IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2013 0855

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

*Section 67 of the **Coroners Act 2008***

I, AUDREY JAMIESON, Coroner having investigated the death of TROY DANIEL SAINT

without holding an inquest:
find that the identity of the deceased was TROY DANIEL SAINT
born 16 November 1983
and the death occurred on 24 or 25 February 2013
at The Melbourne Clinic, 130 Church Street, Richmond Victoria 3121
from:

1 (a) MIXED DRUG TOXICITY (INCLUDING HEROIN)

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

1. Troy Daniel Saint[1] was 29 years of age at the time of his death. Troy lived in Mildura and had two young children. He had previously worked in the security industry, as well as in the mining industry as a plant operator. Troy had a history of illicit drug use and drug-related

[1] During the course of the Mention Hearing on 12 May 2016, Troy Daniel Saint was referred to as Troy. For consistency, I have, in most part, avoided formality and also referred to him only as Troy throughout this Form 28 Decision.

criminal offending. He was prescribed a number of medications including desvenlafaxine, esomeprazole, baclofen, quetiapine and zopiclone.

2. On 21 February 2013, Troy was admitted as a voluntary patient to The Melbourne Clinic, a facility managed by Healthscope Operations Pty Ltd (Healthscope), to participate in a drug detoxification program for amphetamine addiction. Troy's possessions were searched upon his arrival at the clinic, and no illicit drugs were located. He had no recorded visitors during his time at the clinic. In addition to his pre-existing medications, Troy was prescribed diazepam *pro re nata* (as needed) to manage withdrawal symptoms.

3. At 5.22pm[2] on Sunday 24 February 2013, Closed Circuit Television (CCTV) footage indicated that Troy left The Melbourne Clinic for about 90 seconds. At 11.03pm, CCTV footage showed Troy speaking with three other patients, Marcus Hall, Justin Boughton and Annabella Bontschek outside his room. Shortly afterwards, Troy entered his room alone, having appeared to borrow a phone from one of the males. At 11.32pm, Mr Hall entered Troy's room and left soon after, having retrieved his mobile phone from the room.

4. At approximately 7.25am on 25 February 2013, a morning shift nurse located Troy unconscious. He was lying on his left side on the bed, with his head facing the door, and with his legs hanging off the bed. The nurse alerted other staff, who commenced cardiopulmonary resuscitation (CPR). As Troy was rolled from his side onto his back, staff located a syringe cap underneath him. Emergency services were contacted, and Ambulance Victoria paramedics, a Mobile Intensive Care Ambulance (MICA) and Metropolitan Fire Brigade personnel attended. At 7.38am, another MICA arrived and continued resuscitation efforts. However, Troy was unresponsive and ambulance paramedics declared him to be deceased at approximately 7.50am. Police attended shortly afterwards at 7.59am.

INVESTIGATIONS

5. By way of Form 8, pursuant to section 24 of the *Coroners Act 2008* (Vic) 'the Act' and dated 27 February 2013, I used *inter alia* a latent fingerprint identification report to determine the identity of the deceased to be Troy Daniel Saint.

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[2] I note that Director of Nursing Fiona Langley has stated that the footage was at 5.22pm; whereas Coroner's Investigator Christopher Spillane stated that he was advised by Director of Nursing Langley that footage showed Troy leaving the clinic at about 6.22pm.

Forensic pathology investigation

6. Dr Yeliena Baber, Forensic Pathologist at the Victorian Institute of Forensic Medicine performed a full post mortem examination upon the body of Troy, reviewed a post mortem computed tomography (CT) scan and General Practitioner medical records, and referred to the Victoria Police Report of Death, Form 83. At autopsy, Dr Baber identified a fresh puncture mark on the flexor aspect of Troy's left forearm. No significant natural disease was identified.

7. Toxicological analysis of post mortem blood and urine identified morphine,[3] diazepam and nordiazepam,[4] desmethylvenlafaxine,[5] and quetiapine.[6] In addition, 6-monoacetylmorphine,[7] codeine,[8] temazepam,[9] oxazepam,[10] and paracetamol[11] were detected in Troy's urine.

8. Dr Baber ascribed the cause of Troy's death to mixed drug toxicity (including heroin).

Police investigation

9. Upon attending The Melbourne Clinic after Troy's death, Victoria Police did not identify any signs of third party involvement. Drug paraphernalia was located in Troy's room; including a foil of white powder and a syringe. Police also located a notebook on Troy's bedside table, which contained a handwritten note referencing his depression and use of drugs of dependence, dated 21 February 2013. CCTV security footage was obtained from a security camera directly outside Troy's room from 8.00pm on 24 February 2013, to 8.30am on 25 February 2013.

10. Detective Sergeant Chris Spillane, the nominated coroner's investigator,[12] conducted an investigation of the circumstances surrounding Troy's death, at my direction, including the

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[3] Morphine is the principal form of heroin detected in blood. Morphine is a depressant of the central nervous system, causing reduced rate and depth of breathing and eventually cessation of the breathing reflex.

[4] Diazepam is a sedative/hypnotic drug of the benzodiazepines class. Nordiazepam is the active metabolite of diazepam.

[5] Desmethylvenlafaxine is indicated for the treatment of depression.

[6] Quetiapine is an antipsychotic drug used in the treatment of schizophrenia.

[7] Heroin is an illegal drug produced from morphine obtained from the opium poppy. Within minutes of injection into a person, heroin is converted to morphine via the intermediate compound 6-acetyl morphine (6-AM). Morphine is the principal form of heroin detected in blood, although 6-AM may be detected in urine for about six hours after an injection and in blood only for a short time.

[8] The presence of a small amount of codeine in the blood, urine or other tissues of morphine-positive cases is consistent with its presence from the use of heroin, in which it is a contaminant. However, the use of codeine cannot be excluded.

[9] Temazepam may be present as a result of the metabolism of diazepam.

[10] Oxazepam may be present following the metabolism of temazepam.

[11] Paracetamol is an analgesic drug available in many proprietary products either by itself or in combination with other drugs such as codeine and propoxyphene.

preparation of the coronial brief. The coronial brief contained, *inter alia*, statements made by Troy's father Daniel Saint; sometime partner Amanda Stainer; General Practitioner Dr Gerald Murphy; Addiction Medicine Specialist Dr John Chow; employees at The Melbourne Clinic: Registered Nurse and Associate Unit Manager Helen Lobby, Registered Nurses (RNs) Jenny Meaney, Caroline Yeaman and Jimmy William; three patients: Marcus Hall, Justin Boughton and Anabella Bontschek and a MICA paramedic. Statements were also subsequently received from additional staff at The Melbourne Clinic: Director of Nursing Fiona Langley, Enrolled Nurse (EN) (Division 2) Marie Pepper, General Manager Andrew McKenzie, as well as a second statement from RN Jenny Meaney.

Events preceding admission to The Melbourne Clinic

11. Daniel Saint stated that his son never attempted to take his own life, but over the years, it was not uncommon for him to threaten suicide upon the breakdown of relationships. He noted that Troy's amphetamine dependency expanded to include the drug 'ice' in 2012, and his condition deteriorated as the year progressed. Troy was first admitted to The Melbourne Clinic for detoxification from 31 October 2012 until 10 November 2012, but relapsed after discharge.

12. In the course of the investigation, police learned that Troy was the victim of an aggravated burglary at his home on 3 January 2013. Daniel Saint reported that following the incident, his son's mental health deteriorated and he became paranoid and depressed. Troy threatened to take his own life around this time and texted his intention to the two mothers of his children. Police were contacted and conducted a welfare check at his home. Towards the end of January 2013, Troy moved back in with his parents. According to his father, Troy's relationship with Amanda Stainer was over during this period, but he had contact with her for about a week at one point prior to his admission to The Melbourne Clinic.

13. Dr Murphy, a General Practitioner at Deakin Medical Centre in Mildura, stated that over the years he had arranged a number of referrals to various residential drug rehabilitation hospitals, but Troy never really reformed his drug taking. Dr Murphy reported that he saw Troy early in 2013. At this consultation, Troy complained of fluctuant moods, ranging from utter

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[12] A coroner's investigator is a police officer nominated by the Chief Commissioner of Police or any other person nominated by the coroner to assist the coroner with his/her investigation into a reportable death. The coroner's investigator takes instructions direction from a coroner and carries out the role subject to the direction of a corner.

hopelessness to periods of feeling 'great' where he had lots of energy. Dr Murphy considered diagnoses of cyclothymic disorder or bipolar disorder.

Clinicians' evidence regarding Troy's admission at The Melbourne Clinic

14. Director of Nursing Fiona Langley reported that on Troy's admission to The Melbourne Clinic on 21 February 2013, he told staff he had self-harmed with a heroin overdose two years beforehand. He said he had experienced suicidal thoughts over the past few months but currently had no suicidal plans or intent, or any other self-harm issues. A risk assessment was conducted which determined Troy had an overall low level of risk. He was granted no leave until he had safely detoxed.

15. Specialist in Addiction Medicine Dr Chow reported that Troy's admission diagnosis was methamphetamine dependence. Dr Chow reported that at The Melbourne Clinic, Troy's withdrawal program involved compulsory attendance at daily group therapy, and his progress was monitored by program staff daily and regularly. Up until Troy's death, his progress in the withdrawal process had been considered satisfactory and as anticipated. Dr Chow reported that Troy's death was totally unexpected; there was no excessive or inappropriate use of prescription medications as recorded in The Melbourne Clinic's drug chart, raising the possibility of unsanctioned use of a central nervous system (CNS) depressant drug, possibly illicit, such as heroin. Dr Chow noted that Troy did not have heroin dependence and would therefore not have a tolerance for it, meaning he would be susceptible to the CNS effect of its use.

16. Associate Unit Manager RN Lobby worked from 7.00am until 3.00pm on 24 February 2013. She observed that Troy was 'crashing' during her shift, as he withdrew from his amphetamine addiction, and slept in until 10.30am. RN Lobby woke Troy up and stated that he had no agitation nor aggression, but had huge cravings so she gave him 15mg of diazepam.

17. RN Meaney reported that she worked the afternoon shift of 24 February 2013, and Troy did not look drug affected during this period. Troy was concerned about how he would stay clean for two weeks in between the detoxification program and subsequent rehabilitation. RN Meaney could tell that Troy was agitated and having cravings because he kept pacing. She observed that during a review meeting between 8.00pm and 8.20pm, Troy was engaged and alert. RN Meaney last saw Troy at 9.00pm and stated that handover to RN Yeaman and RN William took place between 9.30pm and 10.00pm. RN Meaney informed them she had given Troy some diazepam because he was having huge cravings.

18. RN Yeaman stated that at handover on the night of 24 February 2013, the only concern raised about the health status of a patient in Troy's unit, was in relation to Marcus Hall. RN Yeaman said she was informed that Mr Hall was suspected of using heroin while out on leave, and had admitted to using heroin during a collection of urine for a drug screen. RN Yeaman stated she was told that Mr Hall was upset at the thought of being discharged, due to fears for his safety. She said she was told to 'keep an eye on him' as Dr Chow had been notified and had instructed that Mr Hall was to be discharged in the morning. RN Yeaman said there was no mention of any risk whatsoever to Troy.

19. At the first routine visual observation at approximately 10.08pm, RN Yeaman spoke with Troy and formed the opinion that there were no concerns. Shortly afterwards, RN Yeaman spoke with Mr Hall in the corridor. In the presence of patients Justin Boughton and Annabel Bontschek, RN Yeaman said she asked Mr Hall if he had brought any drugs into the unit, which he denied. Around this time, a syringe had been found in the bedroom of a female patient (referred to as 'patient D'), who Mr Hall had just visited. RN Yeaman said Mr Hall denied knowing anything about the syringe but shrugged and said he did not want the other patient blamed for anything.

20. RN Yeaman stated that throughout the rest of the shift, she and RN William conducted the usual routine. Other than the first check conducted on Troy at 10.08pm, she had no independent recollection of doing the other checks that night. RN William noted that during the shift, he and RN Yeaman did the checks, sometimes together and sometimes separately.

21. RN Yeaman stated she was suffering from an increasingly severe headache as the shift progressed. She recalled having a break around 4.00am on 25 February 2013, and took medication between approximately 4.20am and 4.40am, which allowed her to remain working for the remainder of the shift. RN William vaguely recalled completing a check around 5.15am. RN Willliam stated that Troy was asleep, lying on his back on the bed and was snoring. He also recalled that at various times he was snoring loudly. RN Yeaman recalled RN William commenting on the fact that on occasions Troy snored quite loudly and could be heard some distance away from his room. RN Yeaman had also noticed the previous night that Troy was snoring.

22. RN Yeaman noted that the usual practice with checks on nightshift is to conduct them from the door. RN William stated that while doing the bedroom checks, they sometimes shine the torch from a distance so as to minimise waking patients, due to numerous complaints of sleep

disturbance. RN Yeaman added that when a client can be heard snoring in a regular way, nurses may or may not open the door, so as not to disturb their sleep. She said that this practice arose from the Healthscope observation policy that provides 'the least intrusive level of observation that is appropriate to the situation should always be adopted so that due sensitivity is given to the patient's dignity and privacy whilst maintaining safety for the individual and those around them'. RN Yeaman noted that Troy was assessed as low risk, and where the risk assessment puts a patient at moderate or high risk, a more intense and intrusive observation level is undertaken.

23. RN Yeaman stated that on the morning of 25 February 2013, she wrote the clients' progress reports. She remembered looking at the sheet documenting the checks and seeing that RN William had recorded the 5.30am round of checks as being that all patients were sleeping well. She completed the progress reports on this basis. On the basis of CCTV footage she had subsequently reviewed, RN Yeaman stated that she commenced checking one end of the ward for the final checks at 6.30am; believing RN William was checking the other end of the ward including Troy's room. RN Yeaman stated that due to a severe headache and performing a number of tasks at the time, she could not recall the sequence of events at this time, nor what was done by RN William or by her.

24. General Manager at The Melbourne Clinic, Andrew McKenzie reported that on the morning of 25 February 2013, RN Yeaman also recorded in Troy's hospital record, 'settled to sleep at 2300. Slept well and was checked hourly overnight.'

25. RN Lobby commenced a shift at 7.00am on 25 February 2013. She reported that RN Yeaman conducted the handover and said there were no issues with Troy and he slept overnight.

26. The Coronial Brief contained an 'Hourly Sleep Chart' from The Melbourne Clinic, indicating that Troy was asleep during checks conducted at hourly intervals from 11.30pm on 24 February 2013, to 6.30am on 25 February 2013.

Leave and access to illicit substances

27. The Coronial Brief included The Melbourne Clinic's 'Addiction Service Contract and Guidelines' document, signed by Troy on 21 February 2013. The guidelines included that any positive drug tests would result in discharge; and that Troy would not leave the clinic without a staff member or written authority for unaccompanied leave from his doctor. Troy also signed an 'Inpatient Agreement' on 21 February 2013, agreeing to not consume alcohol or illicit drugs while an inpatient, or return to the facility from an outing, having consumed alcohol or

illicit drugs. Troy's leave arrangements were marked as 'no leave' on Healthscope's Consultant / Medical Practitioner Initial Risk Assessment.

28. Detective Sergeant Spillane reported that when he attended The Melbourne Clinic on 25 February 2013, RN Langley informed him *inter alia* that Troy had no leave while at the clinic.

29. Marcus Hall reported that on 24 February 2013, while on gym leave, he purchased heroin in Victoria Street, Richmond and used the entire quantity himself. Mr Hall subsequently used Troy's urine to pass a screening test at The Melbourne Clinic. RN Meaney confirmed that Mr Hall passed this drug test.

30. Mr Hall reported that at approximately 4.00pm that day, another inpatient at the clinic, Christian, said that he was getting heroin delivered. Mr Hall said he told Troy that Christian was getting heroin for him, and Troy said he had already organised to get 'two points' from Christian. Mr Hall reported that Christian provided him with the drugs at around 6.00pm in the cafeteria, and he also saw Christian give Troy some heroin and a needle as well.

31. At a review meeting between approximately 7.30pm and 8.00pm, a female patient informed RN Meaney that Troy was one of three male patients who supplied a urine sample for Mr Hall. RN Meaney said she did not confront Troy because it was hearsay. Mr Hall stated that he was asked to give a fully supervised urine drug test at 9.00pm, at which point he admitted to using drugs. Mr Hall said that at around this time, Troy informed him that he had already used some of the heroin. However, he did not look like he had used drugs.

32. RN Langley noted that Mr Hall was discharged on the morning of 25 February 2013, because it was considered unsafe to do so the night before, given the late hour.

33. RN Langley added that if illicit drugs were brought into the clinic, she did not know how this occurred. She stated that many of the patients at the Clinic are entitled to go on leave during their admission.

34. Detective Sergeant Spillane reported that Christian Kiley was interviewed at the Springvale Police Station on 13 June 2013. Mr Kiley said he did not really have any dealings with Troy and they just spoke at meals. Mr Kiley stated that you could just walk in and out of the clinic as you please; there was no regulation. He noted that the building is right next to Victoria Street, a known drug area. Mr Kiley said that on the occasions that he left the clinic, he was able to just walk out, past reception. Mr Kiley said that once he was told not to leave, but it depended on who was manning reception. He denied using, purchasing or supplying other

patients with illicit drugs while he was at the clinic. Mr Kiley indicated that the day after Troy's death, staff started shining torches in patients' faces at night.

35. In her statement, Ms Bontschek reported that on occasions when she returned from escorted leave, she was not searched properly when she returned. The staff looked in her handbag, and that was the extent of the search.

CCTV footage

36. Detective Sergeant Spillane noted that CCTV footage showed Troy interacting with other patients outside and inside his room on the evening of 24 February 2013. At about 10.08pm RN Yeaman opens Troy's door and appears to speak with him for about 20 seconds, while he is alone in his room. Troy later exits his room and interacts with other patients outside his room, before going back inside. He exits again at about 11.03pm for the last time, and speaks with Mr Hall, Mr Boughton and Ms Bontschek. Detective Sergeant Spillane stated that in the footage, the group appears to be in good spirits. Troy is given a mobile phone by Mr Hall and appears to be using the phone. At about 11.05pm, Troy enters his room for the last time and closes the door. At about 11.32pm, Mr Hall knocks on Troy's door, waits for a short time, then enters. Mr Hall exits the room about 20 seconds later, holding a mobile phone in his hand. At about 12.35am, RN Yeaman places her head near Troy's room door for about a second and then leaves. At about 4.38am,[13] RN William opens Troy's room door, and shines a torch inside the room from the doorway. He remains at the doorway, without entering the room, for about 10 seconds and then closes the door and leaves. At 5.33am, RN William walks past Troy's room and down the hallway checking rooms. He walks past Troy's room, towards the nurses' station and does not check the room. At 6.27am, RN Yeaman walks past Troy's room with a clipboard and then goes back towards the nurses' station. At 7.26am, RN Pepper enters Troy's room and contacts other staff members who attend with resuscitation equipment.

37. RN Langley reported that CCTV footage indicated Troy left the building at 5.22pm on 24 February 2013, and returned around 90 seconds later at 5.24pm. She said that Troy did this without the knowledge of staff and without having been granted leave. RN Langley did not know what Troy did during this time and as far as she was aware, no one else at the clinic knew either.

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[13] I note that this time is referred to as 4.37am in some submissions and statements.

38. A Form 18, Authorisation by Coroner to a Member of the Police Force[14] was issued by Deputy State Coroner Iain West on 8 March 2013, in order for police to obtain additional CCTV footage from The Melbourne Clinic. However, RN Langley informed Detective Sergeant Spillane by letter dated 25 March 2013, that due to a misunderstanding about the time that security footage was stored for prior to automatic deletion, The Melbourne Clinic was unable to retrieve or provide any footage other than that which had already been provided, which showed Troy's door from 24 to 25 February 2013.

39. In her statement, RN Langley reported that prior to the footage being deleted, she had the opportunity to view it. She said that the footage did not show Mr Hall, Troy and Mr Kiley together in the ground floor cafeteria on the afternoon of 24 February 2013.

Policies and Procedures at The Melbourne Clinic

40. RN Langley reported that 'Healthscope Policy 9.07 – Risk Assessment and Observations – Patient'[15] sets out the frequency with which nursing staff are to carry out observations for patients assessed as low, moderate and high risk. As Troy was assessed as a low risk patient, RN Langley noted that the policy makes clear that overnight observations must be hourly, visual observations, meaning that the nurse responsible for making the observation must sight the patient. They were required to record these on an 'Hourly Sleep Chart'.

41. While the Hourly Sleep Chart indicated hourly checks were conducted on Troy, RN Langley noted that CCTV footage suggested that contrary to what was recorded, the nurses did not in fact carry out visual checks of Troy at hourly intervals.

42. In his statement received by the Court on 21 February 2014, General Manager of The Melbourne Clinic, Andrew McKenzie reported that Policy 9.07 had not been changed in five years.[16] He stated that the requirement that patients be visually checked, hourly overnight has always been in that policy, and that all staff are required to complete compulsory annual training with respect to Policy 9.07.

43. Policy 9.07 also includes that a Clinical Risk Assessment is to be undertaken *inter alia* prior to a patient going on leave and upon their return from leave. It also provides that the 'least

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[14] Pursuant to sections 39, 40 and 41 of the *Coroners Act 2008* (Vic)

[15] The version of Policy 9.07 provided to the Court was issued February 2013

[16] I note, however, that the version provided to the Court appeared to have been issued in February 2013.

intrusive level of observation that is appropriate to the situation should always be adopted so that due sensitivity is given to the patient's dignity and privacy, whilst maintaining safety for the individual and those around them.'

44. RN Langley said there is always a risk that patients will bring drugs into the clinic upon their return from leave, which they might then use or provide to other patients to use. She noted that in order to minimise the risk of this occurring, 'Healthscope Policy 9.01 – Leave from mental health facilities – patient'[17] requires that all items brought back from leave will be checked to ensure they are not an item of risk, and a search will be conducted when a patient returns from leave and presents with an identified risk such as a change in behaviour, where risk assessment changes on return from leave, or where concerns are identified by staff or others. If the patient has a prior history of bringing in illegal substances or contraband, this may also warrant a search.

45. Healthscope Policy 9.01 provides that a 'sign in / sign out' leave register be used for patient leave, incorporating a checklist to ensure appropriate steps have been taken to minimise the risk of harm to the patient. The checklist should include confirmation that *inter alia*, leave has been approved by the treating psychiatrist.

Remedial action against Nurse Yeaman and Nurse Williams

46. General Manager McKenzie stated that following Troy's death, an internal investigation was undertaken at The Melbourne Clinic. It was identified that overnight nursing staff had failed to conduct hourly, visual observations pursuant to Policy 9.07. The internal investigation found that of the ten checks that policy mandates (overnight between the hours of 10.30pm and 6.30am the next morning) they only performed two visual checks, at 10.08pm on 24 February and at 4.37am on 25 February 2013. General Manager McKenzie said that both nurses were performance managed for failure to follow hospital policy and procedure, including falsifying documents and failure to perform overnight hourly, visual observations as required by Policy 9.07.

47. RN Langley noted that RN Yeaman and RN William are no longer employed by Healthscope.

48. As of 26 July 2016, the Australian Health Practitioner Regulation Agency (AHPRA) website[18] indicated that both RN Yeaman and RN William were subject to conditions on their nursing

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[17] The version of Policy 9.01 provided to the Court was issued February 2013

[18] See: https://www.ahpra.gov.au/

registrations. These conditions included *inter alia* a requirement that they complete further education, as well as a law and ethics course. However, I do note that AHPRA has not explicitly connected the publishing of these registration conditions with the circumstances surrounding Troy's death. As of 3 November 2016, the AHPRA website no longer listed conditions for RN Yeaman, but conditions remained listed for RN William.

Troy's mental and physical health

49. Mr Hall reported that Troy had asked him several times to use his mobile phone to call Ms Stainer. Mr Hall said he knew they were having relationship problems and did not hesitate to let him use his phone several times. Mr Boughton reported that during the day, Troy seemed fine but towards the end of the night he started arguing with his girlfriend over something minor.

50. Mr Hall observed that when he spoke with Troy, Ms Bontschek and Mr Boughton at around 11.00pm on 24 February 2013, Troy appeared in good spirits and at no stage did he seem suicidal or even depressed. Mr Boughton observed that Troy seemed fine, happy and did not appear to be under the influence of drugs. Ms Bontschek reported that Troy appeared to be completely fine and sober. He was in a relaxed and quiet mood. Mr Hall said that when he returned to Troy's room to retrieve his telephone at approximately 11.30pm, he observed that he was snoring, but his eyes were a bit open.

51. Ms Stainer reported that she spoke to Troy daily over the telephone for hours every day during his admission. She stated that Troy seemed depressed but happy at the same time. On 24 February 2013, Ms Stainer spoke to Troy numerous times. During the course of the phone calls, it became apparent to Ms Stainer that Troy was drug affected. She thought he sounded strange just after lunchtime, and during a phone call around 6.00pm, she was sure he had taken drugs. Ms Stainer questioned Troy, and he said he was only on diazepam. When Ms Stainer did not believe him, as he kept falling asleep during their phone calls, Troy said he had used 'smack', which Ms Stainer knew to be heroin. Ms Stainer said that they spoke again throughout the evening and at times she could hear voices in Troy's room, which were expressing concern that staff at the clinic had found out there were drugs on the premises.

52. Ms Stainer stated that she received a number of text messages from the phone Troy was using on 24 February 2013. Two messages were sent through that Ms Stainer did not see until the next morning. One of these messages asked Ms Stainer to call Troy back, the other included a

photo of a person holding a syringe. The text beneath the photo said that if Ms Stainer did not ring him back, he would give himself a 'hot shot'.

FAMILY CONCERNS AND REQUEST FOR INQUEST

53. An undated letter of concern, written by Daniel Saint, was received by the Court on 25 March 2013. Daniel Saint indicated the family's concerns as to whether the clinic rostered on sufficient staff to enable proper hourly checks, and queried whether staff received a verbal response or had sufficient training to recognise concerning issues such as Troy snoring with his eyes open. Daniel Saint also questioned whether his son was given the correct dosage of prescription medication. In addition, it was asked whether staff held concerns about other patients having heroin. Daniel Saint also raised concerns in relation to security, and asked - if someone who was unsupervised and outside of the clinic came back - whether they were searched for drugs on their return.

54. The Court received a Form 26 Request for Inquest into Troy's death from Daniel Saint, dated 4 June 2014 and pursuant to section 52(5) of the Act. The letter accompanying the Form 26 received from Ryan Legal on behalf of Daniel Saint and dated 4 June 2014, identified concerns regarding a perceived systems failure during Troy's admission to The Melbourne Clinic. The letter emphasised that Troy was a vulnerable individual, attending the clinic in order to undergo detoxification in a safe, controlled environment. It was noted that nursing staff at the clinic appeared to have falsely recorded observations on a sleep chart, and CCTV footage indicated the observations were not in fact carried out during the night of Troy's death. The letter indicated Troy's family were concerned about the internal operating procedures and level of staff training. The letter also noted that a fellow patient who had taken unsupervised leave from the facility was able to purchase quantities of heroin which were subsequently smuggled back and potentially supplied to Troy. It was noted that this patient was not isolated by nursing staff, after it was discovered he had purchased heroin.

FURTHER INVESTIGATIONS

Coroners Prevention Unit review

55. Following the receipt of the Form 26 request for inquest, I asked the Coroners Prevention Unit (CPU),[19] to review the circumstances of Troy's death on my behalf. The CPU noted that after

[19] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the coroner with research in matters related to public health and safety and in relation to the formulation of

the 10.08am round completed by RN Yeaman, rounds occurred at 0.35am when RN Yeaman leaned her head briefly next to Troy's door, and at 4.38am when RN William opened Troy's door and shone a torch from the doorway. It was noted that RN Yeaman entered the area outside of Troy's room covered by the camera, at 1.12am and 6.27am, and RN William at 0.58am, 1.02am, 5.33am and 6.52am.

56. The CPU identified a number of matters which led to additional enquiries, which included but were not limited to:

- An apparent lack of compliance with the required frequency of checks. RN Yeaman and RN William referred to the usual practice of conducting checks from the patient's door, so as to minimise sleep disturbance and limit intrusiveness. The CPU noted that while patients do frequently complain about sleep disturbance and a balance is required,[20] nevertheless compliance with the frequency of checks is required and no type of check was performed between 0.35am and 4.38am, clearly working outside of the clinic's policy. It was noted that the inadequacy of the frequency and quality of the observations made by RN Yeaman and RN Williams, meant the likelihood of them detecting a change in Troy's respiration rate, pallor and colour was low.
- An absence of guidance to staff in the 'Risk Assessment and Observations – Patient' policy about what is meant by the phrase 'visual observation'.[21] The CPU noted that the policy does not explicitly state what level of engagement with the patient meets the threshold of a visual observation, and whether they are required to check their respiration, pallor and skin temperature, or if noting their position in bed is adequate. The CPU suggested that the Healthscope policy does not reflect the contemporary approach to psychiatric inpatient observations, in that 'nursing observation involves the performance of highly developed skills in several areas of practice, including

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prevention recommendations, as well as assisting in monitoring and evaluating the effectiveness of the recommendations. The CPU comprises a team with training in medicine, nursing, law, public health and the social sciences.

[20] See: Victorian Department of Health, Mental Health, Drugs and Regions Division, Nursing observation through engagement in psychiatric inpatient care, Department of Health Guideline September 2013, page 15.

[21] See: Victorian Department of Health, Mental Health, Drugs and Regions Division, Nursing observation through engagement in psychiatric inpatient care, Department of Health Guideline September 2013, page 1.

building therapeutic relationships and attending to psychosocial, physical health and safety needs.'[22]

- A query as to whether sufficient risk minimisation action was taken once staff at The Melbourne Clinic discovered that a patient had used illicit substances and possibly possessed them within the facility during the relevant period. Regardless of the voluntary status of patients, the CPU suggested that the clinic had a responsibility to maintain the safety of patients in the Substance Withdrawal Program, including trying to restrict access to illicit substances while a patient is in the program, and if that fails, to ensure patients are as safe as reasonably possible. It was noted that while it was unreasonable to expect a unit wide search, it was reasonable for staff who were aware that there had been use of and access to heroin by at least one patient, to have been alerted to the possibility of increased risk and shown greater commitment to completing visual observations.
- An apparent lack of knowledge and recognition of risk by nursing staff working in the Substance Withdrawal Program about the significant risk associated with the combination of illicit substances and prescription medications that are CNS depressants.
- The relevance and significance of the observations of loud snoring by nurses involved in the Substance Withdrawal Program and how that might be indicative of a substance overdose.[23] The review of the available information suggested both RN Yeaman and RN William were unaware of the implications of Troy's loud snoring; therefore it was unclear if The Melbourne Clinic provided specific training to nurses working in the Substance Withdrawal Program to identify the signs and symptoms of a drug overdose and how to respond.

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[22] See: Victorian Department of Health, Mental Health, Drugs and Regions Division, Nursing observation through engagement in psychiatric inpatient care, Department of Health Guideline September 2013, page 1.

[23] The CPU noted that one of the indicators of a drug overdose (including opioids, benzodiazepines and CNS depressants, including antipsychotics and antidepressants) is snoring. See: Better Health Channel accessed on 26 July 2016 at <http://www.betterhealth.vic.gov.au/bhcv2/bhcarticles.nsf/pages/Heroin?open>; Australian Drug Foundation, 2014. Fact sheet – Overdose. Accessed on 26 July 2016 at: <http://www.druginfo.adf.org.au/topics/overdose>; Virtual Medical Centre 2044, Medicine or Drug Overdose accessed on 26 July 2016 at: <http://www.myvmc.com/lifestyles/medicine-or-drug-overdose/#c5>. Virtual Medical Centre (VMC) is an Australian medical information website. It delivers medical information, written by medical professionals, about current conventional medicine.

Request for further information

57. Following the receipt of the request for inquest and the CPU's review, further information was also sought from RN Langley by way of Form 4 dated 2 April 2015, issued pursuant to section 42 of the Act.[24] RN Langley provided a response by way of statement dated 8 April 2015.

58. As the Healthscope 'Risk Assessment and Observations – Patient' policy did not appear to explicitly state the level of engagement expected of nursing staff with patients when they complete 'visual observations', RN Langley was asked to clarify what 'visual observations' means and how this expectation is communicated to staff. RN Langley noted that observations always require a nurse to use their judgment and to consider the context when determining the appropriateness of engagement with a patient. Relevantly, Healthscope's expectation is that during hourly night time observations, when a patient is asleep, the patient must be visually sighted to make sure they are present and appear to be physically well, such as breathing normally. RN Langley stated that new nursing graduates undergo a two day orientation, during which they are taught how to perform observations. When experienced psychiatric nurses are employed, they are asked to familiarise themselves with relevant Healthscope policies. RN Langley stated that Healthscope expects experienced psychiatric nurses to understand how to perform observations, as it is a basic skill of any experienced registered psychiatric nurse.

59. In responding to a query regarding The Melbourne Clinic's risk mitigation strategies to address the possibility of illicit substances being in the Substance Withdrawal Program unit, in addition to Policy 9.01 relating to leave, RN Langley referred to Policies 9.13 and 1.4.10. RN Langley noted that 'Healthscope Policy 9.13 – Search of Patient Rooms and Belongings'[25] requires that a search be conducted when there is evidence of or identified risk of self harm, harm to another patient, threat to another person or illegal/non authorised substances being present with the patient. In addition, a search will be conducted on admission of all patients assessed as having a potential of self harm, suicide or harm to others, or in accordance with program requirements. RN Langley reported that 'Healthscope Policy 1.4.10 – Alcohol, Illicit and Non Prescribed Drugs'[26] outlines that patients are given information about the behaviour expected of them; patients are educated about the effects of substances; and clinic security

[24] A Form 4 – Document or Prepared Statement Required to be given to the Coroner is issued pursuant to section 42 of the *Coroners Act 2008*, and requires the provision of information within a specified timeframe.

[25] The version of Policy 9.13 provided to the Court was issued February 2013.

[26] The version of Policy 1.4.10 provided to the Court was issued May 2002 and revised May 2009.

personnel are employed as a visible deterrent to reduce the presence and sale of illicit substances on the premises. RN Langley added that staff are expected to search relevant rooms and possessions if drugs are known to have been brought onto the premises, and patients who have taken drugs are discharged when it is safe and responsible to do so. RN Langley confirmed that Healthscope does not discharge patients late in the evening.

60. RN Langley stated that The Melbourne Clinic provides information to nursing staff working in the Substance Withdrawal Program that is specific to the detection and treatment of drug overdose. Resources available on the unit include 'Alcohol and Other Drugs: A Handbook for Professionals' and the National Guidelines for Medication Assisted Treatment of Opioid Dependence. The Melbourne Clinic also runs education seminars with the University of Melbourne where registrars present case studies relating to these issues.

Mention Hearing and submissions

61. A Mention Hearing was held on 12 May 2016, in order to progress the coronial investigation; provide interested parties with an opportunity to be heard on any outstanding issues; and to advise that I was of mind to make adverse comments in any Finding following the investigation into Troy's death.

62. In advance of the Mention Hearing, the Court received submissions from Ryan Legal, on behalf of the Saint family, dated 18 January 2016, and from Acting National Clinical Risk Manager at Healthscope, Damien Lloyd, dated 19 February 2016.

63. The submissions on behalf of the Saint family outlined a number of concerns. In particular, it was suggested that RN Langley's explanation of the meaning of 'visually sighted' did not properly explain the process of visually sighting a patient. In addition, the submission queried what training material was provided to new staff regarding observations, and how the relevant Healthscope policies were circulated to experienced staff. It was noted that Policy 9.13 - Search of Patient Rooms and Belongings, requires that if drugs are known to have been brought onto the premises, a search of the relevant rooms and possessions will be conducted. The submission suggested that this policy was not followed after it was established that heroin was present on the premises, and concern was expressed that necessary searches were not undertaken. It was added that there appeared to be no relevant policy in place to manage the potential offender once possession of illicit substances was known, in circumstances where they could not be discharged until the following day.

64. Mr Lloyd's submissions acknowledged that the CCTV evidence is unequivocally clear that RN William and RN Yeaman failed in their duty to perform all the hourly overnight visual observations required by Healthscope. Mr Lloyd submitted that any assertion that the nurses' failure to conduct visual observations stemmed from inadequate training and/or a lack of understanding of their responsibilities, was not credible. Mr Lloyd confirmed that Healthscope referred the incident to AHPRA and both nurses have since had conditions placed upon their registration.

65. In response to the Saint family's concerns regarding the process of visually sighting patients, Mr Lloyd noted that Healthscope is not prescriptive about the length of time a nurse must spend performing the observation; it is done for the period necessary to establish that the patient is present and appears to be physically well. In addition, the patient's breathing is monitored by watching and listening for signs of normal breathing. Mr Lloyd noted that there was no evidence at 4.37am, when RN William performed a proper visual observation, that Troy was suffering from the effects of a drug overdose, which RN William failed to respond to. Mr Lloyd stated that Healthscope did not consider that any further investigation into the adequacy of nurses' training on how to respond to signs of overdose was relevant.

66. In addition, Mr Lloyd asserted that it was not correct to suggest that Healthscope's Search of Patient Rooms and Belongings policy was not followed. Mr Lloyd noted that RN Langley's statement dated 13 February 2014 indicated that nursing staff received information that patient Marcus Hall was in possession of drugs, and he was found in patient D's bedroom. Patient D's bedroom was searched for drugs, which were found and removed. In regards to managing a patient found in possession of drugs in circumstances where they cannot be discharged until the following day, Mr Lloyd referred to Healthscope's Risk Assessment and Observations policy. In these circumstances, a risk assessment is performed to assess whether the patient's level of risk and requirement for observation needs to be increased based upon the risk to him or herself and the risk posed to others. Mr Lloyd stated that the patient will then be monitored in the most appropriate way to ensure his or her own safety and the safety of others.

67. At the Mention Hearing, Michael Regos, solicitor at DLA Piper appeared on behalf of Healthscope, and Daniel Wallis of Counsel appeared on behalf of the Saint family. Troy's parents, Daniel and Norma Saint were in attendance. It was submitted by my Assistant, Senior Constable Paul Collins, that following the thorough investigation, complemented by the provision of additional information statements from Healthscope, the Court was unlikely to

learn new information or address outstanding public health and safety issues through the holding of an inquest in relation to Troy's death.

68. I indicated that the area of greatest concern to me was in relation to how Troy was monitored overnight. I noted that given the investigations by other bodies, including AHPRA, I had to consider the possibility of a duplication of process. Had the two nurses involved in Troy's care overnight still been employed by The Melbourne Clinic, I indicated that I might have taken a different view. However, as the nurses' apparent failure to comply with their own employer's policies and procedures regarding overnight observations appeared to have been adequately addressed, I indicated that I did not need to explore this issue further.

69. I also noted that even though Troy was a voluntary patient, The Melbourne Clinic had a responsibility to maintain a safe environment for him, which included trying to restrict access to illicit substances while patients were participating in the program. Sen. Constable Collins had raised the issue of restricting patients leaving the clinic and searching them upon their return. I noted that this issue, along with other issues that Sen. Constable Collins had referred to, including improvement of risk minimisation strategies when patients are known to have accessed drugs and brought them into the clinic, could be dealt with by way of an in chambers Finding.

70. Mr Wallis noted, *inter alia*, that the Saint family was concerned about The Melbourne Clinic's policies regarding the response, once drugs are positively identified as being on the premises, including whether offending patients are segregated. Written submissions provided at the hearing emphasised that the Saint family viewed that in circumstances where Troy was known to have interacted with Mr Hall, comprehensive searches should have been conducted after the presence of drugs were identified. In addition, it was suggested that in these circumstances, it was especially critical for staff to assess Troy's mental and physical state, and ensure visual observations were performed appropriately. Concerns were also raised in relation to the manner in which patients enter and exit the clinic, and how easy it might be to bring drugs back. Mr Wallis submitted that it was a failing on the part of the clinic, for Troy to have been exposed to drugs in that setting. It was submitted that the Saint family wished to proceed with the formal Form 26 application, in light of unresolved issues including *inter alia* the manner in which patients enter and exit the Clinic, and the steps taken once drugs are discovered on the premises.

71. Mr Regos informed the Court that Healthscope's position was that an inquest was not required to progress the coronial investigation. Mr Regos provided further written submissions and noted *inter alia* that given staff were informed that Troy had provided a urine sample to help Mr Hall pass a drugs test, this information may have suggested that he had not used drugs. Mr Regos emphasised that The Melbourne Clinic is a voluntary clinic, and that it is not possible to 'fool proof' whether patients are able to leave the premises, or bring in drugs. It was noted that the clinic operates on the basis that patients must be willing to take personal responsibility for dealing with their issues; exemplified by the Inpatient Agreement and Addiction Service Contract. However, the submissions did note that at the time of Troy's death, patients granted leave were given a paper permission slip to show reception staff. Nowadays, there is an electronic system, including patient photos, which is signed on the ward, and reception staff can access it to check if a patient has been granted leave before buzzing them out. It was noted that this system is not watertight and relies on patient cooperation.

72. Moreover, Mr Regos stated that Healthscope conceded that the two nurses did not do observations as they were expected to have been done. The submissions noted that Healthscope had conducted a review and found that there have been no similar incidents in the past five years in which an employee has been found to have failed to carry out their duties to conduct patient checks. It was submitted that there was no lack of clarity regarding what constitutes a 'visual observation', which common sense, experience and the language used indicates must involve the nurse seeing the patient. The submission confirmed that neither RN William nor RN Yeaman have worked for Healthscope since the incident occurred.

73. The submissions added that Healthscope's 'Search of Patient Rooms and Belongings' Policy 9.13 has been altered since Troy's death. It now requires patients' belongings to be searched on each occasion when they return from leave; irrespective of whether they present an increased level of risk. It was reiterated that this system is not watertight and relies on the cooperation of patients.

DETERMINATION NOT TO HOLD AN INQUEST

74. By way of Form 28 dated 29 July 2016, and pursuant to section 52(6)(b) of the Act, I determined not to hold an Inquest into Troy's death, as I did not identify a legitimate coronial purpose that was likely to be served by a public hearing.

COMMENTS

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

1. There is clear and cogent evidence that nursing staff did not monitor Troy in accordance with The Melbourne Clinic's policies on the night of 24 February 2013 and into the morning of 25 February 2013. While this issue does not relate to Troy's ability to access drugs, it is significant. The lack of observations were causative in that an opportunity was missed to intervene in a timely way to provide medical attention to Troy. As I indicated at the Mention Hearing, I am aware that AHPRA has conducted investigations into RN Yeaman and RN William, there were conditions placed on their nursing registrations, and they are no longer employed at The Melbourne Clinic. In the circumstances, I am satisfied that their lack of compliance with policies and procedures has been adequately addressed, and I am obliged to avoid a duplication of investigations by exploring this issue further.

2. Moreover, I am not convinced that the lack of observations and falsifying of documentation in this instance is indicative of systemic, entrenched behaviour of nursing staff at The Melbourne Clinic, nor that this was common practice. Any alleged shortcomings in the policies and procedures at the clinic are not sufficiently egregious to justify the nurses' actions that night. Further debate about the adequacy of policies should not bypass the most grave and central issue: between 12.35am and 4.38am on 25 February 2013, no type of check was performed on Troy, which is completely contrary to the clinic's policy requirements of one hourly visual observations.

3. In addition, the registered nurses appear to have been unaware of the significance of snoring in a substance user, which in a substance withdrawal unit is inadequate. It is reasonable to expect that registered nurses working in a substance withdrawal unit would be aware of and able to respond to a person who presents with loud snoring, and at the very least, that they enter the bedroom and check the patient is only snoring and exclude any acute issues with the patency of the patient's airway. Again, I am not convinced that this evinces a systemic problem amongst staff at The Melbourne Clinic. I note RN Langley's statement that the clinic provides information to nursing staff that is specific to the detection and treatment of drug overdose, including text-based resources and education seminars.

4. The phrase 'visual observations' used in Healthscope policy documents should be clarified to give greater guidance to nursing staff regarding the intensity of purposeful visual observations,

especially overnight. I acknowledge that Healthscope provide training for new nursing graduates regarding the performance of observations, and I note that experienced psychiatric nurses are asked to familiarise themselves with policies, but it is expected they understand how to perform observations. I do not accept Healthscope's submission that the meaning of the phrase 'visual observation' is common sense. Those undergoing detoxification at The Melbourne Clinic have analogous features with inpatients at psychiatric units; they are compromised by addiction and are vulnerable; they are at risk to themselves and require regular observations. The core principles of nursing observation in the Department of Health Guideline 'Nursing observation through engagement in psychiatric inpatient care', include that it is multifaceted, interrelated with assessment, and grounded in therapeutic engagement with the person.[27] The guideline provides that observation levels should be maintained through the day, evening and night shifts. However, if a less intrusive form of observation has been determined for when a patient is asleep, such details should be adequately recorded and nurses should be made aware of the observation requirements. Varying practices indicate that the meaning of 'visual observation' is not intuitive, and I see no reason for there to be continuing ambiguity about what a visual observation entails.

5. Attempts to maintain a controlled environment, with a restriction upon access to illicit substances, are important in the context of treating vulnerable patients who are undergoing drug detoxification. I commend Healthscope for making technology updates to its leave system since Troy's death, and for changing Policy 9.13 so as to require patients to be searched on each occasion when they return, irrespective of whether they present an increased level of risk. While I acknowledge that this system is not watertight, I also note that patients at The Melbourne Clinic are there on a voluntary basis. The facility has no basis upon which to disallow voluntary patients from leaving the premises. However, in the circumstances surrounding Troy's death, notwithstanding that patients were participating in a voluntary program, it is of some concern that staff were not more aware of the comings and goings of vulnerable patients – including Troy during the early evening of 24 February 2013.

6. I concur with the Saint family that more could have been done by The Melbourne Clinic to ensure the safety of patients, including Troy, in light of the discovery of drug paraphernalia on the premises. Their concern is supported by the fact that patients like Troy were already experiencing cravings as a result of the withdrawal process and being prescribed Central

[27] See: Victorian Department of Health, Mental Health, Drugs and Regions Division, Nursing observation through engagement in psychiatric inpatient care, Department of Health Guideline September 2013, 3.

Nervous System depressants, making them particularly vulnerable to both taking drugs and experiencing severe effects as a consequence. The lack of action, knowledge and recognition of risk by nursing staff working in a withdrawal unit was inadequate. Regardless of the voluntary status of patients, The Melbourne Clinic has a responsibility to maintain their safety. This includes trying to restrict access to illicit substances while a patient is in the program, and if that fails, to ensure the patients are as safe as reasonably possible. I acknowledge that in these circumstances, it may have been unreasonable to expect a unit-wide search as a response to information that Mr Hall had used drugs, and the discovery of drug paraphernalia in Patient D's bedroom. However, it was reasonable to expect that staff be alerted to the possibility of increased risk and show greater commitment to completing visual observations.

7. Ultimately, Troy was a voluntary patient and there is no evidence to suggest he used heroin against his will. Troy was aware he was using an illicit substance while in a detoxification unit, and that this was contrary to the contracts he had signed to participate in the program.

RECOMMENDATIONS

Pursuant to section 72(2) of the **Coroners Act 2008**, I make the following recommendation connected with the death:

1. With reference to the analogous, contemporary approach to psychiatric inpatient observations, and with a view to preventing harm and like deaths, **I recommend** that Healthscope amends Policy 9.07 'Risk Assessment and Observations – Patient' to include greater guidance to nursing staff regarding the intensity of purposeful visual observations, especially overnight.

FINDINGS

The investigation has identified that a number of inadequate practices took place at The Melbourne Clinic in the circumstances surrounding Troy's death. In particular, I note that the Registered Nurses on duty failed to perform the required hourly 'visual observations' upon Troy, between 10.08pm on 24 February 2013, and 4.38am on 25 February 2013. The inadequacy of the frequency and the quality of the observations, meant the likelihood of them detecting a change in Troy's respiration rate, pallor and colour was low. The lack of observations meant an opportunity was missed to intervene in a timely way to provide medical attention to Troy. Moreover, the evidence indicates that the Registered Nurses were not alert to the potential for harm, given that another patient had used heroin; drug paraphernalia was found in Patient D's room; and Troy was heard snoring loudly which

can suggest a drug overdose. In light of these facts, little comfort can be drawn from Healthscope's submission that there is no evidence that Troy was suffering from the effects of a drug overdose at 4.37am, to which RN William failed to respond.

I acknowledge that a number of factors suggest that Troy's death may have been intentional. Troy sent a text message to Ms Stainer that referenced taking a 'hotshot'; he had reportedly been feeling low after being a victim of crime in January 2013; a handwritten note dated 21 February 2013 referenced his depression and use of drugs of dependence; and he had previously threatened to take his own life upon the breakdown of relationships. In addition, Troy was not heroin dependent. However, I also note that Troy was not being treated for depression or suicidal ideation at The Melbourne Clinic. Upon admission on 21 February 2013, he referred to suicidal thoughts over the past few months but had no current plan or intent. Notes were found which referenced his future goals, and no witnesses observed Troy feeling low or expressing suicidal thoughts on 24 February 2013. On balance, and in the absence of a direct expression of intention, I am unable to make a finding as to whether or not Troy intended to take his own life.

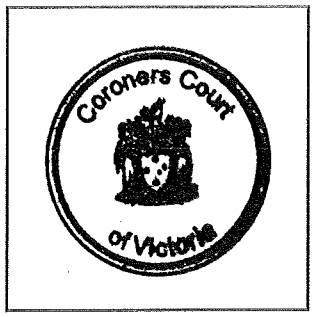
I accept and adopt the medical cause of death as opined by Yeliena Baber and find that Troy Daniel Saint died from mixed drug toxicity including heroin, in circumstances where I am unable to make a finding as to whether he intended to take his own life.

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

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

Mr Daniel Saint
Mr Andrew McKenzie, The Melbourne Clinic
Ms Fran Ibson-Turner, Ryan Legal
Mr Michael Regos and Ms Clare Cheesewright, DLA Piper Australia
Mr Daniel Wallis of Counsel
Mr Andrew Munro and Ms Kristy Sharp, Australian Health Practitioner Regulation Agency
Chief Psychiatrist of Victoria
Ms Kym Peake, Secretary of the Department of Health and Human Services
Detective Sergeant Chris Spillane

Signature:



AUDREY JAMIESON
CORONER
Date: **7 November 2016**