless or at risk of using substances, AIS did not discharge Mr Stewart until accommodation became available at Flagstaff.

[44] Accommodation options for homeless individuals with mental illness were very limited in 2012. Statistically, males over 25 years of age are the largest group seeking access to crisis and short-term accommodation and support. Moreover, a high proportion (about 50%) of homeless individuals are alcohol dependent or dependent on another substance and that over half of those with a substance use disorder suffer at least one comorbid psychiatric disorder. There is emerging evidence that the key to breaking the cycle of homelessness, additions, non-compliance with mental health treatment (and offending) is access to suitable, affordable, safe and independent homes from where a person with complex needs can made choices and engage with supports. Since Mr Stewart's death in 2012, government programs (funded by Department of Health and Department of Human Services) have been developed to provide tenancy and psychosocial support for the chronically homeless, mentally ill and mentally ill individuals with co-occurring problematic substance use and/or physical or intellectual disability.

this occurring. At the time, intake decisions at IWCCT were not subject to clinical oversight and AIS discharge transfer policy did not require staff to ensure that a referral of care had been accepted.

i. Both AIS and IWCCT were obliged to provide appropriate follow up to Mr Stewart post-discharge and a gap in processes for developing and implementing discharge plans and effectively transferring care between services was identified.

j. Peter Kelly, Director of Operations at NWMH, advised that IWAMHS underwent a restructure in 2013 such that the intake service for the newly merged community clinical team was allocated a duty psychiatrist each business day with whom intake staff could consult as required. In addition, all intake interactions were recorded electronically and periodically reviewed by a consultant psychiatrist, applying particular scrutiny to referrals not accepted into the service.

k. Clinical Director of St Vincent's Mental Health Service, Dr Peter Bosanac, reported that in 2013 an Acute Care Transition Coordinator was established to proactively follow-up with discharged patients to ensure that they have had contact with any service to which they were referred. If no contact has occurred, the Coordinator will make enquiries on the patient's behalf (with his/her consent) or contact the referral service if the patient cannot be contacted. Moreover, St Vincent's Discharge Transfer Policy has been revised to require documentation of acceptance of transfers of care to other services and escalation of refused transfers of care to the Director of Clinical Services with a view to a discussion occurring with the referral service.

l. AIS medical records suggest that naltrexone and baclofen were not effective in reducing Mr Stewart's cravings. In addition, reconciliation of the medications prescribed and dispensed to Mr Stewart in the six months prior to his death and post-mortem toxicological analysis suggest that he had not been taking naltrexone, baclofen or quetiapine as directed in the days following his discharge from AIS, though venlafaxine was detected post-mortem at a therapeutic blood level.

m. Mr Stewart appears to have made an appointment with Dr Chow and requested methadone for illicit substance use, stating that he had not used substances in many years until recently. Mr Stewart did not inform Dr Chow that he was prescribed benzodiazepines, naltrexone, baclofen or quetiapine. This information would have been relevant to Dr Chow's decision-making. Dr Chow's notes record that Mr Stewart reported seeing a psychiatrist and a case worker, but did not disclose his admission to AIS. All prescribing permits, urine drug screen, blood serology and Dr Chow's prescribed titrated dosing levels were according to relevant legislation and clinical guidelines.

38. CPU concluded that the clinical management and care provided to Mr Stewart at AIS was appropriate, notwithstanding the ineffective referral to IWCCT for voluntary psychiatric case management in the community. While the involvement of IWCCT in Mr Stewart's post-discharge management would have provided an opportunity to monitor compliance with medications and identify his commencement of illicit substance use and methadone, potentially resulting in earlier intervention, it may not have changed the outcome in this case, given Mr Stewart's refusal of in-reach services offered at Flagstaff. There is no indication that Mr Stewart's depression had worsened, or that his risk of self-harm had increased, following his discharge from AIS.

Conclusions

39. I find that Mr Stewart, late of Roden Street, West Melbourne, died there on or about 24 November 2012 as a result of combined drug toxicity involving heroin, methadone, diazepam and amphetamines. The available evidence does not support a finding that Mr Stewart intentionally took his own life but rather that he died in circumstances of an accidental or inadvertent overdose.

40. 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.[45] The effect of the authorities is that Coroners should not make adverse findings against or adverse comments about individuals or institutions, unless the evidence provides a comfortable level of satisfaction that they materially departed from the standards of their profession and in so doing, caused or contributed to the death. Applying that standard to the available evidence does not support a finding that there was any want of clinical management or care on the part of the staff of AIS, Flagstaff, IWCCT or Dr Chow that caused or contributed to Mr Stewart's death.

COMMENTS

Pursuant to section 67(3) of the Coroners Act 2008, I make the following comment/s connected with the death:

41. In the course of the coronial investigation of their son's death, Mr Hunter's parents raised fundamental questions about the prevailing paradigm for the delivery of mental health services, and drug and alcohol services, in Victoria, and the interface between the two. The Hunter family is not alone in having such concerns. They are echoed from time to time by others who find themselves involved in the coronial jurisdiction due to the death of a loved one in reportable circumstances.

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[45] *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..."

42. For instance, Mr Hunter's parents felt that information that they would have wanted to know so as to assist their son was kept from them on the basis of Mr Hunter's right to information privacy and/or medical confidentiality. They were concerned that Mr Hunter could commence on methadone by way of opiate replacement therapy without the prescribing doctor being aware of all his other medications, a matter that has concerned a number of coroners and is reflected in coronial recommendations about the need for real-time prescription monitoring. They felt that had better information been provided to them about some of the treatment options proposed or available for their son, they may have persevered with providing him with accommodation so as to monitor his compliance and support him in his efforts to detoxify and rehabilitate himself.

43. To some extent these concerns were informed by hindsight. My investigation focused on those matters I considered fell within the reasonable scope of a coronial investigation, and the advice I received was that Mr Hunter's clinical management and care was reasonable and appropriate, by reference to current standards. That is not to say that the family's concerns are without merit, or that there is not a better way for services to be delivered. In my view, however, these are matters more appropriately addressed to a broader review of the delivery of mental health and drug and alcohol services than is feasible or appropriate in a coronial investigation of an individual death.

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

Mr and Mrs Stewart

St Vincent's Health

NorthWestern Mental Health

Salvation Army Flagstaff Crisis Accommodation

Chief Psychiatrist

DSC Toby Dernelley (#34817) c/o O.I.C. Melbourne Crime Investigation Unit

Signature:

PARESA ANTONIADIS SPANOS
CORONER
Date: **12 February 2016**

Coroners Court of Victoria