IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2017 4664

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

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

Findings of:	Paresa Antoniadis Spanos, Coroner
Deceased:	John Alexander King
Date of birth:	6 May 1957
Date of death:	Between 14 and 15 September 2017
Cause of death:	Mixed Drug Toxicity
Place of death:	Ringwood North

INTRODUCTION

1. Mr King was a 60-year old man who resided in Ringwood North and was the father of two sons.

2. Mr King had a history of depression and schizophrenia. He was primarily treated by his General Practitioner (**GP**), Dr Josephine Kavanagh, and remained relatively stable for several years while using prescription medications trifluoperazine and doxepin.

3. Mr King's medical history also included long-standing chronic degenerative condition of the lumbar spine, chronic obstructive pulmonary disease caused by heavy cigarette smoking, morbid obesity and hypertension.

CIRCUMSTANCES IMMEDIATELY PROXIMATE TO DEATH

4. At about 10.15pm on 13 September 2017, Mr King contacted his friend, Simon Read, and said he was not feeling well and was very down on himself. As Mr Read was aware that Mr King suffered from a mental illness and needed medication, he took Mr King to the Maroondah Hospital ED.

5. Mr King arrived at the Maroondah Hospital ED and was triaged at 11.38pm. He told the triage nurse that he was experiencing a decline in his mental health, paranoia, delusions and depression. At 1.59am on 14 September 2017, the triage nurse noted that Mr King's symptoms appeared to be worsening with no improvement after taking his own supply of prescribed diazepam and he was given olanzapine, an antipsychotic.

6. On review by the ED doctor, Dr Emily King-Oakley, at 3.40am, Mr King reported low mood, little sleep and that he had stopped taking trifluoperazine in December 2016. Mr King strongly believed that his house was 'bugged', that people were trying to kill him and that he was the devil. Dr King-Oakley documented that Mr King appeared to be agitated with pressured speech, loud volume, was unable to answer questions and continued to talk while in the room alone. She documented an impression that Mr King was psychotic and referred him to the mental health team.

7. At 4.18am and 6.26am, the triage nurse documented that Mr King's symptoms continued to worsen and that he had become more erratic, agitated and spoke continuously despite nobody being present. Mr King refused further antipsychotic medication.

8. Due to unscheduled leave, Maroondah Hospital had no mental health staff working overnight and Dr King-Oakley suggested that Mr Read take Mr King to Box Hill Hospital but Mr King

was unwilling to leave Maroondah Hospital. At 7.25am, Dr King-Oakley documented that Mr King had remained agitated over the previous five hours but was never aggressive. Mr King said he was not willing to wait any longer and left the ED. Dr King-Oakley did not consider Mr King to be at acute risk of harm to himself or others at that time but noted a risk of self-neglect and that his level of risk was difficult to predict due to the symptoms of psychosis.

9. Mr King and Mr Read were provided with contact details for the local mental health team prior to leaving the hospital. Dr King-Oakley asked the triage nurse to consult ED care coordinators to ensure that Mr King would be seen by a mental health service in the community.

10. The following day, on 14 September 2017, Mr Read contacted Mr King and did not note any apparent concerns. Mr Read attempted to again contact Mr King later that day but did not receive a response.

11. At about 11.00am on 15 September 2017, Mr Read again attempted to contact Mr King without success before driving to his home around midday and finding that Mr King did not answer the door. Mr Read then called Victoria Police and asked them to conduct a welfare check on his friend.

12. Victoria Police members attended Mr King's home a short time later and, after forcing entry, found Mr King deceased inside his home.

PURPOSE OF A CORONIAL INVESTIGATION

13. The purpose of a coronial investigation of a reportable death is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[1] For coronial purposes, *death* includes suspected death.[2]

14. The *cause* of death refers to the *medical* cause of death, incorporating where possible the *mode* or *mechanism* of death. For coronial purposes, the *circumstances* in which death occurred refers to the context or background and surrounding circumstances but is confined

[1] Section 67(1).

[2] See the definition of "death" in section 3 of the Act.

to those circumstances sufficiently proximate and causally relevant to the death, and not all those circumstances which might form part of a narrative culminating in death.[3]

15. The broader purpose of any coronial investigations is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of recommendations by coroners, generally referred to as the *prevention* role.[4]

16. Coroners are empowered to report to the Attorney-General in relation to a death; 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 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.[5] These are effectively the vehicles by which the coroner's prevention role can be advanced.[6]

17. Coroners are not empowered to determine the civil or criminal liability arising from the investigation of a reportable death and are specifically prohibited from including in a finding or comment any statement that a person is, or may be, guilty of an offence.[7]

CORONIAL INVESTIGATION

18. One of the members was Detective Acting Sergeant (**Det A/g Sgt**) Matthew Phelan, who investigated Mr King's death and compiled the coronial brief on which this finding is largely based. Det A/g Sgt Phelan reported that numerous used and unused prescription medications and packages were located throughout Mr King's home. He also noted that Mr King was wearing his jewellery when he was found, something which he had not done for several years according to those who knew him. No suicide or evidence of any message in any other media indicating an intention to take his own life was found in Mr King's home.

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[3] This is the effect of the authorities – see for example *Harmsworth v The State Coroner* [1989] VR 989; *Clancy* v *West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J.)

[4] The 'prevention' role is now explicitly articulated in the Preamble and purposes of the Act, compared with the *Coroners Act 1985* where this role was generally accepted as 'implicit'.

[5] See sections 72(1), 67(3) and 72(2) regarding reports, comments and recommendations respectively.

[6] See also sections 73(1) and 72(5) which requires publication of coronial findings, comments and recommendations and responses respectively; section 72(3) and (4) which oblige the recipient of a coronial recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation.

[7] Section 69.

IDENTIFICATION

19. John Alexander King was visually identified by his friend, Simon Read, who signed a Statement of Identification before police on 15 September 2017. Identity was not an issue and required no further investigation.

20. I formally find that the deceased's identity is John Alexander King, born 6 May 1957, late of a Ringwood North address.

MEDICAL CAUSE OF DEATH

21. On 18 September 2017, senior forensic pathologist Dr Matthew Lynch, from the Victorian Institute of Forensic Medicine (**VIFM**), reviewed the police report of death to the coroner, information from the VIFM contact log and post-mortem computed tomography scanning of the whole body (**PMCT**) and performed an external examination on the body of Mr King in the mortuary.

22. Dr Lynch advised that PMCT revealed coronary artery calcification, increased lung markings and no obvious pill residue within the stomach, and external examination revealed no evidence of significant traumatic injury.

23. Routine toxicological analysis of post-mortem blood specimens taken from Mr King detected codeine,[8] oxycodone,[9] diazepam and its metabolite, nordiazepam, temazepam,[10] doxepin,[11] paracetamol,[12] verapamil[13] and olanzapine.[14] The toxicologist's report advised that the levels detected were consistent with excessive and potentially fatal use.

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[8] Codeine is a narcotic analgesic related closely to morphine but having approximately one-tenth the activity of morphine as an analgesic and possessing antitussive activity.

[9] Oxycodone is a semi-synthetic opiate narcotic analgesic related to morphine and used clinically to treat moderate to severe pain.

[10] Diazepam, temazepam and oxazepam are all sedative or hypnotic drugs of the benzodiazepine class which may be prescribed separately but may also derive from the metabolism of diazepam.

[11] Doxepin is a prescription anti-depressant medication.

[12] Paracetamol is an analgesic drug available in many proprietary products either by itself or in combination with other drugs such as codeine and propoxyphene. The level of paracetamol was particularly high at ~431mg/L where the minimum lethal dose is about 10mg/L and liver toxicity and necrosis may occur at plasma concentration of 120-300mg/L.

[13] Verapamil is a drug used to treat high blood pressure, angina and irregular heart beat (arrhythmias).

[14] Olanzapine is indicated for the treatment of schizophrenia and related psychoses. It can also be used for mood stabilisation and as an anti-manic drug.

24. Dr Lynch advised that it would be reasonably to attribute Mr King's cause of death to *mixed drug toxicity*, without the need for an autopsy.

25. Based on Dr Lynch's advice the toxicologist's report, I find that the medical cause of Mr King's death is mixed drug toxicity.

CIRCUMSTANCES IN WHICH DEATH OCCURRED

26. In December 2016, Mr King's prescription for trifluoperazine was unable to be filled due to the medication being discontinued by the manufacturer. He attended the Maroondah Hospital Emergency Department (**ED**) and was provided with three days' supply.

27. Mr King's GP, Dr Kavanagh, contacted Eastern Health Psychiatric Triage for advice about an alternate antipsychotic medication. The outcome of this consultation was not evident in the Eastland Natural Health medical record and a complete copy of the Eastern Health Psychiatric Triage record was not available. However, Dr Kavanagh reported that Mr King declined to take any other antipsychotic medication.

28. Mr King last saw Dr Kavanagh on 7 September 2017, at which time she documented that he had again declined an alternative antipsychotic or referral to a mental health service. Dr Kavanagh recorded no indication that Mr King presented as an acute risk of harm to himself or others at that time.

CORONERS PREVENTION UNIT

29. Given the circumstances in which Mr King died, I sought advice from a Mental Health Investigator (**MHI**)[15] from the Coroners Prevention Unit (**CPU**).[16] An MHI from CPU conducted a review of the mental health treatment afforded to Mr King by both Dr Kavanagh and Eastern Health (the Maroondah Hospital).

[15] MHIs are employed within the CPU and are qualified and experienced psychiatric nurse or psychologists independent of the healthcare professionals involved who review the medical records and, where appropriate the literature, and advise the coroner about the adequacy of the clinical management and care provided to the deceased by reference to current standards of healthcare, with a particular focus on whether the death was preventable or reveals any systemic issues in healthcare delivery.

[16] The CPU was established in 2009 to assist coroners with fulfillment of their prevention role. More specifically, CPU assists coroners with the investigation of deaths occurring in a healthcare setting. The CPU is staffed by healthcare professionals, including practising physicians and nurses, who are independent of the health professionals and institutions involved in the clinical management and care of the deceased and who draw on their medical, nursing and research experience to evaluate the clinical management and care provided in particular cases by reviewing the medical records, the autopsy report and any particular concerns which have been raised by family or other parties.

30. In relation to the availability of trifluoperazine, the MHI advised that the drug was discontinued by the manufacturer[17] causing supply problems from late 2016 and it was removed from the market in January 2018.

31. The MHI noted the evidence that Dr Kavanagh sought advice from Eastern Health psychiatric triage regarding an alternative antipsychotic medication for Mr King. Dr Kavanagh's clinic (Eastland Natural Health) medical records do not indicate the response from the Eastern Health Psychiatric Triage and the medical records from Eastern Health Psychiatric Triage were unavailable to the MHI. However, the MHI found that the clinic medical records and Dr Kavanagh's statement both indicate that Mr King declined to start alternate antipsychotic medication when trifluoperazine became unavailable.

32. As there was no evidence that Mr King was experiencing psychotic symptoms or presenting as an imminent risk at the time of his last consultation with Dr Kavanagh on 7 September 2017, he was unable to be treated as a compulsory patient under the *Mental Health Act* 2014 (Vic) (**MHA**), and to be compelled to comply with an alternative antipsychotic medication regime.

33. The MHI also considered the availability of mental health services at the Maroondah Hospital. According to Maroondah Hospital medical records, no mental health staff were working on the night that Mr King presented to the ED. Mr King was advised to present to Box Hill Hospital for a mental health assessment but initially stated that he wished to wait. After awaiting mental health services for about seven hours, Mr King left Maroondah Hospital ED.

34. Further information was sought from Eastern Health regarding the frequency with which mental health services are unavailable in the Maroondah Hospital ED, and the process in place to address this in order to assist in determining whether there is scope for improved practice so as to prevent deaths occurring in similar circumstances in the future.

35. The MHI noted that according to Eastern Health medical records, Mr King presented with psychotic symptoms, which worsened over the course of his ED admission. While he accepted oral antipsychotic medication initially, towards the end of the admission he declined further medication and declined to remain at the hospital for a mental health assessment. The

[17] Amdipharm Mercury Pty Ltd.

MHI found nothing to suggest that Mr King presented at imminent risk when he left the ED and he did not satisfy the criteria for compulsory treatment under the MHA.

36. According to the medical records, the triage nurse was to refer Mr King to the ED care coordinators to ensure that he received follow-up care in the community after leaving. Furthermore, Dr King-Oakley made a referral to the mental health team at about 3.40am. As such, when the mental health team became staffed during the day, it was possible that they may have become aware of Mr King's overnight presentation. However, there is nothing in the medical record to indicate that the triage nurse made a referral to the ED care coordinators as planned. As mental health medical records were unavailable to the MHI, it is unknown whether any follow-up care was provided to Mr King after he left. Given his presentation, it would have been reasonable for Eastern Health mental health services to provide follow-up care to Mr King the following day.

37. At my direction, Eastern Health were asked to provide a statement in relation to these issues. In a statement dated 9 August 2018, Ms Ebony Sharma, Manager of the Mental Health Triage Team, explained that there are usually two overnight psychiatric triage clinicians at Eastern Health - one at Maroondah Hospital and the other at Box Hill Hospital. In the event of unplanned leave at short notice in circumstances where an absent clinician cannot be replaced, the remaining clinician is deployed to the busier of the two EDs and provides secondary consultation to the unstaffed ED. If there are no psychiatric triage clinicians available, the ED doctor can liaise with the on-call consultant psychiatrist, the on-call mental health manager or the ED Consultant in Charge. Ms Sharma also noted that an ED doctor can also make a patient subject to an inpatient assessment order under the MHA if the patient satisfies the criteria.

38. The MHI also considered an earlier statement dated 3 May 2018 provided by Ms Jessica Counsel from Eastern Health, in which Ms Counsel advised that an electronic referral was made to psychiatric triage at 12.46am but there was no psychiatric triage clinician available due to sick leave.[18] However, there was nothing to suggest that Maroondah Hospital ED staff contacted the psychiatric triage clinician at Box Hill Hospital for secondary consultation in accordance with the process outlined by Ms Sharma. They did consider an assessment order pursuant to the MHA but did not consider that Mr King met the criteria for compulsory treatment and the MHI concurred with this view.

[18] The clinician had attended at the commencement of the shift but had left due to illness around midnight.

39. While the process described by Ms Sharma allows for advice from mental health staff to be provided to ED staff in relation to the management of a patient who presents with mental health concerns, it does not allow for patients to receive a timely assessment by a mental health clinician in the event of unplanned sick leave.

40. The MHI also considered the follow-up care provided by the Eastern Health Psychiatric Triage Service (**PTS**). Mr King left the Maroondah Hospital ED at 7.25am and a referral was made to PTS at 7.50am. The referral advised that Mr King had presented with a relapse of psychosis after ceasing trifluoperazine in December 2016; was agitated but not aggressive at the time of his ED admission; was assessed by the ED doctor as being at "no acute risk of harm to self or others"; was at risk of self-neglect; and presented with risk that was difficult to predict due to psychosis. Further, the PTS was informed that Mr King left in the company of Mr Read, who appeared sensible and who was given information about how to contact mental health services.

41. The MHI noted that the PTS contacted Mr Read by telephone at 9.15am on 14 September 2017 and he reiterated Mr King's symptoms. A plan was made for the PTS to contact Mr King and then to advise Mr Read of the outcome of that call. The PTS made five attempts to contact Mr King that day and a message was left for Mr Read, asking him to call the PTS. Mr Read contacted the PTS at 7.00pm and a plan was made for him to attend Mr King's home to facilitate an assessment by the PTS. Mr Read advised the PTS that as Mr King often slept until about midday and he planned to attend his home at about that time.

42. Mr Read attended Mr King's home at about midday as discussed with the PTS and then contacted the PTS to say that he had knocked on the front door of Mr King's home for some 30 minutes and had not received a response. Mr Read then called police asking for a welfare check.

43. The MHI advised that the PTS made reasonable attempts to contact Mr King after his voluntary discharge from the ED and sought collateral information from Mr Read. The decision to have Mr Read assist with an assessment was reasonable. As no acute risks of harm to himself or others were noted during Mr King's ED admission and given Mr Read's advice that Mr King often slept until midday, it was reasonable for the PTS to wait until that time to make contact.

PROPOSED COMMENTS AND RECOMMENDATION

44. On 6 August 2019, Eastern Health were appraised of the state of the coronial investigation, my intention to make comments and recommendations[19] about potential improvements in patient safety and invited to provide any additional relevant material.

45. Dr Jose Segal, Clinical Director, Adult Community Mental Health Program provided Eastern Health's response. He agreed that the timeliness of mental health assessment is of critical importance to patients and commented that the subject was addressed in Eastern Health's submissions to the Royal Commission into Victoria's Mental Health System. The submissions went on to recommend the incorporation of Emergency Department Access Hubs which would enable people who need urgent mental health treatment to access the specialist care they need, freeing up busy ED's to treat other patients.

46. As well as advocating for structural reforms, Dr Segal advised of other significant initiatives to address the need for improvements in access to specialist mental health assessment, including -

a. In June 2019, the introduction of Mental Health Program Coordinators (**MHPC**),[20] who are rostered on 24 hours per day, seven days a week to provide support for after hours ED mental health assessments and to coordinate resources after hours. The role is required to work across the 24-hour continuum of care, with primary functions of management of access, staffing and resource requirements of unplanned absences and clinical leadership to the after-hours workforce. If there was an unplanned staff absence the MHPC would create a plan and arrange resources to be secured or diverted if possible, and if necessary, the MHP would assist in the ED, via telehealth or in person.

b. Implementing changes to improve recruitment and create flexibility in the workforce to enhance access to acute mental health assessment and treatment services. These changes involve reorganising staff into one pool, rotating them through the various functions and redirecting staff to areas of particular need to meet demand.

[19] See pages 12 to 13 below.

[20] In December 2019, Dr Segal clarified that this is a new, additional resource to existing ED staffing. All staff in the MHPC role are at the level of a Registered Professional Nurse level 5, Social Worker, Occupational Therapist level 4 with a minimum of ten years of specialist mental health experience and equivalent management experience in mental health.

c. Expansion of the use of telehealth which had been operational at the Angliss Hospital ED for a number of years. As at September 2019, telehealth was in the final stages of becoming fully operational at the Box Hill Hospital and Maroondah Hospital ED's and the procedures already in place at the Angliss Hospital were being adapted to suit. Also, telehealth had been used by the MHPC's to undertake overnight assessments to facilitate access to urgent specialist psychiatric assessment.

d. Restructuring the Access Teams (which includes Crisis Assessment and Treatment Team, ED Response, telephone triage and police liaison) to improve the responsiveness of the service. "Access Leads" are at grade 5 level (Registered Nurse, Social Work or Occupational Therapist), work morning and evening shifts covering from 7.30am to 10pm daily (including weekends), and are primarily responsible for managing demand, coordinating resources, providing an escalation point for difficult issues and providing operational management. The role has improved workforce flexibility to cover unplanned vacant shifts and assist during periods of high demand in the ED, including undertaking clinical work in exceptional circumstances.

FINDINGS/CONCLUSIONS

47. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the *Briginshaw* gloss or explications. [21]

48. Adverse findings or comments against individuals or institutions are not to be made with the benefit of hindsight but only on the basis of what was known or should reasonably have been known or done at the time, and only where the evidence supports a finding that they departed materially from the standards of their profession and in so doing caused or contributed to the death under investigation.

49. Applying the standard of proof to the available evidence my conclusions are that:

a. Mr King died at 4/101 Warrandyte Road, Ringwood North between 14 and 15 September 2017.

[21] *Briginshaw v Briginshaw (1938) 60 C.L.R. 336 esp at 362-363. "The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences…"*

b. While there is evidence that he ingested an excessive quantity of the drugs to which he succumbed, I am unable to make a positive finding that Mr King intended to end his own life due to the confounding effect of the recent deterioration of his mental state and and the likelihood that his judgement was impaired at the time he ingested the drugs.

c. When Mr King presented to Maroondah Hospital ED on the evening of 13 September 2017 accompanied by his friend Mr Read, he reported a decline in his mental health, including a recurrence of paranoia and delusions, and his observed clinical presentation deteriorated while he remained in the ED.

d. Mr King was not offered a timely mental health assessment while he remained in the ED for over seven hours, in the context of unplanned staff leave.

e. This amounted to a missed opportunity to undertake a comprehensive assessment of Mr King's needs and to determine whether any short-term interventions, such as recommencement of antipsychotic medication, may have improved his mental state and reduced his risk.

f. Eastern Health had a procedure in place for ED staff to access specialist mental health staff, that procedure was not followed and may have improved timely access to a specialist mental health assessment.

COMMENTS

Pursuant to section 67(3) of the ***Coroners Act 2008,*** I make the following comments on a matter/s connected with the death, including matters relating to public health and safety or the administration of justice:

1. The Department of Health and Human Services (**DHHS**) supports the use of telehealth[22] for healthcare delivery to remove the barriers experienced by consumers and professionals which can prevent or delay the delivery of timely and appropriate healthcare services. The Medical Board of Australia and the Australian Nursing and Midwifery Federation also support the use of telehealth.

2. The use of telehealth by psychiatric triage clinicians would increase the opportunities for patients in both the Maroondah Hospital and Box Hill Hospital EDs to receive timely mental

[22] Telehealth refers to the use of information and communication technologies used to provide health care and related process (such as education).

health assessments, especially in circumstances when unplanned staff leave (or high demand) may limit resources to one or both hospitals.

3. The use of telehealth in Mr King's case would have provided an opportunity for Mr King to be assessed by psychiatric triage in a timely manner, despite the unplanned sick leave of the mental health clinician rostered to work at Maroondah Hospital ED that night, and Mr King's refusal to attend the Box Hill Hospital ED.
4. Through Dr Segal, Clinical Director, Adult Community Mental Health Program, Eastern Health have advised of a number of improvements made following (but not necessarily as a consequence of Mr King's death) which should minimise the risk that a person presenting to an ED in the same circumstances as Mr King would not receive a timely specialist mental health assessment and treatment where indicated.
5. The nature and extent of the improvements made by Eastern Health are impressive and I commend them for their work in this regard.

RECOMMENDATION

Pursuant to section 72(2) of the ***Coroners Act 2008***, I make the following recommendation on a matter connected with the death, including recommendations relating to public health and safety or the administration of justice:

1. To enhance the suite of improvements already made, I recommend that Eastern Health considers the use of video conferencing at Box Hill Hospital ED and Maroondah Hospital ED to enable clinician to access specialist mental health clinicians to assess patients in the ED when specialist mental health clinicians are unavailable at their campus.

PUBLICATION OF FINDING

Pursuant to section 73(1A) of the Act, I order that this finding, comments and recommendation made following the investigation of Mr King's death be published on the Internet in accordance with the rules.

DISTRIBUTION OF FINDING

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

The family of Mr King

Dr Josephine Kavanagh

Eastern Health

Office of the Chief Psychiatrist

Detective Acting Sergeant Matthew Phelan (#28900) c/o O.I.C. Maroondah Police

Signature:

PARESA ANTONIADIS SPANOS

Coroner

Date: 23 April 2020