IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2017 5208

FINDING INTO DEATH WITH INQUEST

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

Findings of:	**CORONER JOHN OLLE**
Deceased:	**PATIENT A***
Date of Birth:	[redacted]
Date of Death:	12 October 2017
Delivered on:	13 March 2020
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing date:	13 March 2020
Coroners Assistant:	Senior Constable Kelly Ramsey

* This published finding has been de-identified to preserve the privacy of Patient A's family.

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HIS HONOUR:

BACKGROUND

1. Patient A was a 35-year-old woman who was born on [redacted]. She was the eldest of four children which included two brothers and a sister.

2. Patient A had longstanding diagnoses of schizoaffective disorder, opiate use disorder, amphetamine use disorder and hepatitis C. Since 2014, she had at least 38 admissions to the Swanston Centre,[1] an admission to Ballarat Health Services Secure Extended Care Unit (**SECU**) from 4 March 2009 to 21 March 2011,[2] and two admissions to Thomas Embling Hospital in 2007 and 2015.[3] She also had one admission to the Alfred Hospital psychiatric ward in 2007, after being transferred from the Swanston Centre due to frequent absconding that was unable to be managed at the Swanston Centre.[4] In July 2008, Patient A absconded from the Swanston Centre and had a near fatal heroin overdose.[5]

3. Patient A began using intravenous (**IV**) heroin and amphetamines in her late teens. From 2013 until early 2016 she reported that she primarily used IV morphine with periods of IV amphetamine. From 2016 until her death she used IV morphine and IV methamphetamine.[6] Barwon Health staff who knew Patient A well identified a significant deterioration in her mental state around early 2016 when she began using methamphetamine.[7] According to the Barwon Health medical record, Patient A was considered a chronic high risk of misadventure and accidental overdose.[8]

4. Patient A frequently absconded from the Swanston Centre, including multiple times during her most recent admission. Between 25 January 2016 and her death, Patient A was reported to police as a missing person on 36 occasions, with 16 of these missing person reports related to incidents when she was a compulsory inpatient at the Swanston Centre.[9] According to Patient A's parents and the medical record, Patient A would abscond from the

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[1] Barwon Health digital medical record, Community and Mental Health History dated 30 May 2017, page 969 of 1127.
[2] Barwon Health digital medical record, Community and Mental Health History dated 30 May 2017, page 957 of 1127.
[3] Barwon Health digital medical record, Community and Mental Health History dated 30 May 2017, page 957-958 of 1127.
[4] Barwon Health digital medical record, Risk Assessment History and Context dated 14 September 2017, page 957 of 1127.
[5] Barwon Health digital medical record, Risk Assessment History and Context dated 14 September 2017, page 961 of 1127.
[6] Statement of [redacted] dated 27 October 2017, page 18 of coronial brief.
Barwon Health digital medical record, Risk Assessment History and Context dated 14 September 2017, page 955-956 of 1127.
Barwon Health digital medical record, progress note dated 25 September 2017, page 615 of 1127.
[7] Barwon Health digital medical record, Community and Mental Health General Assessment dated 30 May 2017, page 974 of 1127.
[8] Barwon Health digital medical record, Progress note dated 8 September 2017, page 636 of 1127.
[9] Page 2 of coronial brief.

Swanston Centre, use illicit substances and then return to the Swanston Centre and inform staff of what she had taken.[10]

5. On 13 February 2016, Patient A was admitted to the Swanston Centre from the community and was transferred between the Swanston Centre and the Barwon Health Prevention and Recovery Care unit (**PARC**) several times prior to her death. She was treated on a treatment order for several years prior to her death, which was varied several times between a community treatment order (**CTO**) and an inpatient treatment order (**ITO**) multiple times, as required. Based on her extensive history of worsening psychotic symptoms and associated increased risks after using illicit substances, her treatment plan involved admission to the Swanston Centre on an ITO if she used illicit substances.

6. On 17 March 2017, Patient A's mother, [redacted], was appointed by the Victorian Civil and Administrative Tribunal (**VCAT**) as her guardian and was able to make decisions regarding Patient A's medical treatment and accommodation.

THE PURPOSE OF A CORONIAL INVESTIGATION

7. The role of a coroner is to investigate reportable deaths to establish, if possible, the identity, of the deceased, the medical cause of death and, with some exceptions, surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The law is clear that coroners establish facts; they do not lay blame, or determine criminal or civil liability.[11]

8. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[12] The *Coroners Act 2008* (Vic) (**the Act**) provides for a system whereby reportable deaths are independently investigated to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[13]

9. The Act provides that a coroner must hold an inquest into all deaths which occurred while a person is "*in custody or care*",[14] except in those circumstances where the death is considered

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[10] Statement of [redacted] dated 27 October 2017, page 13 of coronial brief.
Statement of [redacted] dated 27 October 2017, page 19 of coronial brief.
Barwon Health digital medical record, Community and Mental Health History dated 30 May 2017, page 969 of 1127.

[11] In the coronial jurisdiction facts must be established on the balance of probabilities subject to the principles enunciated in *Briginshaw* v *Briginshaw* (1938) 60 CLR 336. 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 as to those matters taking into account the consequences of such findings or comments.

[12] Section 89(4) *Coroners Act 2008*.

[13] See Preamble and s 67, *Coroners Act 2008*.

[14] Section 52(2)(b) of the *Coroners Act 2008*.

to be due to natural causes.[15] Patient A was an involuntary patient at the time of her death, and thus an inquest is mandatory.

10. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[16] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation, or to determine disciplinary matters.

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

12. 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.

13. 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.

14. 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.

15. 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*.[17] 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.

[15] Section 52(3A) of the *Coroners Act 2008*.
[16] *Keown v Khan* (1999) 1 VR 69.
[17] (1938) 60 CLR 336.

16. 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

17. On 13 October 2017, Patient A was formally identified by her father, [redacted].

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

18. On 16 October 2017, Dr Matthew Lynch, Senior Forensic Pathologist at the Victorian Institute of Forensic Medicine (**VIFM**), conducted an inspection on Patient A's body. Dr Lynch provided a written report, dated 11 December 2017, which concluded that Patient A died as a result of mixed drug toxicity (fentanyl, morphine, clozapine and aripiprazole).

19. Toxicological analysis of post-mortem specimens detected fentanyl[18] (~11ng/mL), morphine[19] free (~0.03 mg/L), clozapine[20] (0.7 mg/L) and aripiprazole[21] (0.1 mg/L). At my request, further testing of Patient A's post-mortem specimens was undertaken and naloxone[22] was detected in trace amounts.

20. According to the medical records, clozapine was administered to Patient A by the Swanston Centre at 8.00pm the day prior to her death, and aripiprazole was administered to Patient A by the Swanston Centre at 12.00pm on the day of her death.

21. Dr Lynch noted that the external examination showed recent venepuncture marks at the left elbow and sites of chronic intravenous access on the right. The computed tomography (CT) scan revealed nil of note.

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

[18] Fentanyl is a narcotic (opioid analgesic) used as perioperative analgesic and as an adjunct to surgical anaesthesia.
[19] Morphine is a narcotic analgesic used to treat moderate to severe pain. It is also a metabolite of codeine.
[20] Clozapine is currently available for the treatment of schizophrenia unresponsive to or intolerant of classical neuroleptics (i.e. Treatment resistant schizophrenia).
[21] Aripiprazole is an anti-psychotic drug and is indicated for the treatment of schizophrenia.
[22] Naloxone hydrochloride is a drug which can reverse opioid overdoses.

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

23. On 7 July 2017, Patient A was admitted to the Swanston Centre from PARC on an ITO after absconding and using IV morphine. She was discharged back to PARC on 14 July 2017 on a CTO. On 15 July 2017, Patient A left PARC and smoked and injected methamphetamine and morphine. Her CTO was varied to an ITO and she was transferred back to the Swanston Centre, as per her treatment plan.

24. Throughout this admission, Patient A absconded four times; on 21 August 2017, 27 August 2017, 30 August 2017 and 6 September 2017. On one of these occasions she absconded from the ward, on one occasion she absconded from unescorted leave and on two occasions she absconded from escorted leave with family members. On three occasions she returned to the ward within 4.5 hours and on one occasion she remained absent without leave overnight, for approximately 16 hours. She returned herself to the Swanston Centre either independently or in the company of a friend on three occasions, and was transported back to the ward by police on one occasion. On two occasions she reported using methamphetamine and morphine, on one occasion she reported using morphine alone and on one occasion she reported using methamphetamine and oxycontin.

25. On 12 September 2017, Patient A attended the Mental Health Tribunal and her inpatient treatment order was extended until 20 November 2017. A plan was developed for Patient A to be discharged from the Swanston Centre on 16 October 2017 to a transitional housing unit in South Geelong managed by Me Well[23], which Patient A would share with another Barwon Mental Health Services consumer. At a family meeting on 6 October 2017 attended by her parents, Patient A expressed excitement about her new accommodation. She hoped to eventually move to her own two-bedroom unit, to enable her son to stay overnight. Further, she expressed the desire to attend a Christian-based in-patient facility at some time in the future. Her consultant psychiatrist noted Patient A's excitement about her pending discharge, stating "I can't wait".

26. In the morning of 12 October 2017, Patient A was noted to be somewhat teary however declined to speak with staff or take extra medication. She went on escorted leave with her case manager from the SECU diversional team at approximately 11.30am and again declined to discuss what had made her teary earlier in the morning. Patient A did not appear overtly distressed and returned to the ward without incident. Patient A went on escorted leave with her mother in the afternoon and again returned to the ward without incident. At

[23] Me Well is a division of Neami National, who provide NDIS funded mental health services. Neami National is a community mental health service supporting people living with mental illness to improve their health and live independently.

2.10pm a nursing progress note reported Patient A to be "settled upon RTW (return to ward), compliant with meds, nil risk to self or others." At 4.42pm routine nursing observations documented Patient A to be "sitting in dining room, settled".

27. At approximately 5.00pm, Patient A ran out through the front door of the Swanston Centre. The nurse allocated to Patient A's care, the Associate Nurse Unit Manager (**ANUM**) and a number of other staff were attending to a code grey[24] regarding another patient at the time that Patient A absconded. Police were also present assisting with the code grey.

28. At 5.52pm, upon resolution of the code grey, police communications received the report of Patient A's absconding. This resulted in operational members attending premises which Patient A was known to frequent, when drug seeking. However, Patient A was unable to be located.

29. The coronial investigation revealed that, upon leaving the Swanston Centre, Patient A caught a taxi to the premises of PW in Belmont, where she borrowed money. After 20 minutes, she left the premises and caught a taxi to the premises of CM in Norlane, arriving at 5.46pm. It is unknown how long Patient A remained at CM's premises, before heading on foot toward the Princes Highway.

30. Some hours later, Patient A arrived at the Norlane premises of RW. She entered the home and awaited the return of RB, who occupied a caravan in the backyard.

31. Upon arriving at her caravan after 9.00pm, RB observed Patient A exit the rear of RW's house. Patient A entered the caravan, explaining she was in possession of drugs. RB declined Patient A's request to stay at the caravan, as she planned to visit her brother, who was unwell. Prior to Patient A leaving the caravan, RB provided her a spoon and a fresh syringe.

32. About 5-10 minutes later, RB stated she left the caravan and discovered Patient A on the ground, unconscious. She immediately called RW from the house, and together they moved Patient A to the lawn, cleared vomit from her mouth, commenced CPR and called triple '0'.

33. Prior to the arrival of paramedics, in an attempt to reverse the opioid impact, RB injected 2 doses of naloxone.[25] RB and RW continued compressions, until replaced by paramedics who arrived at 9.42pm. Paramedics performed CPR and administered adrenalin until Patient A was declared deceased at 10.16pm. Patient A at no stage regained consciousness.

[24] A code grey is a hospital-wide coordinated clinical and security response to actual or potential aggression or violence (unarmed threat). Code grey activates an internal alert or emergency response.
[25] Naloxone hydrochloride is a drug which can reverse opioid overdoses.

34. Investigators subsequently located drug paraphernalia within the caravan and used syringes and empty vials of Naloxone Juno (Narcan) within the vicinity of the caravan.

35. I am satisfied that Patient A absconded from the Swanston Centre in order to obtain and use illicit drugs. Despite a thorough investigation, Patient A's movements between approximately 6.00pm - 9.00pm are unaccounted for.

36. Despite concerns about the veracity of accounts of various individuals whose premises Patient A attended that evening, and whilst the investigation has not identified the supplier of the drugs which Patient A injected, or the means by which the drugs were injected, I am satisfied that Patient A willingly ingested the drugs which tragically resulted in an unintentional overdose.

37. Accordingly, I endorse the conclusion of my coronial investigator that the investigation has not identified suspicious circumstances.

Review of medical treatment

Barwon Health's internal review

38. Immediately following Patient A's death, on 13 October 2017, Barwon Health released a media statement related to the death of an unidentified mental health patient. The media release stated that Barwon Health had "commissioned an external review to determine the circumstances" surrounding the patient (Patient A's) death. However, on further inquiry, Barwon Health advised that the reference to an "external review" referred to the inclusion of an external consultant psychiatrist on the internal Root Cause Analysis (**RCA**) team.

39. As part of the RCA conducted by Barwon Health, a deidentified Sentinel Event Report was provided to Safer Care Victoria in accordance with reporting requirements. The Office of the Chief Psychiatrist was also notified of Patient A's death in accordance with the *Mental Health Act 2014* (Vic).

40. Barwon Health advised the RCA did not result in any clinical recommendations, however, there were four building and infrastructure recommendations identified. These recommendations were as follows:

    (a) Consult with engineering to investigate potential modifications to the operation of the sliding door and external door of the inpatient unit;

    (b) Identify alternative access points to the acute mental health ward for hotel services and consider traffic flow through the ward;

(c) Consult with building and engineering to investigate modifications to line of sight of the sliding door from the nurses' station; and

(d) Investigate options for an intensive care facility in the inpatient mental health unit.

41. On the progress of these recommendations, Barwon Health advised:

(a) Recommendation 1

- On 14 June 2018, the sliding door to the inpatient psychiatric unit and the front door of the building housing unit were synchronised so that both doors would not open at the same time.
- Additionally, since August 2019, a second set of doors between the inpatient area and the sliding exit doors to the unit now require staff swipe cards for access. This means consumers are dependent on staff to grant access to the external sliding doors.

(b) Recommendation 2

- Traffic flow was considered, and whilst there is no current plan to install a separate hotel services entrance, the changes to the main entry outlined in recommendation 1 above have created an improved access route for hotel services.
- Further, alteration to the area immediately adjacent to the doors at the existing second entrance to the unit (the ambulance bay) has created an appropriate alternative route to the main entry for hotel services.

(c) Recommendation 3

- The modifications to the second set of doors outlined in recommendation 1, now means a line of sight to the external sliding door is no longer required as the line of sight to the swipe card access doors immediately adjacent to the consumer care area is uninterrupted from the nurses' station and a consumer cannot exit unaided by staff.

(d) Recommendation 4

- At the time of Patient A's death, Barwon Health had applied to the Department of Health and Human Services for funds for the redevelopment of Barwon Health's inpatient Mental Health Unit. The grant of funds was confirmed in 2018, and covers, among other things, the development of a four bed High Dependency Unit.
- The project is currently out to tender and has a planned start date of May 2020.

42. Based on the information provided to me by Barwon Health, I am satisfied with the recommendations made and their continuing progress. I consider the current and ongoing improvements will assist in the prevention of similar events in future.

Response by the Swanston Centre

42. Patient A was documented to be settled throughout the day on 12 October 2017 with no behaviours noted that were indicative of plans to abscond. She was noted to have been somewhat teary during the morning, however based on the available documentation this was not an unusual presentation. She had utilised escorted leave with staff in the morning and with her mother in the afternoon. On both occasions, she returned to the ward without incident. The last nursing progress note at 2.10pm indicated that Patient A was settled, compliant with medication and no current risk to herself or others. The last nursing observation documented at 4.42pm indicated that Patient A was sitting in the dining room and settled.

43. The last documentation of staff suspecting that Patient A was planning to abscond was on 6 October 2017.[26] Staff were also suspicious that Patient A may abscond on 5 October 2017, however she did not.[27] When Patient A displayed behaviours indicating that she may abscond, appropriate preventative measures were taken such as limiting her leave or avoiding areas where her drug using friends lived.

44. Given there was no indication that Patient A was planning to abscond, there did not appear to be any opportunity for Swanston Centre staff to take measures to prevent Patient A from absconding. It appeared that Patient A's decision to abscond was impulsive and took advantage of the reduced level of supervision available while clinical and allied Swanston Centre staff, were attending to a code grey incident.

45. The Swanston Centre is not a locked ward, though staff are able to lock the ward when clinically indicated. When making a decision to lock the ward to prevent a patient from absconding, staff must weigh the risk of one patient absconding against the restrictions that locking the ward would place on all other patients (many of whom are voluntary patients). Staff must also weigh the risk to the patient against the aim to provide recovery-oriented and least restrictive treatment.[28]

46. At times, the immediate risk to a patient may necessitate the ward being locked and restrictions thereby being placed on all patients, however this should not be done without

[26] Barwon Health digital medical record, Nursing Visual Observations and Engagement Record dated 6 October 2017, page 63 of 1127.
[27] Barwon Health digital medical record, progress note dated 5 October 2017 at 9.00pm, page 605 of 1127.
Barwon Health digital medical record, progress note dated 5 October 2017 at 2.00pm, page 608 of 1127.
[28] https://www2.health.vic.gov.au/mental-health/practice-and-service-quality/service-quality/recovery-oriented-practice-in-mental-health.

due consideration of the consequences. Patient A was known to have a significant history of absconding, however, this alone would not be a reason to keep the ward locked for the duration of her admission and in doing so, also restrict all other patients.

47. Patient A's history of absconding indicated that her primary goal for absconding was to use substances, she often returned to the ward of her own volition and rarely came to significant harm after absconding. This pattern of behaviour continued during the current admission, during which she absconded on four previous occasions, returning of her own volition three times and agreeing to accompany police back to the Swanston Centre on one occasion.

48. There was evidence that the Swanston Centre staff implemented interventions to reduce Patient A's absconding risk without restricting other patients on the ward. This was done by nursing staff being vigilant to warning signs of absconding, providing regular periods of leave to reduce feelings of restriction, restricting leave when immediate signs of intent to abscond were observed, and discussing and addressing with Patient A the factors that made her want to abscond.

49. There were no immediate signs that Patient A was planning to abscond on 12 October 2017, and there had not been over the previous six days. It appeared that Patient A was not planning to abscond, but made an impulsive and opportunistic decision when a reduced level of supervision was available. Patient A had spent a significant amount of her life in mental health wards and therefore would have been cognizant of a temporarily reduced staffing level when a code grey was called.

50. In consideration of Patient A's extensive history of absconding from the Swanston Centre and using illicit substances before returning herself to the ward, Patient A was not considered at imminent risk of harm to herself or others after absconding from the Swanston Centre. The clinical decision was made to report Patient A's absconding to police, as soon as the code grey was managed. I consider in all the circumstances, this decision was not unreasonable.

Access to means

51. RB stated that she administered two doses of naloxone to Patient A after she was located unresponsive.

52. Barwon Health have advised that RB is recorded as receiving training in the use of naloxone at Barwon Health and was subsequently prescribed naloxone on a number of occasions from the Barwon Health Pharmacy. Further, post mortem toxicology of specimens identified trace amounts of naloxone. In addition, two empty ampules of naloxone (Naloxone Juno) were

found at the scene[29]. Barwon Health has corroborated RB's explanation to investigators that she was prescribed naloxone by Barwon Health to reverse the effects of overdose. According to the Barwon Health *Take Home Naloxone* consumer pamphlet, consumers are encouraged to promptly call triple '0' following an overdose.

Conclusion

53. Based on Patient A's history and her presentation throughout 12 October 2017, it appears as though her absconding from the Swanston Centre was impulsive and opportunistic. There were no indications throughout the day that would have alerted Swanston Centre staff to an increased risk of absconding and therefore no need to alter Patient A's treatment accordingly. Based on the available information, the Swanston Centre staff took appropriate steps after Patient A absconded, including informing Police, her next of kin and the consultant psychiatrist. Consequently, no issues were identified with the treatment provided by the Swanston Centre, and I am satisfied with Barwon Health's RCA recommendations and outcomes.

54. The provision of Naloxone Juno and syringes to RB appeared to be in line with the relevant Barwon Health procedure and the DHS *Victorian Needle and Syringe Program Operating Policy and Guidelines* written in 2001 and updated in 2008. Barwon Health procedure stated that Barwon Health provide naloxone in both ampoules and prefilled syringes.

55. It is unclear where Patient A obtained the fentanyl and morphine, and further, whether Patient A self-injected the drugs or was assisted at her request. According to Patient A's parents[30] and the medical record,[31] Patient A had a history of asking others to inject her as she disliked injecting herself. While she was known to use IV morphine, there was no evidence in the medical record that Patient A had a history of fentanyl use. Whether or not Patient A was assisted with administration, it remains a matter of speculation whether she knew fentanyl was being injected, and if so, whether Patient A was aware of the overdose risk posed by fentanyl.

56. Fentanyl has a potency approximately 75 to 100 times greater than morphine. The risk of fentanyl toxicity is recognised to be particularly dangerous because of the drug's potency and rapid onset of action; even a small dose can lead to sudden death[32].

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[29] Pages 75 and 82 of coronial brief.
[30] Statement of Susan Brown dated 27 October 2017, page 14, para 34 of coronial brief.
Statement of [redacted] dated 27 October 2017, page 17, para 8 of coronial brief.
Statement of [redacted] dated 27 October 2017, page 18, para 12 of coronial brief.
[31] Barwon Health digital medical record, Risk Assessment History and Context dated 14 September 2017, page 958 of 1127
[32] H Bagheri, et al., "Determination of fentanyl in human plasma by head-space solid-phase microextraction and gas chromatography–mass spectrometry", Journal of Pharmaceutical and Biomedical Analysis, vol 43, no 5, April 2007, p.1763; Martin, et al., "Fentanyl-related deaths in Ontario, Canada", p.603.

57. Patient A was fentanyl naïve and I am satisfied her tragic death was unintentional. Further, I am satisfied that Patient A was either unaware of the inherent toxicity of fentanyl, or was unaware she was taking fentanyl.

58. Finally, I note that, despite the significant challenges posed by Patient A's mental ill-health which was exacerbated by her propensity to self-medicate with illicit drugs, her family never stopped loving or supporting her.

FINDINGS

59. Having investigated the death of Patient A, and having held an Inquest in relation to her death on 13 March 2020, at Melbourne, I make the following findings pursuant to section 67(1) of the Act:

    (a) the identity of the deceased was Patient A, born [redacted];

    (b) the death occurred on 12 October 2017 at Norlane Victoria, from mixed drug toxicity (fentanyl, morphine, clozapine and aripiprazole); and

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

60. I convey my sincerest sympathy to Patient A's family.

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

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

    (a) Patient A's family, senior next of kin;

    (b) Investigating Member, Victoria Police; and

    (c) Interested Parties.

Signature:

Coroners Court of Victoria

CORONER JOHN OLLE

Date: 13 March 2020