IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2017 1877

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

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

Findings of:	Paresa Antoniadis Spanos, Coroner
Deceased:	Joshua Brown
Date of birth:	16 November 1959
Date of death:	Between 20 and 22 April 2017
Cause of death:	1(a) Clozapine toxicity on a background of right lower lobe of lung lesion (unspecified aetiology)
Place of death:	125/25 King Street, Prahran, Victoria 3181

INTRODUCTION

1. Joshua Brown was born in Adelaide on 16 November 1959 and moved to Melbourne when he was about 50 years old. According to his mother, Christine Kinnane, the move was prompted by his dislike of the hot Adelaide summers.

2. Mr Brown was a single man who lived alone in a public housing apartment at 125/25 King Street, Prahran, where he was found deceased on 22 April 2017. He had maintained regular contact with his mother via weekly phone calls and was good spirits and seemed happy when she last spoke to him the week before his death.

CIRCUMSTANCES IMMEDIATELY PROXIMATE TO DEATH

3. As Mr Brown lived within the Alfred Health catchment, he was involved with the Alfred Health mental health service and their partners since shortly after his move to Melbourne. After an inpatient admission in January 2017, preceded by a period of non-compliance with his medication regime, Mr Brown was being managed in the community with support from the Alfred and Waiora Community Continuing Care Team (Waiora) and Star Health, a Mental Health Community Support Service (Star Health).[1]

4. Mr Brown missed a scheduled morning appointment with Suzanne Ross, his Star Health Case Manager, on 20 April 2017, however she did manage to contact him on the telephone at about 3.00pm that day. He seemed disoriented and confused during the telephone call, prompting Ms Ross to report her concerns to the Waiora team through established channels. One of Mr Brown's neighbours saw him alive when they crossed paths in the apartment complex at about 11.30am on 20 April 2017. His presentation did not arouse any concerns in his neighbour for his welfare.

5. Ms Ross's message was received by Mr Brown's Case Manager on 21 April 2017 and members of the Alfred Health Crisis Assessment Team (CAT) attempted a home visit on 21 April 2017. When they knocked on the door of Mr Brown's home and there was no answer, they left a calling card.

[1] Star Health is a Mental Health Community Support Service, a voluntary service providing psychosocial support to clients. The service is not a crisis service and does not replace area mental health services. The service works collaboratively with Alfred Health. The Alfred and Waiora Community Health Continuing Care Team (Waiora) used the "stepped" approach whereby client services are stepped up or down depending on the client's needs. Final decisions about Mr Brown's treatment were made by or involved the treating team at Waiora. All steps, such as contact with other Alfred Health services, including CATT, admissions to hospital or a Prevention and Recovery Centre (PARC), were to go through Waiora.

6. At about 5.00pm on Saturday 22 April 2017, members of Victoria Police were requested to conduct a welfare check on Mr Brown accompanied by Wesley Wapschott, a CAT clinician who knew Mr Brown well and provided a set of keys to the apartment.

7. Mr Brown was found deceased lying on his back on his bed. He had vomit on his face and mouth and appeared to have vomited tablets. Police found traces of vomit in the kitchen, a plastic bag containing in excess of 50 tablets of Clozapine in the kitchen and tablets strewn on the floor throughout the apartment.

CORONIAL INVESTIGATION

8. This finding is largely based on the investigation and brief compiled by Coronial Investigator (CI) Senior Constable Ryan Gilmore at my request and direction which includes statements from Ms Kinnane, Mr Brown's neighbour, the CI, scene photographs and Mr Brown's patient profile from the Prahran Amcal Pharmacy.

9. Whilst not provided to the CI for inclusion in the brief, I have also based this finding on a statement of Dr Nicky Zigouris, Alfred Health Consultant Psychiatrist in the Mental Health Quality and Risk department dated 3 December 2018 and a statement of Suzanne Ross, Mental Health Recovery Practitioner at Star Health dated 2 May 2018.

10. The coronial investigation was also informed by one of the Court's in-house mental health clinicians/investigators within the Coroners Prevention Unit (CPU) who reviewed the Alfred Health medical records, Medicare and Pharmaceutical Benefits Scheme (PBS) records and other available evidence and advised about aspects of Mr Brown's clinical management and care by reference to current standards.

PURPOSE OF A CORONIAL INVESTIGATION

11. The purpose of a coronial investigation of a *reportable death*[2] is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[3] In this case, Mr Brown's death was reported it appeared to be unexpected and/or unnatural.

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[2] The term is exhaustively defined in section 4 of the ***Coroners Act 2008*** [the Act]. Apart from a jurisdictional nexus with the State of Victoria a reportable death includes deaths that appear to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from an accident or injury; and, deaths that occur during or following a medical procedure where the death is or may be causally related to the medical procedure and a registered medical practitioner would not, immediately before the procedure, have reasonably expected the death (section 4(2)(a) and (b) of the Act).

[3] Section 67(1).

12. 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 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.[4]

13. The broader purpose of any coronial investigation 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.[5]

14. 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.[6] These are effectively the vehicles by which the coroner's prevention role can be advanced.[7]

15. It is important to stress that 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.[8]

IDENTIFICATION

16. On 22 April 2017, Joshua Brown born on 16 November 1959 was identified by Wesley Wapschott who had known him for nine years and signed a formal Statement of

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[4] 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.)

[5] 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'.

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

[7] 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.

[8] Section 69(1). However, a coroner may include a statement relating to a notification to the Director of Public Prosecutions if they believe an indictable offence may have been committed in connection with the death. See sections 69 (2) and 49(1).

Identification to this effect before a member of Victoria Police. Mr Brown's identity was not in issue and required no further coronial investigation.

MEDICAL CAUSE OF DEATH

17. Mr Brown's body was brought to the Coronial Services Centre. Senior forensic pathologist Professor Stephen Cordner, from the Victorian Institute of Forensic Medicine (VIFM), reviewed the Police Report of Death for the Coroner (Form 83), post-mortem CT scanning of the whole body undertaken at VIFM (PMCT) and performed an external examination of the body in the mortuary.

18. Having done so, Prof Cordner provided a four-page report of his findings. On review of the PMCT, Prof Cordner found a lesion in the right lower lobe of the lung which was not previously known. The precise nature of this lesion and its potential consequences for Mr Brown's health had he lived, are unclear. Otherwise, PMCT revealed nothing of consequence, and relevantly, disclosed no significant natural disease or traumatic injury of a type likely to cause or contribute to death. Nor was there any evidence of traumatic injury on external examination of Mr Brown's body.

19. Routine toxicological analysis of post-mortem samples taken from Mr Brown's body detected clozapine at a concentration of ~ 11mg/L, described by the toxicologist as consistent with excessive and potentially fatal use. No ethanol (alcohol) or other commonly drugs or poisons were detected.

20. Clozapine[9] is available in Australia as "Clozaril" and "Clopine" and is indicated for the treatment of schizophrenia unresponsive to or intolerant of classical neuroleptics, otherwise referred to a treatment-resistant schizophrenia. It is not generally administered as first line treatment for schizophrenia; is a highly regulated drug given in titrated doses initially until a therapeutic dose is achieved for the individual patient; is administered subject to strict protocols including regular screening for known adverse side-effects; and needs strict medication compliance due to risks associated with stopping and re-starting therapy.

[9] Clozapine is a psychoactive medication, specifically a second-generation antipsychotic medication used in treatment resistant schizophrenia. There is ample evidence for the psychological benefits to many patients who take the drug, however, the side effects are also many and range from mild to life-threatening. Prescribing only follows evidence of the failure of a patient to respond to other antipsychotic therapy and/or in whom such therapy produces intolerable adverse effects. Clozapine is part of the Commonwealth Highly Specialised Drugs Program and only registered centres should prescribe it and then only medical practitioners registered at each of those centres.

21. According to the toxicologist's report, in a review of deaths in the UK and Ireland caused by self-poisoning with clozapine, the median post-mortem blood clozapine and norclozapine (a clozapine metabolite) concentrations were 8.2 (3.7-12) and 1.9 (1.4-2.4) mg/L, respectively. These overdoses were in poorly compliant or non-adherent patients or those who had taken clozapine prescribed to someone else. In 54 further deaths of people who were prescribed clozapine, the median post-mortem blood clozapine and norclozapine concentrations were 1.9 (0-7.7) and 1.4 (0-6.9) mg/L, respectively.[10]

22. Furthermore, in a review of deaths attributed to clozapine undertaken by VIFM, there was evidence of blood concentrations from 8-100mg/L. These deaths occurred following an overdose to the rug, that is ingestion of a single large amount leading to death, rather than as a consequence of long-term therapy.

23. Noting the toxicology results, Prof Cordner concluded by advising that, without autopsy, Mr Brown's death could reasonably be attributed to *1(a) probable clozapine toxicity on a background of right lower lobe of lung lesion (unspecified aetiology).*

24. Since Prof Cordner's report was received, the history of Mr Brown's clozapine therapy and dosage has been elucidated by the coronial investigation,[11] and I find that the medical cause of Mr Brown's death is clozapine toxicity on a background of right lower lobe of lung lesion (unspecified aetiology).

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

25. The focus of the coronial investigation of Mr Brown's death was on (a) the clinical management and care provided to him in the days immediately preceding his death, (b) his access to excess quantities of clozapine and (c) whether or not he intentionally took his own life.

26. Mr Brown was last seen by Suzanne Ross, his Star Health Case Manager,[12] on 11 April 2017 when he participated in a group activity and his presentation seemed unusual. Ms Ross contacted Mr Brown by telephone the following day, 12 April 2017, to check in with

[10] The toxicologist's report also noted that *"In any case there is considerable overlap in clozapine concentration that are well tolerated to those than can caused death. Clozapine toxicity cannot be assessed solely on post-mortem blood concentrations; information on dose, duration of dose and interactions with other drugs need to be considered in addition to any significant pathology findings."*

[11] See paragraphs 34 and following below.

[12] Star Health (previously Inner South Community Health) is a not-for-profit health service that offers services including GPs, counselling, mental health case management and other allied health services.

him given his unusual presentation the day before and was then prompted to email Mr Brown's Waiora Case Manager to update them about these presentations.

27. Mr Brown was scheduled for a face-to-face appointment with Ms Ross on 20 April 2017. When he did not attend and did not contact her to say he would not be coming, Ms Ross attempted to contact him between 11.00am and 3.00pm. When she finally made contact with him at about 3.00pm that day, Mr Brown said he was confused, had forgotten his appointment and conceded he may have missed one dose of his medication.

28. Ms Ross then attempted to report this to the Waiora team three times that day, however Mr Brown's Case Manager was away, and the Duty Worker was unavailable. Messages were left with the receptionist, and on the duty phone voicemail stating that the issue was urgent. These messages were forwarded to Mr Brown's Case Manager on 21 April 2017. Contact was unable to be made on or after this date and it is possible that Mr Brown was already deceased by that time.[13]

29. In her statement, Dr Zigouris conceded that staff did not follow Alfred Health processes which resulted in Ms Ross being unable to communicate her concerns about Mr Brown's mental state to Waiora staff and receive a timely response. According to Dr Zigouris, a new staff member had commenced on reception and was not aware of the process for escalation to senior staff or managers when Star Health clinicians call multiple times in a single day with clinical concerns for a patient. Additionally, the Duty Worker did not address all the messages that were on voicemail at the end of the day as was expected.

30. In terms of changes made at Alfred Health since Mr Brown's death, Dr Zigouris advised that reception staff have been oriented to a decision tree for phone calls that advises the escalation process if there are clinical concerns for a patient, and information in the decision tree diagram has been further enhanced to make information easier to understand. Furthermore, expectations of the Duty Worker role were re-presented to all staff following Mr Brown's death and followed up directly with the staff involved, and the Duty Worker role was reviewed and guidelines developed for that role.

31. The clozapine tablets found at Mr Brown's home by police comprised over 50 tablets of 200mg clozapine found loose in a plastic bag, some crushed and some whole tablets on the

[13] This is referred to in paragraphs 4-5 above.

kitchen floor and some on the kitchen bench, including some that appeared to be 100mg tablets of clozapine.[14]

32. According to Dr Zigouris, Mr Brown was last provided with a script for 200mg clozapine tablets in April 2016 and then not directly. Rather, the script was faxed to Prahran Amcal Pharmacy monthly with the original being sent to the pharmacy by mail. Since April 2016 and at the time of his death, Mr Brown was prescribed 550mg daily dispensed as 5.5 100mg tablets and given to him weekly in blister packs. A blister pack dated 29 March 2017 was located at Mr Brown's home. Blister packs due for collection on 5, 12 and 19 April 2017 may or may not have been collected by him.[15]

33. Dr Zigouris suggested that excess clozapine can be accessed in a number of ways - stockpiling during episodes of non-compliance; having leftover clozapine at home after changes in dose and/or being provided with a new script before the previously dispensed tablets were taken; receiving additional dispensing to prevent an interruption to treatment such as when usual dispensing falls on a public holiday; and having a few days extra clozapine available to accommodate for the coordination required for monthly blood tests, psychiatrist reviews, scripting and dispensing of medication.

34. In Mr Brown's case, Dr Zigouris opined that he may have accumulated clozapine left over from previous prescriptions, since he had commenced treatment with clozapine in 2008 and had not been prescribed 200mg tablets for the twelve months before his death.

35. According to Dr Zigouris, patients of community mental health teams are generally responsible for their own medication. Those who do require supervision are monitored by the mobile support treatment service which had not been involved in Mr Browns' care since 2014. Dr Zigouris advised that it is routine practice for community mental health staff to ask patients about medication compliance and this is evident in the medical records. While the extent of Mr Brown's non-compliance was unclear there were several episodes of non-compliance that led to hospital admissions and raised the theoretical possibility of access to excess clozapine.

[14] This is based on their appearance in scene photographs perused by a Mental Health Clinician/Investigator from the CPU.

[15] According to a representative of Prahran Amcal Pharmacy, dispensing records are destroyed after two years and were not available when the CPU/MHI enquired after them prior to writing their report dated 2 July 2019.

36. Dr Zigouris also advised that it is routine practice for all staff involved in a patient's care (including their pharmacist) to advise the patient to dispose of excess medication and for staff to assist with the disposal if the patient allows. Dr Zigouris stated that there did not appear to be any clinical suspicion that Mr Brown was intentionally accumulating clozapine. There is no evidence in the medical record that staff advised Mr Brown about disposal of excess clozapine or offered to assist in its disposal. While it is true that staff were unable to force Mr Brown to dispose of excess medication, there was limited evidence to indicate that he would decline such a recommendation if it were made by staff.

37. The evidence from which Mr Brown's intent in taking excess clozapine is somewhat ambiguous. Mr Brown had not recently expressed suicidal ideation and left no suicide note or other indicators of suicide (such as preparation, disposal of property, funeral plans). Whilst Mr Brown's mother felt he was happy and in good spirits when she last spoke to him the week before his death, Ms Ross who was very familiar with his mental state had several interactions with him between 11 and 20 April 2017 which were concerning to her.

38. There is evidence that Mr Brown was experiencing psychosis in the period immediately preceding his death, including on 11 April 2017 when he presented as distracted, disorientated and unable to follow basic instructions at a Warm Water Exercise Group; on 12 April 2017 when he expressed fears to Ms Ross that he had drowned the previous day; and on 20 April 2017 when he told Ms Ross he was "confused about what was at the centre of the universe." This coupled with his admission to Ms Ross on 20 April 2017 that he had missed at least one dose of clozapine and the evidence at his home that he had cut off some of his hair suggests that he may have been suffering from psychosis at the time and raises the possibility that he took excessive clozapine as a result of his psychotic thoughts or in an effort to quell his psychotic symptoms.

FINDINGS/CONCLUSIONS AS TO CIRCUMSTANCES

39. 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.[16]

[16] *Briginshaw v Briginshaw (1938) 60 C.L.R. 336 especially 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…"*

40. 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.

41. Applying the standard of proof to the available evidence I find that:

i) The deceased's identity was Joshua Brown, born 16 November 1959.

ii) Mr Brown died at his home at 125/25 King Street, Prahran at some time between 20 and 22 April 2017.

iii) Mr Brown's death was due to clozapine toxicity on a background of right lower lobe of lung lesion (unspecified aetiology).

iv) The available evidence does not support a finding that Mr Brown took excess clozapine with the intention of ending his own life. Nor does it support a finding that this was an entirely accidental or inadvertent overdose.

v) The available evidence supports a finding that Mr Brown was suffering from the symptoms of his psychotic illness at the time he took an excessive quantity of clozapine, either while his judgement was impaired by that illness, or in an effort to quell the disturbing symptoms of that illness.

vi) The available evidence does not support a finding that there was any want of clinical management or care on the part of Ms Ross or any of the staff of Star Health that caused or contributed to Mr Brown's death.

vii) The breakdown in communication between Ms Ross and the Waiora team resulted in a delay in Mr Brown's Case Manager being alerted to changes in his mental state and proved to be a lost opportunity for earlier intervention with the *potential* to have prevented Mr Brown's death.

COMMENTS

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

1. Clozapine is a high-risk medication that is subject to mandatory monitoring and restrictions around prescribing as part of the Commonwealth Highly Specialised Drugs Program. It is lethal in overdose.

2. Despite the strictures of the clozapine regime, Mr Brown was able to access an excessive quantity of clozapine as evidence by the excessive and potentially fatal concentration found in routine post-mortem toxicological analysis of his blood, and the number of tablets found by Victoria Police members in a plastic bag in his kitchen and strewn on the kitchen bench and floor.

3. This case highlights the need for all staff involved in the care of patients taking clozapine in the community to be vigilant about the risk of stockpiling and the need to explore a patient's access to excess clozapine, especially at times of dose changes and non-compliance, and not limited to times when stockpiling is suspected, or when the patient is perceived to be at acute risk of suicide.

4. Alfred Health is to be commended for their response to Mr Brown's death as outlined in Dr Zigouris' statement - that is the improvements already made to reception staffs' understanding of escalation processes where there is clinical concern for a patient, and the improvements to the Duty Worker role which has been reviewed and subject to new guidelines.

PUBLICATION OF FINDING

Pursuant to section 73(1A) of the Act, I order publication of this finding on the Internet in accordance with the rules.

DISTRIBUTION OF FINDING

I direct that a copy of this finding is provided to the following for their information:

The family of Mr Brown

Star Health

Prahran Amcal Pharmacy

Alfred Health

The Proper Officer, Commonwealth Highly Specialised Drug Program

Senior Constable Ryan Gilmore (#37171) c/o O.I.C. Malvern Police

Signature:

Paresa Antoniadis Spanos

Coroner

Date: 20 October 2021