IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2014 6358

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of Marc Phillip Vella

Delivered On:	14 October 2015
Delivered At:	65 Kavanagh Street Southbank, Victoria, 3006
Hearing Dates:	14 October 2015
Findings of:	Coroner Jacqui Hawkins
Counsel Assisting the Coroner	Ms K Mellier, Coroner's Solicitor, Coroners Court of Victoria

I, Jacqui Hawkins, Coroner having investigated the death of Marc Phillip Vella

AND having held a summary inquest in relation to this death on 14 October 2015
At Melbourne
find that the identity of the deceased was Marc Phillip Vella
born on 11 March 1975
and the death occurred on 15 December 2014
at St Vincent's Hospital, 59 Victoria Parade, Fitzroy, Victoria 3065
from:

1 (a) INFECTIVE ENDOCARDITIS
CONTRIBUTING FACTORS – INTRAVENOUS DRUG USE

in the following circumstances

1. Marc Vella lived in Broadmeadows and was 39 years old at the time of his death.

2. Mr Vella's parents separated when he was 12 years old. His father and two eldest sisters moved to Queensland and Mr Vella lived in Bairnsdale with his mother and sister. His mother, Margaret Beechey, reported he took the separation of his family very hard. Mr Vella travelled between his father's home in Queensland and Ms Beechey's home in Bairnsdale. He lived in Queensland for a short time before returning to live with his mother. Mr Vella left school at the end of Year 11 and returned to live with his father.

3. Ms Beechey reported that on returning to Queensland, Mr Vella lived with his sister, Robyn and they frequently used and sold illicit drugs.[1] Mr Vella was diagnosed with Schizophrenia when he was 19 years old. He was hospitalised many times. Ms Beechey reported he received treatment from the Queensland mental health services, including fortnightly medication injections.[2]

4. While in Queensland, Mr Vella was engaged to a woman named Marnie. The relationship lasted for approximately 18 months before ending. Mr Vella was greatly affected by the break up and Ms Beechey believed he never recovered.

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1 Statement of Margaret Beechey, dated 31 March 2015, page 2, Coronial Brief of Evidence.
2 Ibid.

5. In 2006, Robyn died from cervical cancer. Mr Vella's father suffered a stroke and was unable to continue caring in any capacity for his son. In 2008, Mr Vella returned to Victoria. His financial affairs were handled by State Trustees and he moved into a transitional boarding house.

6. Ms Beechey remained in close contact with her son. She visited him weekly and assisted with the shopping, cleaning and utility bills. She ensured he had his medication and that he would attend Court when required.

7. In September 2011, Mr Vella started receiving treatment from North West Mental Health Service. Dr Partha Pratim Das, Consultant Psychiatrist reported that Mr Vella was admitted to hospital on a number of occasions. Since 2008, he received treatment under a Community Treatment Order (CTO) and had poor engagement with mental health services.[3]

8. Michael Giacobbe, Clinical Psychologist was assigned as Mr Vella's key clinician in early 2012. He reported Mr Vella was diagnosed with Schizophrenia and antisocial personality traits with co-morbid cannabis, opiate, amphetamine and benzodiazepine abuse. When he was unwell, he presented with persecutory and bizarre delusions, grandiose delusions, referential delusions and thought disorder. Historically, the onset of Mr Vella's illness was precipitated by non-adherence with medication and substance use.[4]

9. Mr Vella was prescribed 100mg of Zuclopenthixol fortnightly by intramuscular injection.[5] Mr Giacobbe reported that apart from presenting for his fortnightly depot appointments, Mr Vella did not engage in any kind of support from North West Mental Health.[6] When he attended for his depot appointment, he was seen by a member of his treating team and at certain intervals, would have a medical review.

10. Dr Das reported Mr Vella's last involuntary admission was on 23 October 2014, due to non-attendance for his depot appointment. He was admitted through the Northern Hospital Emergency Department and discharged back into the community on 24 October 2014, after receiving his depot injection. Dr Das reported blood investigations on 24 October 2014, were

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3 Statement of Partha Pratim Das, dated 19 January 2015, page 1, Coronial Brief of Evidence.
4 Statement of Michael Giacobbe, dated 9 April 2015, page 1, Coronial Brief of Evidence.
5 Also known as 'depot' injection.
6 Statement of Michael Giacobbe, dated 9 April 2015, page 1, Coronial Brief of Evidence

normal except for a raised c-reactive protein,[7] marginally raised aspartate aminotransferase[8] and borderline values for lipids.[9] Mr Vella denied other physical health problems except hepatitis C.

11. Dr Das saw Mr Vella on 28 November 2014. He presented with grandiose and paranoid beliefs with thought disorder. Dr Das assessed Mr Vella to have chronic static risks of aggression and was at risk of ill-judged behaviours. No imminent risk to self was identified. Dr Das assessed his presentation as fairly chronic and believed Mr Vella may have been under the influence of drugs. Dr Das planned to assertively follow up Mr Vella and monitor his compliance with depot treatment. Mr Vella's next depot injection was due on 11 December 2014. Dr Das was advised by Mr Giacobbe that Mr Vella was in police custody due to breach of his order. On his release, he was refusing to attend the clinic on 12 December 2014. He was informed that if he failed to attend, his treatment order would be varied.

12. On 12 December 2014 at approximately 5.10pm, Mr Vella attended the clinic.[10] Senior Nurse Jenny Meighan reported that on arrival, Mr Vella was puffed and wheezy, as he had been running. Nurse Meighan asked Mr Vella if he was asthmatic and he responded that he was. She advised him to use his inhaler and to see his general practitioner. Mr Giacobbe saw Mr Vella and assessed him to be appropriate in manner. He pleaded with Mr Giacobbe to have his injection rather than have his CTO varied to inpatient.[11] Nurse Meighan administered the depot injection and Mr Vella rested for a few minutes before leaving. Mr Giacobbe called Ms Beechey to inform her of her son's attendance.

SURROUNDING CIRCUMSTANCES

13. On 13 December 2014 at approximately 10.30pm, an ambulance was called to the corner of Elizabeth Street and Little Collins Street. Mr Vella was experiencing chest pain and was having difficulty breathing. He had been attempting to purchase Ventolin[12] from a Pharmacy that was closed. Attending paramedics found Mr Vella difficult to assess. He would not provide a clear and consistent history of his medical complaint or cooperate with their

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7 C-reactive protein is a marker of inflammation in the body.
8 Test usually used to detect liver damage.
9 A group of blood tests used to assess risk of developing cardiovascular disease.
10 Statement of Jenny Meighan, dated 18 December 2014, Coronial Brief of Evidence.
11 Statement of Michael Giacobbe, dated 9 April 2015, page 1-2, Coronial Brief of Evidence
12 Salbutamol

examination. They were able to establish that Mr Vella was an intravenous drug user.[13] He was transported by ambulance to St Vincent's Hospital Emergency Department.

14. On arrival at the Emergency Department at 11.06pm, Mr Vella was triaged as a category two patient and was seen by the Senior Emergency Medicine Registrar, Dr Hamed Akhlaghi. Dr Akhlaghi also found Mr Vella difficult to assess due to his imprecise recollection of events. Mr Vella informed Dr Akhlaghi that he had been unwell for approximately two weeks with difficulty breathing, a fever and an occasional cough. He reported developing chest pain.[14] Dr Akhlaghi noted Mr Vella's mental health and his regular illicit drug use. Mr Vella stated he had injected methamphetamine the day before.[15] Dr Akhlaghi assessed Mr Vella and noted he appeared significantly unwell with tachycardia, hypotension, tachypnoea, a mild fever and hypoxaemia. Examination of his chest revealed signs of infection. He was confused and there was a visible injection mark on his inner right elbow.

15. Dr Akhlaghi's initial impression was that Mr Vella had pneumonia and septicaemia in the setting of intravenous drug use. Bacterial endocarditis was also a possible associated diagnosis.[16] Pathology results showed he had a high white blood cell count and c-reactive protein, consistent with an infection. A chest x-ray revealed evidence of right-sided pneumonia, right sided plural effusion and cardiomegaly. Dr Akhlaghi commenced Mr Vella on oxygen, intravenous antibiotics and fluid. He was referred to the medical Registrar for admission to the General Medical Unit.[17] On 14 December 2014 at approximately 2.35am, the Medical Registrar assessed Mr Vella. He was unwilling to give specific details about his symptoms but indicated his chest pain was made worse by deep breathing. He informed the Registrar that he was receiving fortnightly depot injections.[18] The Medical Registrar agreed with the likely diagnosis of pneumonia and possible bacterial endocarditis, given his history of intravenous drug use, fresh track marks, fever and the presence of a systolic cardiac murmur.[19] Significant leg swelling was also noted.

16. At approximately 7.30am, Dr Wilma Beswick, Consultant Physician received a clinical handover from the Medical Registrar. Dr Beswick determined Mr Vella would be the first patient reviewed because he was significantly medically unwell, he demonstrated behavioural

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13 Statement of Andrew Walby, dated 2 June 2015, page 2, Coronial Brief of Evidence.
14 Ibid
15 It is not known if this was on 12 December 2014 or 13 December 2014, given the late night hospital admission.
16 Ibid, page 3.
17 Ibid, page 4.
18 Statement Wilma Beswick, dated 14 May 2015, page 3, Coronial Brief of Evidence.
19 Ibid.

issues and wanted to discharge himself from hospital.[20] Before Dr Beswick conducted ward rounds, Mr Vella was reviewed by the Alcohol and Other Drug Clinical Consultant for withdrawal symptoms and the Emergency Department Mental Health Clinician.

17. At approximately 9am, Dr Beswick saw Mr Vella in the Emergency Department. She reported Mr Vella was very agitated, restless and he wanted to leave hospital.[21] Dr Beswick conducted an examination and noted he had increased work of breathing with wheezing and intercostal in-drawing. He also had crackles in both lung bases suggestive of infection or cardiac failure. A systolic cardiac murmur was also detected. Dr Beswick reviewed Mr Vella's chest x-ray and blood parameters. She also agreed with a likely diagnosis of septicaemia, pneumonia and bacterial endocarditis. Further investigations were ordered and hydrocortisone and a ventolin nebulizer were administered to improve Mr Vella's breathing. Dr Beswick explained his ill health and the treatment plan to Mr Vella and the need for him to remain in hospital. At this time, Mr Vella requested Cogentin[22] which was administered. Dr Beswick subsequently determined an urgent referral to the psychiatric team was required.

18. At approximately 10.30am, Mr Vella was reviewed by Dr Prem Chopra, Consultant Psychiatrist. Dr Chopra reported Mr Vella believed he had taken himself to hospital for a check up and now wished to leave. He also believed he had been diagnosed with 'polynecium' a 'blood entity' and did not need to be admitted. He reported his symptoms had been relieved by benztropine[23] and he did not require further treatment.[24] On mental state examination, Dr Chopra noted Mr Vella was agitated, restless and continually affirmed his intention to leave. His affect was irritable, his speech was normal in rate and volume, although he was markedly dyspnoeic. He demonstrated formal thought disorder with evidence of neologisms. He demonstrated persecutory ideation towards staff, who he believed were against him. He had no suicidal ideation or homicidal ideation. He denied perceptual disturbances. Dr Chopra determined Mr Vella had poor insight into his illness as he believed he did not require medical treatment.[25] In view of his mental state and his incapacity to make an informed decision regarding necessary medical treatment, Dr Chopra contacted the on call duty Psychiatrist at North West Mental Health Service.

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20 Ibid.
21 Ibid.
22 Also known as Benztropine Mesylate. Commonly used to counteract the side effects of Zuclopenthixol.
23 Also known as Cogentin.
24 Statement of Prem Chopra, dated 7 September 2015, page 1, Coronial Brief of Evidence
25 Ibid, page 2.

19. Dr Steven Jones, Consultant Psychiatrist at North West Mental Health Service was the on call duty psychiatrist. Dr Jones reported he was informed that Mr Vella had been admitted to St Vincent's Emergency Department with what was thought to be a respiratory condition and he appeared confused, agitated disorganised and he was seeking to leave the hospital without treatment.[26] Dr Jones reported he was sufficiently concerned that Mr Vella's mental health needs could not be managed in the community given the presentation described to him. He was also concerned Mr Vella's current mental state was stopping him from receiving the treatment he required for his physical health issues.[27] Dr Jones concluded it was necessary to vary his order[28] from a Community Treatment Order to an Inpatient Treatment Order.[29] This required a transfer of the order[30] under the *Mental Health Act 2014* (Vic) as Mr Vella was receiving care from a different mental health service.

20. Dr Chopra reported he completed the form 'MHA 130 Substitute Consent to Medical Treatment by an Authorised Psychiatrist.'[31] He then discussed Mr Vella's treatment with the Emergency Medicine Registrar. Mr Vella required close monitoring given the significant risk of aggression and harm to himself if he refused treatment. He authorised the use of urgent physical restraint given Mr Vella's limited capacity to cooperate with staff in regard to his required medical treatment and Dr Chopra also prescribed Quetiapine.[32]

21. At approximately 2.30pm, the Medical Registrar was requested to review Mr Vella due to hypotension, decrease in conscious state and increased work of breathing. He complained of pain and breathlessness and was moved into the resuscitation bay. He was given saline, a ventolin nebulizer, oral pain relief and an oxygen ventilation mask.[33] Dr Beswick reported Mr Vella continued to be very agitated and was non-compliant with the ventilation mask. He was given 10mg of Diazepam to manage his agitation which was believed to be secondary to drug withdrawal.[34]

22. At approximately 4pm, Mr Vella was reviewed by the Medical Registrar and the Intensive Care Unit (ICU) Registrar. At the time, his oxygen saturations were 96% on room air. He continued to be agitated but alert, followed directions and remained non-compliant with

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26 Statement of Steven Jones, dated 2 September 2015, Coronial Brief of Evidence.
27 Ibid.
28 MHA 111 Variation of Temporary Treatment Order or Treatment Order, North West Mental Health Service Medical Records, page 56.
29 Ibid.
30 MHA 123 Transfer of Compulsory Patient, North West Mental Health Service Medical Records, page 64.
31 Statement of Prem Chopra, dated 7 September 2015, page 1, Coronial Brief of Evidence
32 Ibid.
33 Statement Wilma Beswick, dated 14 May 2015, page 5, Coronial Brief of Evidence.
34 Ibid.

oxygen therapy. As a result of further medical investigations it was recommended that monitoring be continued.[35] He remained in the Emergency Department, under close observation and was reviewed by the ICU Registrar later that evening. It was felt that Mr Vella had increased work of breathing so an admission to the ICU was arranged on the basis he may tire and require more intensive respiratory support. Prior to his transfer, a repeat chest x-ray and blood gas were undertaken. The chest x-ray revealed increasing pulmonary infiltrates. Mr Vella remained agitated and restless, he was given a further dose of Diazepam.

23. On 15 December 2014 at approximately 3.50am, an Emergency Medicine Registrar and security personnel transported Mr Vella to the ICU.[36] During transport, he was seated on the bed and remained agitated and was only intermittently complying with oxygen therapy. On arrival at the ICU, Mr Vella became unresponsive and a pulse could not be detected.[37] Cardiopulmonary resuscitation (CPR) was commenced and adrenilin was administered. Mr Vella was intubated and a nasogastric tube was inserted because of abdominal distension and fluid was aspirated from the stomach. Despite extensive resuscitative efforts, Mr Vella could not be revived. He was pronounced deceased at 4.42am.[38]

CORONIAL INVESTIGATION

24. Victoria Police conducted an investigation into the circumstances of Mr Vella's death. They prepared a coronial brief which included statements from Ms Beechey, treating clinicians and investigating officers.

25. On 17 December 2014, Dr Sarah Parsons, Forensic Pathologist at the Victorian Institute of Forensic Medicine performed an autopsy on the body of Mr Vella, reviewed the post mortem computed tomography (CT) scan and the Form 83 Victorian Police Report of Death.

26. Dr Parsons reported the post mortem examination revealed vegetation on the aortic valve that had perforated through the central fibrous body and involved the tricuspid valve. Streptococcus anginosus was cultured from the vegetation. Dr Parsons explained this bacteria is part of the usual human bacterial flora and it can at times cause diseases. Dr Parsons reported changes at autopsy were consistent with intravenous drug use. This included fibrosis and scarring in the epidermis, changes in the lungs and inflammation of the liver. Dr Parsons commented that long-term intravenous drug use increases a person's risk of infective endocarditis.

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35 Ibid.
36 Ibid.
37 Ibid, page 6.
38 Ibid.

27. Toxicological analysis of specimens taken on admission to the hospital and post mortem detected methamphetamine, amphetamine, zuclopenthixol, the metabolite of clonazepam, 7-aminoclonazepam, diazepam, oxycodone, olanzapine, quetiapine, benztropine and paracetamol.

28. Dr Parsons provided an opinion that the medical cause of death was 1a) INFECTIVE ENDOCARDITIS, CONTRIBUTING FACTOR - INTRAVENOUS DRUG USE.

THE PURPOSE OF A CORONIAL INVESTIGATION

29. The Coroners Court of Victoria is an inquisitorial jurisdiction.[39] The purpose of a coronial investigation is to independently 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.[40] The cause of death refers to the medical cause of death, incorporating where possible the mode or mechanism of death. For coronial purposes, the circumstances in which death occurred refers to the context or background and surrounding circumstances to the death, but is confined to those circumstances sufficiently proximate and causally relevant to the death and not merely all circumstances which might form part of a narrative culminating in death.[41]

30. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, the promotion of public health and safety, and the administration of justice.

31. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[42] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation or to determine disciplinary matters.

32. A coroner may comment on any matter connected with the death, may report to the Attorney-General and may make recommendations to any Minister, public statutory authority or entity, on any matter connected with the death, including recommendations relating to public health and safety and the administration of justice.[43]

33. This finding draws on the totality of the material produced as part of the coronial investigation into Mr Vella's death, including the coronial brief, statements and reports. In writing this

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39 Section 89(4) *Coroners Act 2008* (Vic).
40 Section 67(1) *Coroners Act 2008* (Vic).
41 *Harmsworth v The State Coroner* [1989] VR 989, *Clancy v West* (unreported 17/08/1994, Supreme Court of Victoria, Harper J).
42 *Keown v Kahn* (1999) 1 VR 69.
43 Section 72(1) and (2) *Coroners Act 2008* (Vic).

finding, I do not purport to summarise all of the evidence but refer to it only in such detail as appears warranted by its forensic significance.

CORONIAL INQUEST

34. The *Coroners Act 2008* (Vic) (Coroners Act) requires that I must hold an inquest into a reportable death if the death or cause of death occurred in Victoria and if immediately before death, a person was placed in custody or care. The definition of custody and care includes a patient detained in a designated mental health service within the meaning of the *Mental Health Act 2014* (Vic).[44] Just prior to his death, Mr Vella's CTO was varied to an Inpatient Treatment Order. Therefore, a mandatory inquest was required.

35. An inquest into the death of Mr Vella was held in Melbourne on 14 October 2015.

FINDINGS

36. I find that Marc Vella died on 15 December 2014 from 1a) INFECTIVE ENDOCARDITIS, CONTRIBUTING FACTOR - INTRAVENOUS DRUG USE.

37. Mr Vella was seriously unwell when he was admitted to the St Vincent's Hospital; it was unfortunate that he suffered a decline in his mental health which made it difficult for him to understand the seriousness of his condition. Consequently, I find the decision by his mental health clinicians to vary Mr Vella's treatment order was necessary to allow medical treatment.

38. I find the quality of the care and medical management provided to Mr Vella by St Vincent's Hospital was thorough and sound.

39. I acknowledge Ms Beechey's concerns that she was not contacted by St Vincent's Hospital when her son was admitted. This is most regrettable. I reinforce that hospitals should endeavour to make all attempts to contact next of kin particularly when patients suffer a mental illness and are required to have inpatient treatment and do not understand the consequences of their illness.

40. I wish to express my sincere condolences to Mr Vella's family. I acknowledge the grief and devastation that you have endured as a result of your loss.

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[44] Section 3(i) *Coroners Act 2008* (Vic).

Pursuant to section 73(1) of the **Coroners Act 2008**, I order that the finding be published on the internet.

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

Ms Margaret Beechey

Dr Mark Oakley Browne, Chief Psychiatrist

St Vincent's Health

North West Mental Health Service

First Constable Carmen Calle, Coroner's Investigator.

Signature:

JACQUI HAWKINS
CORONER
Date: 14 October 2015