IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2015 710

FINDING INTO DEATH WITH INQUEST

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

Findings of:	**JUDGE SARA HINCHEY, STATE CORONER**
Deceased:	**LUIS LOPEZ**, born 3 October 1962
Delivered on:	13 September 2017
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing date:	13 September 2017
Counsel assisting the Coroner:	Leading Senior Constable Sonia Reed

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HER HONOUR:

BACKGROUND

1. Mr Luis Lopez was a 51-year-old man who lived at Flemington at the time of his death.

2. Mr Lopez was born in Nicaragua as one of eight children to his family. Mr Lopez was raised in extreme poverty, where his father was an abusive alcoholic and his mother worked selling flowers and vegetables in markets to financially support their family.[1]

3. Mr Lopez fought as a young solider for the Sandinista army during the Nicaraguan Revolution. After a number of years of fighting, Mr Lopez showed promise as a solider and was sent to Russia to train as a helicopter fighter pilot for three to four years. Upon his return to Nicaragua he fought as a fighter pilot until the end of the revolution. At that time, the living and political situation in the country was unstable, and Mr Lopez decided to leave Nicaragua.[2]

4. In May 1991 Mr Lopez moved to Australia after marrying Ms Sally Verger, an Australian citizen he had met in Nicaragua.[3] Mr Lopez and Ms Verger's relationship ended, and Mr Lopez entered into a relationship with Ms Carmel Davies from early 1993.

5. Mr Lopez experienced ongoing trauma from his time fighting in Nicaragua, and he began to abuse alcohol. Ms Davies indicated Mr Lopez's drinking became a problem approximately one year into their relationship, and two to three years into their relationship other troubling behaviour began to manifest itself, including paranoia, jealousy and verbal aggression.[4]

6. Mr Lopez's behaviour worsened to the point where Ms Davies sought an intervention order against Mr Lopez. She advised him she did not want to see him unless he stopped drinking. Mr Lopez made promises to seek help but would regularly relapse and drink alcohol again. Mr Lopez contravened the Intervention Order on several occasions and Ms Davies reported this to Victoria Police. Over time Mr Lopez stopped making contact with Ms Davies.[5]

7. In 2004 Mr Lopez made two attempts to end his own life. Following these attempts, Mr Lopez attended Ms Davies' home where he smashed a number of windows at her property. Ms Davies was so concerned by Mr Lopez's mental condition that she raised money to send

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[1] Coronial brief, statement of Carmel Davies, 19.
[2] Ibid.
[3] Coronial brief, statement of Nestor Carrillo, 14.
[4] Above n 1, 19-20.
[5] Above n 1, 20.

Mr Lopez back to Nicaragua to visit his brother and daughter. Ms Davies told Mr Lopez's family not to let Mr Lopez return to Australia, as she feared he may die if he returned. Mr Lopez remained in Nicaragua for 9 months before returning to Australia.[6]

8. In October 2004, Mr Lopez was admitted to the John Cade Unit of the Royal Melbourne Hospital (**RMH**) suffering a paranoid psychotic episode. Mr Lopez was formally diagnosed with schizophrenia. Between 2008 and 2014 Mr Lopez was admitted to the John Cade Unit on 8 separate occasions. Mr Lopez was also admitted to Roselle Hospital, Sydney in 2005 due to a psychotic relapse.[7]

9. Following his initial admissions to the RMH, Mr Lopez was referred to the Continuing Care Team, however his engagement was poor and he avoided treatment. Following an admission in March 2006, Mr Lopez was followed up by the Homeless Outreach Psychiatric team until 2009 as a voluntary patient in the context of reasonable engagement and compliance with treatment. In 2009 he was referred back to the Continuing Care team. In June 2013 Mr Lopez was discharged into the care of his general practitioner due to non-attendance at clinic reviews, and since he was considered to be stable and compliant with oral antipsychotic medication.[8]

10. In August 2013 Mr Lopez was readmitted to the RMH in the context of three months' non-compliance with oral medication. Mr Lopez was managed as an involuntary patient until the time of his death. Mr Lopez was treated with depot antipsychotic medication paliperidone 100mg, on a monthly basis.

11. In December 2014, Mr Lopez's friend Mr Nestor Carrillo moved in to Mr Lopez's flat in Flemington. Mr Carrillo stated the following regarding Mr Lopez's mental and physical state in the months prior to his death:

> *"I lived with him for 2 months before he died. I would like to say that it was time we shared together, but I can't say that. How can you 'share' time with someone who has lost their mind. I kept trying to help him, but he was lost. He was sad a lot of the time. There were a lot of issues there. I think his alcoholism was like a pain killer for him, like an anaesthetic. When he was drunk he could sleep. It made the*

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[6] Above n 1, 20-21.
[7] Coronial brief, statement of Dr Susira Galpayagedon, 24-25.
[8] Above n 7, 25.

pain go. He was far away from when we first met. He was not the same physically or mentally."[9]

12. Mr Lopez was reviewed by Dr Galpayagedon on 7 January 2015 at the Waratah Clinic. His mental state was reported to be stable at this time, and he was not displaying any acute psychotic or depressive symptoms.[10]

13. On 9 February 2015 Mr Lopez failed to attend a scheduled consultant review. Subsequently, Mental Health Clinicians Mr Guy Campbell and Ms Adele Bain conducted a home visit to Mr Lopez on the same day intending to assess Mr Lopez' mental state. Mr Campbell and Ms Bain spoke with Mr Lopez via the flat's intercom, and Mr Lopez stated he could not leave the apartment for fear of 'punishment' and that he felt safe in his flat. The clinician had concerns that Mr Lopez was experiencing increased paranoia. However, Mr Campbell and Ms Bain also took into account the fact that Mr Lopez was only slightly overdue for his depot medication, and that his previous relapse pattern included a fear of remaining inside his apartment rather than a fear of leaving it.

14. Mr Lopez agreed to have the depot injection administered at his home the following day, 10 February 2015. Mr Campbell and Ms Bain returned to the clinic and discussed their interaction with Mr Lopez with treating psychiatrist Dr Galpayagedon. It was confirmed among the clinicians that a home visit to provide the depot medication and to assess Mr Lopez's mental state should proceed the following day.

THE PURPOSE OF A CORONIAL INVESTIGATION

15. Mr Lopez's death constituted a '*reportable death*' under the *Coroners Act 2008* (Vic) (**the Act**), as the death occurred in Victoria and was unexpected and not from natural causes.[11]

16. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[12] The purpose of a coronial investigation is independently to investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.

[9] Above n 3, 16.
[10] Above n 7, 26.
[11] Section 4 *Coroners Act 2008*.
[12] Section 89(4) *Coroners Act 2008*.

17. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[13] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation, or to determine disciplinary matters.

18. The expression "*cause of death*" refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

19. For coronial purposes, the phrase "*circumstances in which death occurred*," refers to the context or background and surrounding circumstances of the death. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the death, it is confined to those circumstances which are sufficiently proximate and causally relevant to the death.

20. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners. This is generally referred to as the Court's "*prevention*" role.

21. Coroners are also empowered:

    (a) to report to the Attorney-General on a death;

    (b) to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and

    (c) to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice. These powers are the vehicles by which the prevention role may be advanced.

22. All coronial findings must be made based on proof of relevant facts on the balance of probabilities. In determining these matters, I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[14] The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about individuals, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

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[13] *Keown v Khan* (1999) 1 VR 69.

[14] (1938) 60 CLR 336.

23. In conducting this investigation, I have made a thorough forensic examination of the evidence including reading and considering the witness statements and other documents in the coronial brief.

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Identity of the Deceased, pursuant to section 67(1)(a) of the Act

24. On 12 February 2015, a fingerprint taken from the right thumb identified the deceased to be Luis Lopez, born 3 October 1962.

25. Identity is not in dispute in this matter and requires no further investigation.

Medical cause of death, pursuant to section 67(1)(b) of the Act

26. On 11 February 2015, Dr Matthew Lynch, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an inspection of Mr Lopez's body. Dr Lynch provided a written report, dated 13 February 2015 which concluded that Mr Lopez died as a result of hanging.

27. Toxicological analysis of post mortem specimens taken from Mr Lopez identified the presence of caffeine (~15mg/L), olanzapine (~0.01mg/L) and hydroxyrisperidone (~70ng/mL). Senior Toxicologist Voula Staikos reported that the level of caffeine seen in Mr Lopez's toxicology results was higher than generally expected following normal use of beverages containing caffeine, as such concentrations range up to approximately 4mg/L. It is not suggested that the concentration of caffeine in Mr Lopez' system contributed to his death.

28. I accept the cause of death proposed by Dr Lynch.

Circumstances in which the death occurred, pursuant to section 67(1)(c) of the Act

29. On 10 February 2015, Inner West Area Mental Health Service Registered Psychiatric Nurses Mr Brendan Bolger and Mr David Jones attended Mr Lopez's flat in Flemington and administered his depot paliperidone injection. Registered Psychiatric Nurse Mr Brendan Bolger stated that Mr Lopez presented as calm, and was cooperative with administration of the depot injection. When asked, Mr Lopez reported feeling well and with no worries. Mr

Bolger and Mr Jones advised Mr Lopez that the service would contact him to make a further appointment for his next treatment.[15]

30. Mr Jones observed Mr Lopez to be quite relaxed during his and Mr Bolger's attendance at the flat, and confirmed that Mr Lopez denied any issues when Mr Bolger enquired post-administration of the depot injection.[16]

31. After Mr Bolger and Mr Jones left the flat, Mr Carrillo encouraged Mr Lopez to eat some food shortly before leaving the flat. Mr Carrillo asked Mr Lopez what he was going to do that day, and Mr Lopez told him, "*I don't know, I'm going out*." Mr Carrillo told Mr Lopez he would return to the flat at 9.00pm. Mr Carrillo returned to the flat at approximately 8.00pm but Mr Lopez was not at home.[17]

32. At approximately 3.00pm Yousra Zien was returning home from school in the Flemington area and saw a person wearing black clothing at a nearby public phone box. At approximately 6.00pm Mr Zien went outside to ride his bicycle and observed a man at the public phone box that he believed to be the person there earlier in the afternoon. Upon returning home at approximately 9.30pm, Mr Zien observed the man, now known to be Mr Lopez, was still at the phone box and became concerned for his welfare. Mr Zien called 000. While he was waiting for emergency services to attend, two passers-by approached Mr Lopez and checked his pulse.

33. Victoria Police members and Ambulance Victoria paramedics attended the scene. At 9.46pm paramedics pronounced Mr Lopez deceased.

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

Assessment of Mr Lopez's mental state on 10 February 2015

34. On 8 December 2015 a statement was requested from the NorthWestern Mental Health Service (NWMHS) regarding how Mr Lopez's mental health was assessed by Mr Campbell and Mr Jones on 10 February 2015, with the following matters to be specifically addressed:

    (a) if a request is made for a mental state assessment, what form does NWMHS expect this to take?

[15] Coronial brief, statement of Brendan Bolger, 30.
[16] Coronial brief, statement of David Jones, 31.
[17] Above n 3, 17.

(b) is there an expectation that the mental state assessment is documented or is there an alternate method for handing over to other staff?

(c) please provide any relevant policy or guideline regarding the assessment of mental state of clients in the community when a specific request has been made by the treating psychiatrist; and

(d) have and community based NWMHS actions of a preventative or restorative nature been undertaken since the death of Mr Lopez?

Statement of Dr Rick Yeatman

35. Subsequently, the Court received a statement of Dr Rick Yeatman, Director of Clinical Services for Inner West Area Mental Health Service. Dr Yeatman's statement provided the following:

(a) a request for mental health assessment is less specific than a request for formal mental state examination. In this case the request for a mental state assessment of Mr Lopez made by the Consultant Psychiatrist was to determine whether there was evidence of worrying mental health issues. Staff were welcomed into Mr Lopez's home, where Mr Lopez appeared happy and denied any concerning symptoms. Mr Lopez accepted treatment and requested a further appointment. By his actions, staff were able to make an assessment of his mental wellbeing at that time, and they documented this assessment;

(b) skilled and experienced mental health clinicians make observations during home based visits that may lower or raise their expectations of concern about their patient. Clinicians did not have concerns about Mr Lopez's behaviour or appearance, the state of his home, his interactions with them, or his willingness to accept treatment. On that basis, clinicians came to the conclusion that there was no evidence of a concerning change in his mental state;

(c) there is an expectation that all direct clinical contact with patients will be documented, and that a comment is made about the patient's mental state. The comment may be brief where there is no change, or may be detailed where the patient is new or is exhibiting a significant change in mental state. Along with documenting this in the patient's record, handover to other clinicians regularly occurs verbally through handover meetings and, if necessary, directly from clinician to clinician;

(d) as with all cases where a patient has died, an internal case review was undertaken. The review concluded that Mr Lopez had a long and complex mental illness but was accepting treatment. Further, there were no clear indications to staff that Mr Lopez was at an increased risk when he was last seen. Following the review, no formal recommendations for change of practice were made;

(e) there is no specific guideline regarding the assessment of mental state of a patient in the community where a specific request for assessment has been made by the treating psychiatrist. There are guidelines that cover assessment, home visits, documentation, and clinical handover which deal with management of a mental state assessment in the home.

36. On the available evidence, I am satisfied that Mr Lopez' mental health care and management by NorthWestern Mental Health Service was appropriate in the circumstances. Mr Lopez had a complex mental health presentation, and the mental health care provided to him was reasonable in the context of his presentation on 9 February 2015 and 10 February 2015.

37. In the course of my investigation I did not identify any prevention matters arising from the circumstances of Mr Lopez' death.

FINDINGS AND CONCLUSION

38. Having investigated the death of Mr Lopez and having held an Inquest in relation to his death on 13 September 2017, at Melbourne, I make the following findings, pursuant to section 67(1) of the Act:

    (a) the identity of the deceased was Luis Lopez, born 3 October 1962;

    (b) the death occurred on 10 February 2015 at 120 Flemington Road, Flemington, Victoria, from hanging; and

    (c) the death occurred in the circumstances described above.

39. I convey my sincerest sympathy to Mr Lopez' family.

40. Pursuant to section 73(1) of the Act, I order that this Finding be published on the internet.

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

(a) Daniela Alvarez, Senior Next of Kin;

(b) NorthWestern Mental Health Service; and

(c) Senior Constable Stacey Dwyer, Victoria Police, Coroner's Investigator.

Signature:

JUDGE SARA HINCHEY
STATE CORONER
Date: 13 September 2017