IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

**COR 2017 004205**

**FINDING INTO DEATH FOLLOWING INQUEST**

*Form 37 Rule 63(1)*

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

**Inquest into the death of Mr SWX[1]**

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| Findings of: | Coroner Ingrid Giles |
| Delivered On: | 24 July 2025 |
| Delivered at: | Coroners Court of Victoria, 65 Kavanagh Street, Southbank, Victoria, 3006 |
| Hearing date: | 5 February 2025 |
| Representation: | Mark O'Sullivan, Minter Ellison, on behalf of Mercy Health, along with Dr Paul Halley of Counsel (written closing submissions)<br>Christopher Lever, on behalf of the International Health and Medical Services<br>Mia Campbell, Kennedys Law, on behalf of Dr Arun Subramaniam<br>Sarah Curran, Meridian Lawyers, on behalf of Correct Care Australasia |
| Counsel Assisting the Coroner: | Kajhal McIntyre, Senior Coroners Solicitor |
| Keywords: | In-patient mental health unit, physiological observations, visual observations, sedation, chemical restraint, combined drug toxicity, acute behavioural disturbance, cultural care |

[1] This Finding has been de-identified by order of Coroner Ingrid Giles which includes an order to replace the name of the deceased, and replace or redact the names of other persons related to or associated with the deceased, with a pseudonym of a randomly generated letter sequence for the purposes of publication.

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## INTRODUCTION

1. Mr SWX was 32 years old when he died on 22 August 2017 in the acute adult inpatient mental health unit at Werribee Mercy Hospital (**WMH**). Mr SWX was an Eritrean national and had arrived in Australia with his family in 1999 on a Global Special Humanitarian Visa (**humanitarian visa**), having fled Eritrea due to conflict in the region and the safety issues this posed to his family.

2. At the time of his death, clinicians were treating Mr SWX as a compulsory patient subject to an Inpatient Temporary Treatment Order (**ITTO**) under the then-applicable *Mental Health Act 2014.* Mr SWX also remained in immigration detention at the relevant time, after his humanitarian visa had been cancelled due to criminal convictions.

3. Mr SWX had a highly complex psychosocial history, which was characterised by longstanding drug use, severe mental illness, and repeated engagements with the criminal justice system, including multiple periods of incarceration.

4. Despite these complexities, Mr SWX's family remained supportive throughout his life. One of his sisters described in a statement to the Court her understanding that Mr SWX's mental ill health had "*led him to a breakdown in the relationship between thought, emotion, and behaviour, leading to faulty perception, inappropriate actions and feelings, withdrawal from reality and personal relationships.*" However, she also noted that, when well, Mr SWX would study, undertake training courses and make plans for the future.

5. His mother lamented that sadly, despite the family's best efforts to continually support Mr SWX in his efforts towards rehabilitation, "*Mr SWX just seemed to always come back to the same environment and wasn't able to separate himself from his old ways."* However, she also noted periods in which Mr SWX was *"happy and outgoing"* and *"doing really well".*

## THE CORONIAL INVESTIGATION

### Jurisdiction

6. Under section 4(2)(c) of the *Coroners Act 2008* (Vic) (**the Act**), Mr SWX's death was a 'reportable death', as his death occurred in Victoria and he was, immediately before his death, a person placed in custody or care as defined in section 3(1) of the Act. Mr SWX's death was also a death that was unexpected, pursuant to section 4(2)(a) of the Act.

7. Deaths that occur in custody or care are reportable to ensure independent scrutiny of the circumstances surrounding the deaths of persons for whom the State has assumed responsibility, whether by reason of an inability to care for themselves, or because the State has deprived them of their liberty, or for some other reason.

8. In this instance, it appears, unusually, that Mr SWX met the legislative criteria in section 3(1) of the Act on two counts: first, as a person placed in care, and secondly, as a person placed in custody.

9. Mr SWX was a 'person placed in care' as immediately before his death, he was detained in a designated mental health service within the meaning of the then-applicable *Mental Health Act 2014*.[2] Specifically, Mr SWX was being treated as a compulsory patient subject to an Inpatient Temporary Treatment Order (**ITTO**) under Part 4 Division 3 of that Act. This category of death is reportable as it falls under subsection (i) of the relevant definition in section 3(1) of the *Coroners Act 2008*.

10. Mr SWX was also a 'person placed in custody', as immediately before his death, he was a person held in detention in Victoria by an authorised person under the law of the Commonwealth or another jurisdiction. Specifically, it appears that Mr SWX formally remained in immigration detention while receiving psychiatric treatment at WMH's psychiatric inpatient unit under section 189 of the *Migration Act 1958* (Cth).[3] This category

[2] I note that a new *Mental Health and Wellbeing Act 2022* commenced on 1 September 2023 and has replaced the 2014 Act.

[3] The Detention Assurance Preliminary Review explained that WMH is commonly designated as an alternative place of immigration detention (**APOID**) for the provision of psychiatric services. However, in this instance, it appears that no WMH clinician was willing to act as a 'designated person' and 'hold [Mr SWX] on behalf of an officer' while he

of death is reportable as it concerns a prescribed person or a person belonging to a prescribed class of person under subsection (l) of the relevant definition in regulation 3(1) and section 7(1)(a) of the *Coroners Regulations 2019*.

11. I note that, under section 67 of the *Mental Health Act 2014*, as then applied, the Assessment Order and ITTO Mr SWX was subject to, ought to have had no effect while Mr SWX was in Commonwealth detention. However, in circumstances in which treating clinicians considered Mr SWX to be a compulsory patient in their care, and there is no evidence that the validity of the orders was a matter impacting upon the care provided, I do not consider this issue critical for the purposes of this investigation, though I will turn to it further below.

12. In any event, pursuant to section 52(2)(b) of the Act, it is clear on that, in light of the fact Mr SWX was a person placed in care and/or custody prior to his death, an inquest into his death was mandatory.

**Purpose of the Coronial jurisdiction**

13. The jurisdiction of the Coroners Court of Victoria (**Court**) is inquisitorial.[4] The purpose of a coronial investigation is to independently investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which the death occurred.[5]

14. The cause of death refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

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was in an APOID, pursuant to the 2008 Memorandum of Understanding (**MOU**) between the Commonwealth and Victoria in relation to the provision of health services for people immigration detention. As such, Mr SWX remained under the presence of Detention Service Provider officers, being Serco staff, throughout his inpatient admission. While WMH would not permit Serco staff to enter the inpatient unit due to privacy concerns, three Serco Staff remained outside the facility with welfare checks conducted every two hours through the relevant duty nurse. On this basis, I am satisfied that Mr SWX formally remained in immigration detention throughout his admission to WMH and was therefore, for the purposes of the Coroners Act, a 'person placed in custody' immediately prior to his death.

4 Section 89(4) Coroners Act.

5 Preamble and s 67 Coroners Act.

15. The circumstances in which the death occurred refers to the context or background and surrounding circumstances of the death. Significantly, it is confined to those circumstances that are sufficiently proximate and causally relevant to the death.

16. In *Harmsworth v the State Coroner* [1989] VR 989 (***Harmsworth***), Nathan J concluded that lines of enquiry within an inquest must be relevant, in the legal sense, which "*brings into focus the concept of 'remoteness'*".[6] Enquiries must be directed to the making of statutory findings.[7] Regard must be had to how wide, prolix and indeterminate the inquest might become if remote issues are pursued[8] and inquests which never end or cannot arrive at coherent or concise findings must be avoided.[9]

17. 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 prevention role. Coroners are empowered to advance their prevention role by:

    a) reporting to the Attorney-General on a death;

    b) commenting on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and

    c) making recommendations to any Minister or public statutory authority or entity on any matter connected with the death, including public health or safety or the administration of justice.[10]

18. 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 a finding or comment or any statement that a person is, or may be, guilty of an offence.[11] It is not the role of the coroner to lay or apportion blame, but to establish the facts.[12] However, a

[6] *Harmsworth* 995
[7] *Harmsworth* 995.
[8] *Harmsworth* 996.
[9] *Harmsworth* 996.
[10] Sections 67(3), 72(1) and (2) of the Coroners Act.
[11] Section 69(1) of the Coroners Act.
[12] *Keown v Khan* (1999) 1 VR 69.

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.[13]

**Standard of proof**

19. All coronial findings must be made based on proof of relevant facts on the balance of probabilities.[14] The strength of evidence necessary to prove relevant facts varies according to the nature of the facts and the circumstances in which they are sought to be proved.[15]

20. In determining these matters, I am guided by the principles enunciated in *Briginshaw v Briginshaw*.[16] The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals or entities, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

21. Adverse findings or comments against individuals in their professional capacity, or against 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.

22. Proof of facts underpinning a finding that would, or may, have an extremely deleterious effect on a party's character, reputation or employment prospects demands a weight of evidence commensurate with the gravity of the facts sought to be proved.[17] Facts should not be considered to have been proven on the balance of probabilities by inexact proofs, indefinite testimony or indirect inferences. Rather, such proof should be the result of clear, cogent or strict proof in the context of a presumption of innocence.[18]

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[13] See ss 69(2) and 49(1) of the Coroners Act.
[14] *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152.
[15] *Qantas Airways Limited v Gama* (2008) 167 FCR 537 at [139] per Branson J (noting that His Honour was referring to the correct approach to the standard of proof in a civil proceeding in the Federal Court with reference to s 140 of the *Evidence Act 1995* (Cth); *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* (1992) 67 ALJR 170 at 170-171 per Mason CJ, Brennan, Deane and Gaudron JJ.
[16] (1938) 60 CLR 336.
[17] *Anderson v Blashki* [1993] 2 VR 89, following *Briginshaw v Briginshaw* (1938) 60 CLR 336.
[18] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at pp 362-3 per Dixon J.

## Investigation

23. My former colleague Coroner John Olle (**Coroner Olle**) initially held carriage of the investigation into Mr SWX's death.

24. Victoria Police assigned an officer, Detective Sergeant Chris Madden (**DS Madden**) of Wyndham Crime Investigation Unit to be the Coronial Investigator for the investigation of Mr SWX's death. The Coronial Investigator conducted inquiries on behalf of the Court, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

25. Subsequently, the matter was also referred to the Coroners Prevention Unit (**CPU**) for advice on the appropriateness of the care and treatment provided to Mr SWX while he was a person placed in care and/or custody.[19] On the CPU's advice, further materials were obtained from WMH, the Office of the Chief Psychiatrist (**OCP**), the Chief Mental Health Nurse, the Commonwealth Department of Home Affairs, and the International Health and Medical Services (**IHMS**). An expert opinion was also obtained from Associate Professor Naren Gunja (**A/Prof Gunja**), Clinical and Forensic Toxicologist.

26. In June 2020, Coroner Olle determined that it was appropriate that the investigation into Mr SWX's death be placed on hold until the inquest into the passing of Jacob Kennedy (**Mr Kennedy**) had been conducted, as this matter addressed similar issues and so it was considered that the findings may have relevance to Mr SWX's case.

27. In November 2023, I assumed carriage of the investigation into Mr SWX's death for the purposes of conducting additional investigative steps, finalising the case, and making findings.

[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 prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health; as well as staff who support coroners through research, data and policy analysis.

28. On 24 May 2024, the findings into the passing of Mr Kennedy were delivered by Coroner Olle.[20] Consequently, I determined that it was appropriate for the investigation into Mr SWX's death to be re-instigated and to harness any relevant outcomes for the present investigation. To assist in this regard, the existing statements and materials received in the course of the investigation, both through the Coronial Investigator and directly by the Court, were compiled into the Coronial Brief Version 1, dated 24 July 2024.

29. At my request, the CPU provided updated advice, having considered all available evidence, in the context of recent developments including findings in the matter of Mr Kennedy, as well as the new *Mental Health and Wellbeing Act 2022* (Vic) (**MHWA**).

30. I also sought, via the CPU, a supplementary statement from Associate Professor Dean Stevenson (**A/Prof Stevenson**), Clinical Services Director of Mental Health Services at Mercy Health (now retired from that role) to provide an update on further reforms undertaken by Mercy Health since the previous statements had been provided to the Court. This statement has been included in the Coronial Brief as 'Additional Material 1'.[21]

**Summary inquest**

31. Whilst an inquest was mandatory in respect of Mr SWX's passing, I considered it appropriate in the circumstances to hold a summary inquest, which was convened on 5 February 2025.

32. The individual witnesses who provided statements in the inquest brief were not required to give evidence at inquest as, after carefully considering all the material within the brief, I was satisfied that there were no significant factual disputes which required the calling of *viva voce* evidence. Accordingly, I was satisfied that I was able to discharge my statutory functions and make the findings required under section 67 of the Act.

[20] Finding into the passing of Jacob William Kennedy (COR 2017 0595), 24 May 2024, available at: https://www.coronerscourt.vic.gov.au/sites/default/files/2024-07/Finding%20into%20the%20passing%20of%20Jacob%20Kennedy%20-%20Amended.pdf

[21] For completeness, I note that correspondence from one Mr Michael Regos of DLA Piper on behalf of Mercy Health dated 18 May 2018 constituted 'Additional Material 2', having not been previously added to the coronial brief.

33. All Interested Parties who appeared at the Inquest were subsequently given an opportunity to make submissions in relation to the evidence, including the proposed comments and recommendations, as well as proposed adverse findings.

34. Following the Inquest, I was also assisted by a supplementary statement from Dr Michael Lograsso, Director of Medical Services at Mercy Mental Health & Wellbeing Service, dated 30 April 2025, in relation to which Interested Parties were also permitted the opportunity to respond. This statement has been included in the Coronial Brief as 'Additional Material 3'.

35. The present finding draws on the totality of the material obtained in the coronial investigation into Mr SWX's death: the coronial brief prepared by Detective Sergeant Chris Madden of Wyndham Crime Investigation Unit, which has been supplemented by further material obtained by the Court; the transcript of the proceedings; exhibits (which in this case, included: (i) the Coronial Brief Version 1 dated 24 July 2024; (ii) Additional Materials 1 and 2; (iii) Additional Material 3, which was received into evidence following Inquest; and (iii) Medical Records); as well as the submissions of Interested Parties.

36. In writing this finding, I do not purport to summarise all the material evidence but refer to it only in such detail as appears warranted by its forensic significance and the interests of narrative clarity. It should not be inferred from the absence of reference to any aspect of the evidence that it has not been considered.

37. While not evidence, I was also greatly assisted at the Inquest by the poignant reflections contained in the Coronial Impact Statement filed and read out by Mr SWX's family members. It is clear to me that their loss is immeasurable.

## BACKGROUND

38. Applying the principles of *Harmsworth*, and in the circumstances of this case, I determined that it was appropriate to limit the focus of my investigation to those circumstances which were proximate and causal to Mr SWX's death, being the six-day period of his attendance and admission to Werribee Mercy Hospital.

39. Nonetheless, I consider that it is relevant to provide a high-level summary of background circumstances leading to Mr SWX's admission to Werribee Mercy Hospital, in order to provide context to my later comments.

**Summary of early life**

40. Mr SWX was born in Eritrea, but fled the country with his family at a young age, following the commencement of a conflict between Eritrea and Ethiopia. After spending a number of years in Sudan and Egypt, Mr SWX's family came to Australia as refugees in 1999, when Mr SWX was 14 years old. Mr SWX and his family members were each granted a Global Special Humanitarian Visa (**humanitarian visa**) by the Australian Government.

41. Mr SWX reportedly adjusted well to life in Australia, and did well at school. However, during his teenage years, Mr SWX commenced using illicit drugs, including cannabis, methamphetamines, heroin and benzodiazepines. Mr SWX would continue to use substances throughout his life.

42. Mr SWX also experienced severe mental illness and received various diagnoses, including schizophrenia, schizoaffective disorder, dissocial personality disorder and substance use disorder. His first psychiatric contact was a 6-day admission in 2006 at Orygen (a specialist mental health service for young people), when he was first diagnosed with schizophrenia.

43. Over the following 10 years, Mr SWX received treatment including depot antipsychotics, opioid replacement therapy, and depo-provera for sexualised behaviour management. He had approximately eight involuntary admissions to psychiatric inpatient units, most commonly in the context of a relapse of psychotic symptoms. When in the community, he also received treatment under Community Treatment Orders. Mr SWX's treatment was reportedly complicated by several factors, including his iterant lifestyle, continued substance use, unstable accommodation, and non-compliance with medication regimes.

44. In addition to substance use and mental health concerns, Mr SWX's life was complicated by ongoing engagement with the criminal justice system, including multiple periods of incarceration. I do not consider that it is necessary or relevant for the purposes of my

finding to detail the nature of his criminal offending, except to note that, by the time of his death, Mr SWX had an extensive forensic history.

45. In 2006 and 2008, Mr SWX was refused Australian citizenship as a result of his criminal convictions at that time, but continued to reside in Australia on the previously issued humanitarian visa. His family members all became Australian citizens.

46. On 16 July 2016, Mr SWX was remanded into custody at the Melbourne Assessment Prison (**MAP**) in relation to various criminal charges, for which he was later sentenced on 23 September 2016 to a total of 13 months imprisonment.

47. Shortly after arriving at MAP, on 23 July 2016, Mr SWX was transferred to Port Phillip Prison (**PPP**) where he remained for over one year, until 12 August 2017.

**Port Phillip Prison**

48. Upon reception at PPP, it was noted that prior to his incarceration, Mr SWX had been subject to a Community Treatment Order (**CTO**) due to noncompliance with medications. The CTO had been managed by the Waratah Clinic where he was receiving mirtazapine (an antidepressant), quetiapine (an antipsychotic), and depot injections of zuclopenthixol (antipsychotic) and medroxyprogesterone acetate (depo-provera). However, upon arrival to prison, Mr SWX reportedly indicated a preference to continue only quetiapine and mirtazapine, and refused both depot medications.

49. On 27 July 2016, Mr SWX was reviewed by a psychiatrist. A plan was formulated for Mr SWX to be transferred to the Psychosocial Rehabilitation Unit at PPP, St Paul's Unit, where he remained for a period of approximately nine months.

50. While housed in St Paul's Unit, Mr SWX received regular mental health assessments by Registered Psychiatric Nurses (**RPNs**) and psychiatrists. He was prescribed depot antipsychotic zuclopenthixol until this was determined to be ceased by his psychiatrist in November 2016. While there was no documented clinical rationale for the decision to cease the medication, it is noted that no psychotic symptoms had been reported or observed at that time.

51. On 24 January 2017, Mr SWX's humanitarian visa was cancelled under section 501(3A) of the *Migration Act 1958* (Cth) as a result of his criminal convictions. This decision meant that Mr SWX became an '*unlawful non-citizen*' (using the words of the legislation),[22] and was liable to mandatory detention and deportation upon release from PPP.

52. Mr SWX's behaviour began to deteriorate following him being informed of the impending deportation. At times, clinicians (and Mr SWX himself) linked his increasingly demanding and abusive behaviour to anxiety and stress associated with the upcoming deportation. However, by February 2017, Mr SWX also showed signs of paranoia and elevated mood and by April, was increasingly erratic and abusive on the unit.

53. In early April 2017, Mr SWX was placed under a management regime in St Paul's Unit.[23] By mid-April, Justice Health records document that Mr SWX was subject to a separation regime, [24] whereby he was only allowed to be outside of his cell for one hour per day.[25]

54. Throughout May 2017, Mr SWX's mental state appears to have further deteriorated and it was noted that there was an increased risk of harm to staff, due to aggressive and antagonistic behaviour and threats of harm.

55. On 26 May 2017, Mr SWX was again assessed by his psychiatrist, who noted that he presented as frustrated and angry, but with no delusions and no suicide or self-harm risk. The psychiatrist recorded that Mr SWX had agreed to be relocated to a different unit, and formulated a plan that his behavioural issues should be addressed with fewer restrictions.

56. Mr SWX was subsequently transferred to the Charlotte Unit, a unit at PPP designed to accommodate people on a 'management regime'. It is evident from medical records that psychiatric reviews became less frequent from this time, though records demonstrate that Mr SWX received weekly welfare checks.

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[22] S 14, *Migration Act 1958* (Cth).
[23] MR-150.
[24] Separation is a practice authorised by regulation 27 of the *Corrections Regulations 2009* – '*If reasonable for the safety or protection of the prisoner or other persons, or the security, good order or management of the prison, the Secretary may, in writing, order the separation of a prisoner from other prisoners*'.
[25] MR-145. A Progress Note recorded on 17 April 2017 by a Psychiatric Nurse records, '*Mr SWX continues to be on a separation order. Had 1 hour run out this morning without any incident*'.

57. Medical records document the first recorded review of Mr SWX by any clinician while housed in the Charlotte Unit was on 14 June 2017, almost 3 weeks following his arrival on the Unit. At this review, a Registered Nurse stated that Mr SWX denied psychotic symptoms and perceptual disturbance, his mood was euthymic, and there were no recorded concerns regarding risk of suicide or self-harm.

58. On 21 July 2017, a Registered Nurse documented a similar presentation.

59. Registered Psychiatric Nurses noted that Mr SWX refused to attend for psychiatric review on 22 June 2017 and 4 July 2017.

60. On 11 July 2017, a Registered Psychiatric Nurse attempted to review Mr SWX, but he refused to get dressed and reportedly stood naked at the trap door of his cell whilst laughing and making lewd comments. The review was suspended.

61. While a reference is made to an appointment scheduled with his psychiatrist on 18 July 2017, there is no documentation of this review contained in the Justice Health records. However, Mr SWX did attend an appointment with a medical officer on this date, who noted his '*disorganised and disinhibited*' state.

62. On 4 August 2017, Mr SWX again refused to attend a review by a Registered Psychiatric Nurse.

63. On 9 August 2017, a Registered Psychiatric Nurse conducted the weekly welfare check and noted that Mr SWX was settled in mood and behaviour.

64. On 11 August 2017, Mr SWX again refused to attend review by a Registered Psychiatric Nurse. Mr SWX's family visited on this day, noting they had not seen him for about one month, and reported that he appeared to be hearing things, and presented as confused and agitated.

65. The following day, on 12 August 2017, Mr SWX was released from PPP into immigration detention at the Maribyrnong Immigration Detention Centre (**MIDC**). A discharge summary completed on 11 August 2017 in Mr SWX's absence recommended monitoring

of his mental state as the deportation procedure was causing angst and anxiety.[26] The discharge summary noted that, at that stage, he was not prescribed (nor discharged) with any anti-psychotic medications.[27]

**Maribyrnong Immigration Detention Centre**

66. On admission to Maribyrnong Immigration Detention Centre (**MIDC**), a Registered Psychiatric Nurse (**RPN**) was concerned regarding Mr SWX's mental state, noting that he presented as paranoid and disorganised in his thoughts. The RPN attempted to refer Mr SWX to Mercy Mental Health (**MMH**) Psychiatric Triage Service (**PTS**), but was advised that MIDC should first arrange a review by a medical officer from the International Health and Medical Services (**IHMS**) who could then contact a MMH psychiatrist for medication advice.

67. MIDC psychiatric nurses reported that Mr SWX's condition deteriorated over 14 to 15 August 2017, with his behaviour becoming increasingly bizarre with elevated mood, rapid speech and concerns he may harm others.

68. On 15 August 2017, an IHMS General Practitioner (**GP**) commenced Mr SWX on the antipsychotic olanzapine.

69. On 16 August 2017, Mr SWX was transferred to Melbourne Immigration Transit Accommodation (**MITA**) for assessment by IHMS psychiatrist Dr Arun Subramanian (**Dr Subramanian**). Dr Subramanian noted that Mr SWX was displaying symptoms of mania and psychosis, that his condition was deteriorating, and there was a high and imminent risk of harm to himself and others. Given the imminent risks to others and self, Dr Subramaniam determined to place Mr SWX under an Inpatient Assessment Order (**IAO**) under the then-applicable *Mental Health Act 2014* (Vic).

**Transfer to Hospital**

70. On 16 August 2017 at approximately 6pm, Mr SWX was transported to Footscray Hospital Emergency Department (**ED**), accompanied by Serco staff. Upon arrival, ED staff asked

[26] MR-344, MR-169.
[27] MR-344.

that Serco staff remain with Mr SWX in the MIDC van while awaiting triaging by ED and review by a mental health clinician.

71. At 6.15pm, the ED staff called a Mercy Mental Health (**MMH**) clinician and were advised that because Mr SWX was on an IAO, he needed to be brought into the ED. At 6.25pm, the clinician attended the ED to see Mr SWX, however he had left with the Serco guards. The Australian Border Force Detention Assurance Preliminary Review indicated that Serco management directed the van to return to MIDC, as the van being on the street was deemed a security risk.

72. Following discussion between IMHS and MMH staff, it was eventually agreed that Mr SWX would instead be taken to Werribee Mercy Hospital Emergency Department (**WMH ED**). Later that evening, at 8.42pm, Mr SWX was taken to WMH ED.

## MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

### Circumstances in which the death occurred

73. Mr SWX remained at WMH from the evening of his arrival on 16 August 2017 until his death six days later, on the evening of 22 August 2017. At the outset of his admission, Mr SWX presented with grossly disorganised behaviour, verbal aggression and demanding behaviour in the context of psychosis and seeking medications.

74. To treat his psychosis and manage his behaviours, Mr SWX was prescribed and administered 64 doses of 11 different medications during his six days in hospital (including his time in the ED), all with potentially sedating effects. Of note, two additional central nervous system depressants were introduced in the two days leading to his death - buprenorphine/naloxone (Suboxone) the day prior to death, and pregabalin on the day of his death.[28]

75. It is relevant to set out a chronology of events occurring throughout Mr SWX's admission.

[28] A/Prof Gunja has included in his expert report a table summarising all medications administered to Mr SWX throughout his admission: CB-296. A copy of this table has been included at **Annexure A**.

76. On arrival at WMH, Mr SWX reportedly demanded morphine, nitrazepam, diazepam and quetiapine. He was given diazepam and quetiapine.[29] Mr SWX was reviewed by Chris Bennett, After Hours Coordinator, MMH, and psychiatric registrar Dr Lubna Yassin, who formed a plan for Mr SWX to remain in the ED for review by a psychiatrist the following morning.

77. The next morning, on 17 August 2017, Mr SWX was reviewed by psychiatrist Dr Manoj Kumar (**Dr Kumar**). He presented with paranoid themes, thought disorder, a preoccupation with somatic complaints, and auditory hallucinations which he said had begun while he was in prison. He continued to demonstrate drug-seeking behaviours (particularly for opiates and pregabalin).

78. Dr Kumar sought collateral information from Mr SWX's sister, who advised that his antipsychotic medication was ceased six months ago.[30] She also advised that Mr SWX previously had side effects from zuclopenthixol and she requested to be involved in treatment decisions. Mr SWX was made subject to an Inpatient Temporary Treatment Order (**ITTO**) and remained in ED while awaiting a bed in the Intensive Care Area (**ICA**).

*Werribee Hospital Mental Health Ward*

79. At approximately 3pm on 17 August 2017, Mr SWX was transferred to the acute adult inpatient mental health ward at WMH. On the basis that Mr SWX presented a high risk of harm to others and himself, he was admitted into the seclusion area within the ICA.[31] Other security arrangements were also implemented, including one extra nursing staff, one extra security guard, and a decision that females would not be admitted to the area where Mr SWX was receiving treatment. Mr SWX was charted on antipsychotic olanzapine 10mg

[29] Diazepam is a long-acting benzodiazepine with several indications including short-term management of agitation and sedation. Quetiapine is an atypical antipsychotic used in the treatment of schizophrenia; it also has a sedative effect**.**

[30] Justice Health records indicate that anti-psychotic medications were ceased on 16 November 2016, almost 9 months prior.

[31] According to section 112 of the then-appliable *Mental Health Act 2014* (Vic), patients in seclusion are to be reviewed by an authorised psychiatrist at least every four hours and if it is not practical for an authorised psychiatrist to conduct an examination at the frequency that the authorised psychiatrist is satisfied is appropriate, the person must be examined by a registered medical practitioner when so directed by the authorised psychiatrist.

twice daily and benzodiazepine lorazepam 2mg twice daily. At 3.07pm, in accordance with this plan, he was administered olanzapine 10mg and the lorazepam 2mg.[32]

80. During a medical review that evening at 6.30pm on 17 August 2017, Mr SWX presented as sedated with significantly slurred speech.[33] Further medications were withheld due to his level of sedation and a decision made to continue nursing him in seclusion as it was assessed that he presented a high risk of sexual violence towards others. The nursing admission note states *"adequately medicated throughout the shift."*[34]

81. Around 10.30pm that same evening on 17 August 2017, Dr Lin, general surgical hospital medical officer, documented that Mr SWX was *"drowsy in appearance however maintains awakeness, slurred words"* and recommended *"no further sedation meds for now (unless agitated)".*[35]

82. Mr SWX continued to be monitored overnight and did not receive any further medication until the following day. Medical reviews at 2am and 5.30am on 18 August 2017 indicated that he was easily roused. At 9.25am, treating psychiatrist Dr Anindya Banerjee (**Dr Banerjee**) observed that Mr SWX was awake, agitated and generally cooperative.

83. At 12.15pm on 18 August 2017, Mr SWX was commenced on 400mg zuclopenthixol long-acting injection, with his next dose due in two weeks. A few hours later, at 3.18pm, he was noted as mildly sedated, drowsy, lethargic and needed prompting when asked questions. A plan was made to cease regular lorazepam, and commence clonazepam 2mg *bis in die* (**BD,** twice a day) as a longer acting alternative, while lorazepam was prescribed to be administered pro re nata (**PRN**, as needed) up to a maximum of 8mg daily. Mr SWX was also planned to be moved out of seclusion.

[32] While in ED, Mr SWX was given 300mg quetiapine, 200mg quetiapine, 10mg diazepam x 3, 10mg olanzapine, 100mg chlorpromazine, 100mg paracetamol and a nicotine inhaler. Olanzapine is a second-generation antipsychotic. Chlorpromazine is an antipsychotic medication indicated for treatment of psychotic disorders and short-term treatment of severe behavioural disturbance and aggressive behaviour.
[33] MR-731.
[34] MR-731.
[35] MR-733.

84. At 7.30pm, Mr SWX was moved from seclusion to ICA but remained on 15-minutely nursing observations. Mr SWX appeared "*drowsy but driven and disorganised*" at this time.[36]

85. Physical observations were completed at 3.05pm and 8pm that day, on 18 August 2017, which revealed that Mr SWX was tachycardic but asymptomatic. An electrocardiogram (**ECG**) and medical review were completed with no other abnormalities identified. A plan was made for the treating team to review his medications and obtain a blood test the following morning. Mr SWX was also advised to tell nursing staff if he was in pain or breathless.

86. There is no indication in the medical records that Mr SWX had a blood test or medication review the following morning.

87. At 4.15pm on 19 August 2017, Mr SWX was medically reviewed and noted to be "*drowsy post sedatives"* with speech very slurred and difficult to understand.[37] Mr SWX requested multiple kinds of pain relief and was commenced on Panadeine Forte with a plan to obtain collateral information from his General Practitioner (**GP**) regarding his history of pain from a previous injury and pain medication regime. Nursing progress notes for 19 August 2017 indicate Mr SWX was agitated and demanding when PRN sedation wore off, but otherwise drowsy or sleeping. Physical observations were completed at 11.30am and 4pm and it was documented that Mr SWX was tachycardic.

88. The following day, on 20 August 2017, Mr SWX was reviewed by a psychiatry registrar due to his continued requests for opiate analgesia. He was noted by the registrar and nursing staff to have slurred speech, though was reportedly not sedated or drowsy. Visual observations charts indicate that Mr SWX slept for portions of the day, including overnight until 7am, from 8am to 8.30am, from 1.15pm to 3.15pm and from 6pm onwards. Physical observations were completed at 10.55am and were unremarkable.

[36] MR-744
[37] MR-750.

89. The following day, at 9.50am on 21 August 2017, treating psychiatrist Dr Banerjee noted Mr SWX's speech was slurred, his mood was labile (changeable) and he continued to obsess about receiving opioid pain medication. He appeared thought disordered with no evidence of hallucinations. Dr Banerjee's impression was of an ongoing thought disorder, and he queried the presence of persecutory delusions or drug-seeking behaviour.

90. A plan was made to liaise with Mr SWX's sister and guardian,[38] to seek further information from Mr SWX's GP about previously-prescribed pain relief, to cease Panadeine Forte and commence buprenorphine/naloxone with view towards long-term opioid replacement therapy.

91. Contact was made with Mr SWX's family regarding a visit. Contact was also made with an MIDC employee who stated it would be some time before deportation was arranged, so a decision was made to manage Mr SWX's medication under a CTO when discharged to MIDC.

92. Throughout the day on 21 August 2017, Mr SWX was noted by nursing staff to be driven and disorganised, but also mildly over-sedated, displaying slurred speech, some drooling, and resisting sleep. An attempt was made to do a blood test, but Mr SWX declined this. No physical observations were recorded.

93. On 22 August 2017, around 10am, Mr SWX was reviewed by Dr Banerjee for the final time before his death. Mr SWX was described as being "*sedated looking*" with slurred speech.[39] It was noted that his mood was more labile than the previous day and he was tearful with no obvious trigger. Mr SWX presented as disinhibited and hugged Dr Banerjee. He continued to request Panadeine Forte and pregabalin. These were denied, however Dr Banerjee agreed to prescribe pregabalin 75mg twice daily. To manage his drowsiness, the dose of clonazepam was reduced from 4mg per day to 3mg per day, with view to tapering off.

[38] On 4 August 2017, the Victorian Civil and Administrative Tribunal made an order that two of Mr SWX's sisters be appointed his joint limited guardians with powers and duties including to make decisions concerning medical or other health care: CB-139. This will be addressed further below.
[39] MR-763.

94. An attempt was made to take blood, however Mr SWX reportedly did not bleed. This was noted by the nurse to be due to inadequate fluid intake.[40]

95. Physical observations were completed at 10am which were unremarkable.

96. Mr SWX spent periods of 15-90 minutes sleeping throughout the day. He briefly got up for lunch and was drowsy and drooling. He was given more medication and returned to bed between 2.15pm and 2.30pm. He was recorded to be asleep with regular respiratory movements and audible respiratory sounds every 15 minutes until 6pm.

97. At approximately 6.30pm on 22 August 2017, Mr SWX's family arrived to visit him. On attempting to wake Mr SWX, a nurse found that he was unresponsive and a 'Code Blue' was called.

98. The attending resuscitation team arrived at 6.43pm and found Mr SWX without signs of life and in cardiac asystole. Cardiopulmonary resuscitation (**CPR**) was commenced and he was intubated, with clinicians noting that he had vomitus and secretions in the airway. The cardiac rhythm was reported as asystole during the 45-minute period of resuscitation.[41] With no return of cardiac output, Mr SWX was verified as deceased at 7.20pm.

**Identity of the deceased**

99. On 23 August 2017, Mr SWX , born [redacted] 1985, was visually identified by his father.

100. I am satisfied that identity is not in dispute and requires no further investigation.

[40] However, where food and fluid intake was noted in nursing notes, it was described as adequate or excessive. This issue will be further addressed below.

[41] In his expert report dated 26 April 2020, A/Prof Gunja contended that the rhythm strips in the documentations suggest that Mr SWX had episodes of torsades de pointes (**TdP**) of ventricular tachycardia (**VT**) during the resuscitation. In response, Dr Andrew Blunt, Emergency Physician at WMH, provided a statement dated 19 June 2020 which disputes A/Prof Gunja's interpretation. Dr Blunt stated that it remains his opinion based on his observations of the rhythm in real time that Mr SWX was in asystole when compressions were paused for rhythm check, and that some of the variability in traces may relate to rotation of staff performing chest compressions and fatigue. Given A/Prof Gunja acknowledges that his alternative narrative may have resulted in different management but "*may not have changed the outcome*," I do not consider it is necessary for me to resolve this difference in opinion.

**Medical cause of death**

101. On 25 August 2017, Forensic Pathologist Dr Michael Burke (**Dr Burke**) from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on the body of Mr SWX and reviewed relevant materials, including the Police Report of Death (**Form 83**) and the Mercy Health Medical Deposition. Dr Burke provided a written report of his findings dated 4 December 2017.

102. According to Dr Burke's report, the post mortem examination showed no evidence of any injury which would have contributed to, or caused, Mr SWX's death. There was no evidence of any central nervous system, pulmonary or heart disease, which would have led to sudden, unexpected death. Further, the microscopic examination of lung tissue showed aspirated gastric contents within terminal bronchioles.

103. Dr Burke observed that the toxicological analysis showed the presence of buprenorphine, codeine, multiple benzodiazepines, olanzapine, chlorpromazine, zuclopenthixol and pregabalin, while the opiate antagonist naloxone was also identified within blood.

104. Taking into account all information available at that time, Dr Burke provided an opinion that the medical cause of death was:

    1(a) Aspiration of gastric contents

    1(b) Combined drug toxicity.

105. I accept Dr Burke's opinion.

**REVIEW OF CARE**

106. As noted above, in investigating the particular circumstances of Mr SWX's death, including in light of the opinion on cause of death proffered by Dr Burke, and having regard to the principles of *Harmsworth*, I determined that it was appropriate to focus my investigation on those circumstances which were proximate to Mr SWX's death, being the six-day period of Mr SWX's attendance and admission to WMH.

107. In making this determination, I recognise that Mr SWX's family have outlined significant concerns in relation to the adequacy of care provided to Mr SWX in the lead-up to this period, and in particular, during the period that he was incarcerated in PPP. These included concerns about Mr SWX's periods of separation at PPP, the discontinuation of Mr SWX's antipsychotic medications during his incarceration, the way in which family visits were facilitated, and reported lack of access by family to information about Mr SWX, his treatment and his whereabouts while he was in custody (in particular, while he was in separation).

108. Amongst others, Mr SWX's family also raised a discrete concern in relation to care provided upon his attendance at Western Health Footscray Hospital (**Footscray Hospital**) Emergency Department (**ED**).

109. I will consider these issues briefly, before turning to the focus of my investigation being the adequacy of care provided to Mr SWX while he was admitted to WMH.

**Mr SWX's care, treatment and placement at Port Phillip Prison**

110. I considered carefully whether concerns related to Mr SWX's care, treatment and placement at PPP ought properly to fall within the scope of the present inquest proceedings and thus be investigated further. However, having consulted with the CPU, I considered that there was insufficient evidence to establish that Mr SWX's death was caused, or contributed to, by any aspect of care provided at PPP in a way that warranted further consideration of his treatment or management during this period.

111. While it appears likely that Mr SWX's mental state declined during the period that he was managed under a separation regime and located in the Charlotte Unit, and that upon his release from PPP, he was experiencing a significant episode of mental ill health, I consider Mr SWX's death was far from inevitable at this stage. Rather, it was reasonable to expect that any mental health treatment required upon release from PPP could be provided, safely, outside of that prison environment.

112. Accordingly, while I acknowledge that Mr SWX's family have raised concerns, including in relation to the possible impact of separation on prisoners' mental health and access to

healthcare (an issue which is currently the subject of examination in other investigations before the Court), I was not satisfied that these issues fall within the proper limits of scope for this investigation. Rather, I considered that the appropriate focus of my inquiry must be the adequacy of treatment received once Mr SWX's deterioration was identified and he was transferred to WMH.

113. In this connection, I note that under the new *Mental Health and Wellbeing Act 2022* (**MHWA**), the Office of the Chief Psychiatrist (**OCP**) has an expanded role to examine more broadly the adequacy of forensic mental health care provided in custodial settings. I am hopeful that the OCP may consider exploring thematically some of those issues raised by Mr SWX's family and that were outside the scope of the coronial investigation, including the impacts of separation on access to appropriate mental health care within custodial settings, and/or providing any relevant resources or guidelines on this issue. I will make a comment to this effect.

**Care provided to Mr SWX prior to transfer to Werribee Mercy Hospital**

114. In correspondence to the Court, Mr SWX's family raised concerns that, upon attendance at Footscray Hospital ED on 16 August 2017, Mr SWX was requested to remain in the van while awaiting triage, which was perceived by family as "*inhumane*".[42]

115. While I acknowledge that some difficulties appear to have arisen with regard to Mr SWX's transfer from MIDC to a designated mental health facility, I am satisfied that there is no evidence to suggest that any resultant delays in treatment, or the manner in which Mr SWX was required to wait for that treatment, were contributory to his death.

116. I note for completeness that, following Mr SWX's death, a Detention Assurance Preliminary Review was conducted by the Australian Border Force to examine the appropriateness of his management while in immigration detention. The report identified a number of actions, including that IHMS and Detention Health follow up with Victorian Medical Facilities to discuss and improve referral processes.[43]

[42] CB-203.
[43] CB-175 *et. seq*.

117. I note further that MIDC is no longer in operation. Nonetheless, I consider it appropriate to notify the present finding to the Victorian Department of Health, the Commonwealth Department of Home Affairs and International Health and Medical Services in order to ensure that any changes made to such referral processes (including pursuant to the Memorandum of Understanding as it relates to the provision of mental health services to people in immigration detention)[44] are duly informed by: (a) the family concerns raised in relation to Mr SWX's treatment during transfer, including as to how best to uphold the rights of those who are held in custody or detention, but are being transferred for urgent medical treatment; and (b) ensuring that there are clear guidelines as to the legal status of such persons (i.e. whether they are considered to be in the care of a state-based mental health service or whether they are in the custody of the Commonwealth), to ensure consistency in the application of state and federal legislative frameworks.

**Care provided to Mr SWX by Werribee Mercy Hospital**

118. I turn now to the heart of these proceedings – the adequacy of the care and treatment provided to Mr SWX while at Werribee Mercy Hospital (**WMH**). In this connection, the Coroners Prevention Unit (**CPU**), having assessed Mr SWX's treatment in detail, and having considered the expert evidence of A/Prof Gunja and Dr Burke, identified some issues of concern for my consideration in relation to review of Mr SWX's medication regime, visual observations and physiological monitoring, certain of which were also identified by Mercy Health via an internal review conducted following Mr SWX's death.

*Mercy Health internal review*

119. The CPU noted that, following Mr SWX's death, Mercy Health conducted a Root Cause Analysis (**RCA**) which identified seven learnings.[45]

120. Mercy Health's reported learnings were as follows:

[44] CB-243 *et seq.*
[45] The outcome of the internal review was provided in a letter to the Court dated 18 May 2018, authored by Michael Regos, Partner of DLA Piper Australia (and which, as noted above, has been included in the coronial brief as Additional Material 2 -**AM2**), with details of RCA recommendations and implementation updates provided by A/Prof Stevenson in statements dated 12 June 2019 (CB-57 – CB-75) and 5 September 2024 (**AM1**) respectively.

a) *On close inspection of the patient's medication charts it was noted that the Best Possible Medication History Taking procedure was not followed.*[46]

b) *Olanzapine was not included as a high risk medication in the High Risk Medication Procedure.*[47]

c) *The patient was not referred to a pharmacy referral despite meeting criteria.*[48]

d) *Blood tests were attempted but bleed was not successful, despite multiple attempts by different staff members over different days. Patient non-compliance was a significant factor to this. There is no documented plan to escalate this. Other options such as general medical team review and possible anaesthetic review could have been utilised.*[49]

e) *The covering medical team was temporarily delayed in attending the code blue as they were unable to access parts of the recently opened Mental Health building. Orientation (both upon commissioning as part of new staff orientation) to building*

[46] The associated recommendation made at the time of the internal review was for 'Review of the *Best Possible Medication History Taking* procedure to ensure clarity of the instructions for required information', which was reportedly completed in August 2017. As of September 2024, it was reported that this procedure has been merged with '*Medication management and prescribing procedure'* to reduce the number of procedures required to be consulted by staff.

[47] The associated recommendation made at the time of the internal review was to 'Review/update the *High Risk Medication Procedure* to include olanzapine as a high-risk medication', which was initially reported as completed. As of September 2024, it was reported that this has been merged with '*Medication management and prescribing procedure'*.

[48] The associated recommendation made at the time of the internal review was for the 'Pharmacy department to conduct daily medication reconciliation for all mental health inpatients'. It was reported by Mercy Health that, due to an increase in inpatient beds, it was not feasible for pharmacists to undertake daily reconciliations for all patients. Therefore, patients identified in the high-medium risk category as per the procedure would undergo reconciliation review. As of September 2024, it was reported that a dedicated pharmacist and assistant have now been appointed to the psychiatric inpatient unit so all medication charts are now reviewed on a regular basis with immediate feedback if concerns are identified.

[49] The associated recommendation made at the time of the internal review was for 'Review of process of escalation to general medical staff for patients with complex medical problems and when specialist mental health staff are unable to complete blood sampling', the outcome of which was noted to be that 'discussions on how to strengthen pre-existing referral pathways have commenced'. As of September 2024, Mercy Health noted that the mental health program has a strong relationship with the medical, subacute and palliative care programs that is supplemented by the *Referral of Adult Inpatients for General Medicine Consultation* (2020) to ensure a clear referral process and that if phlebotomy is challenging, pathology services are asked to assist.

*layout should include all medical health teams who may be required to respond in an emergency situation.*[50]

*f) The Psychiatric Inpatient Unit Visual Observations and Engagement Procedure does not include clear instructions regarding the need to open the door to ensure the wellbeing of the patient in the sleeping area of the room. The visual observation chart includes the opportunity to record 'audible respiratory sounds' which cannot usually be heard through a closed door. Often this is recorded even though the staff member has not opened the door. The design of the doors of the sleeping areas of the ICA unit are not favourable for quiet but clear visual observations. The doors are heavy and the patients are disturbed when they are opened and can become aggressive. Shining a light also disturbs the patient. The understanding and guidelines in relation to the benefit of opening the patient's door and observing them sleeping versus opening the door and relying on observation of them through the glass panel is a complex risk that needs to be considered and mitigated by the program.*[51]

121. The CPU was supportive of all learnings identified. However, the CPU also considered there were additional issues relating to monitoring which were not identified nor addressed by the internal review, namely in relation to: (i) visual observations; (ii) vital signs and other investigations; and (iii) culturally competent care. These issues are outlined below.

[50] The associated recommendation made at the time of the internal review was for 'a tour of the mental health building to be added to the medical staff orientation program to ensure timely access to required areas. Swipe card access to be activated upon employment', which was marked as completed. As of September 2024, Mercy Health reports that this is included in orientation to all new clinical staff upon commencement.

[51] The associated two recommendations made at the time of the internal review were for: (i) 'Review of the *Psychiatric Inpatient Unit Visual Observations and Engagement* procedure to ensure the instructions are clear regarding the need to open the door to ensure the wellbeing of the patient in the sleeping area of the room', which was marked as completed. As of September 2024, Mercy Health has noted that the bedroom doors in the HDU/Intensive Care Area were replaced in August 2024 and have a much larger viewing window and are simple and quiet to open. The procedure remains in place but is being updated; and (ii) the 'Program to consider the feasibility of utilising an appropriate sensor device to enable high risk patients who are sleeping to be appropriately monitored without being woken. If this is not considered feasible alternate risk mitigation strategies to be determined and the visual observation and engagement procedure amended to reflect this and staff training to follow', which was determined by Mercy Health not to be pursued. This is unchanged as of September 2024.

Visual observations

122. The CPU raised concerns in regard to two significant inadequacies in the visual monitoring of Mr SWX during his admission.

123. First, the CPU considered that there was a lack of clarity as to whether staff complied with visual monitoring requirements, including to observe Mr SWX at 6.15pm on 22 August 2017, immediately prior to being discovered unresponsive at around 6.30pm.

124. Throughout his admission, Mr SWX was required to be on 15-minutely visual observations by nursing staff. However, medical records indicate the last recorded observation on 22 August 2017, the date of death, was completed at 6pm. The Nurse Unit Manager (**NUM**) acknowledged that nursing staff did not document a visual observation at 6.15pm and stated that, while they believe the check was undertaken, they are unable to be certain. They noted that where a patient's primary nurse is on a break, it is the collective responsibility of the nurses remaining to complete any required visual observations, and so no particular nurse had been allocated to complete the 6.15pm visual observation in this instance.

125. In the absence of any evidence to confirm whether or not Mr SWX was observed around 6.15pm, the CPU considered that Mercy Health failed to maintain an adequate system of visual monitoring in the period immediately prior to his death. Further, the CPU noted it was concerning that this issue was not identified by Mercy Health in its internal review.

126. The second issue identified by the CPU related to the standard of visual observations more generally. As identified in the Mercy Health internal review, it appears that at the time of Mr SWX's death, nursing staff often recorded that sleeping patients had audible respiratory sounds even though they had not opened the door, and sounds could not usually be heard through the door. The unreliability of this practice is concerning, even more so in the context of over-sedation, as the warning signs of opiate overdose can include being unrousable and snoring.

127. In Mr SWX's case, on the day of his death, all observations conducted from 2.30pm onwards appear to be recorded on the basis that Mr SWX was sleeping but had audible

respiratory sounds.[52] Noting that Mercy Health has acknowledged the unreliability of such observations, the CPU considered that it was possible Mr SWX could have become unresponsive at any time from 2.30pm onwards.

ii. Vital signs and other investigations

128. In addition to concerns regarding the adequacy of visual monitoring, the CPU was concerned that Mr SWX did not receive even the minimum standard of physiological monitoring in a context in which he displayed clinical signs of sedation. The CPU raised specific concerns regarding both staff compliance with existing Mercy Health procedures, as well as the inadequacy of existing procedures and guidance available at that time.

129. At the relevant time of Mr SWX's death, the Mercy Health *Adult Observation and Response Chart Procedure (Excluding Maternity)* provided that:[53]

    a) It was a requirement that every admitted patient have a monitoring plan and that physical observations were to be documented by clinical staff *"at the frequency specified by the patient's monitoring plan/frequency of observations (as per patient's daily care plan) – appropriate for the patient's clinical state."*

    b) The minimum standard for patients in psychiatry was that physical observations should be taken on a daily basis.[54]

130. Despite these requirements, there was no documented evidence of a plan for physical observations once Mr SWX was moved out of seclusion. The Adult Observation and

[52] MR-693. It is noted that the observation recorded at 2:45pm on this date is unclearly notated though may suggest that a change in sleeping position was observed, in addition to regular respiratory movements. In each of the other recorded observations during this period, the Visual Observation chart indicates that Mr SWX was sleeping but observed with 'A – Regular respiratory movements' and 'C – Audible respiratory sounds'. Given that the Mercy Health Visual Observation chart requires that nurses record a minimum of two indicators, and that Mercy Health has acknowledged that it was common practice for nurses to conduct visual observations without entering the room, this calls into question the reliability of observations in relation to 'Regular respiratory movements'. I consider that the recorded observations during this period are not reliable.
[53] CB-261.
[54] The procedure specifies that physiological monitoring should include measuring and recording respiratory rate, oxygen saturation, blood pressure, heart rate, temperature and level of consciousness: CB-261.

Response Chart in Mr SWX's medical record did not have the "Frequency of Observations/Monitoring Plan" section completed.

131. Further, while Mr SWX displayed clinical signs of sedation on every day throughout his admission, physical observations were not even consistently recorded on a daily basis, with no observations completed on 21 August 2017, the day before he died.

132. In addition, there was no evidence of escalation to obtain advice about the safety of continuing to prescribe and administer medications in the presence of clinical signs of sedation and limited physical health monitoring.

133. While nursed in seclusion, Mr SWX had vital signs taken approximately four-hourly as required under the then-applicable *Mental Health Act 2014* (Vic).

134. However, once Mr SWX was moved out of seclusion and the legislative requirement for four-hourly medical reviews no longer applied, Mr SWX's vital signs were not consistently recorded on a daily basis. Mr SWX was moved from seclusion to the ICA at 3.20pm on 18 August 2017 and had observations done at 8.20pm which showed that he was tachycardic. Observations were taken during the morning shift on 19 August 2017 and Mr SWX continued to be observed as tachycardic. After this time, observations were recorded at 10.55am on 20 August 2017 and 10am on 22 August 2017, both of which were unremarkable.

135. It was unclear why Mr SWX's physical observations decreased in frequency from 4pm on 19 August 2017, particularly given he had been tachycardic at multiple observations over the previous 24 hours.

136. Further, there was no evidence in the medical record that vital signs were attempted on 21 August 2017 nor an explanation as to why they were not conducted. The CPU identified that this amounted to a failure to comply with the Mercy Health requirement for minimum daily physical monitoring, and noted this was not identified in the internal review.

137. In relation to the performing of electrocardiograms (**ECGs**), the CPU noted that following the ECG conducted on 18 August 2017 which demonstrated sinus tachycardia, no further

ECGs were performed throughout Mr SWX's admission, and there was no evidence that further ECGs were requested by medical staff nor attempted by nursing staff. This was not identified as an issue in the Mercy Health internal investigation.

138. Finally, the CPU noted that although two documented attempts were made to take blood, pathology testing was never completed during the admission. The Mercy Health internal review stated that *"multiple attempts were made by different staff members over different days."*[55] Given the importance of monitoring the physical condition of Mr SWX while he was being administered multiple sedating medications, the CPU considered that good practice would have been to escalate the matter. As suggested by the internal review, this could have included consulting the general medical or anaesthetic teams.

iii. Culturally competent care

139. In addition to inadequate monitoring, the CPU considered that treating clinicians did not adequately consider Mr SWX's needs in delivering culturally competent care, and noted that this issue was not addressed in the Mercy Health internal review. In particular, the CPU considered that Mr SWX was particularly vulnerable upon his admission as he was facing imminent deportation to Eritrea after residing in Australia for 18 years, in circumstances where his family were to remain in Australia.

140. According to the CPU, Mr SWX's complex background and vulnerabilities raised the need for specific cultural considerations in the delivery of his clinical care. This was particularly the case where staff intended to employ restrictive practices such as seclusion, as well as a high level of sedation. The CPU considered that culturally competent care in this context should have incorporated both trauma-informed and family-centred practices.

141. While the CPU accepted that seclusion appeared to be appropriate upon admission, it considered that the length of seclusion may have been reduced through earlier consideration of less restrictive practices, such as the use of a security guard within the unit. In circumstances in which four-hourly medical reviews showed that Mr SWX was only agitated at the 9.25am review on 18 August 2017 and was otherwise sedated and

[55] AM2.

cooperative, with no reports of aggressive behaviour or threats to staff, it is unclear why other less restrictive practices, such as the use of a security guard, were not employed for more than 24 hours. In the context of Mr SWX's history, such lengthy seclusion was likely to be re-traumatising.

142. The CPU also considered that Mr SWX may have benefited from increased engagement with family members, who had requested to be involved in treating decisions. The treating team did make contact with Mr SWX's sister to obtain collateral information while he was in the ED, when his sister reported that Mr SWX previously experienced side effects from zuclopenthixol (though this was subsequently prescribed to him) and requested to be involved in treatment decisions.

143. Despite this request, there did not appear to be any further contact with Mr SWX's sister (including in relation to restrictive measures deployed by WMH staff) until the morning of 21 August 2017 when there was discussion regarding a family visit. It is possible that greater engagement with Mr SWX's family may have resulted in more family-centred and culturally competent care, which may in turn have had the impact of de-escalating Mr SWX and thus have reduced the need for sedation and seclusion.

144. Mercy Health has indicated that it has "*take[n] on board*" the issues raised by the CPU in relation to culturally competent care.

**ANALYSIS**

145. In considering all of the evidence before me, and in analysing the care provided to Mr SWX by clinicians at Mercy Health, it is necessary to consider two distinct sets of questions:

    a) First, did any aspect of the care provided to Mr SWX by clinicians at Werribee Mercy Hospital cause, or contribute to, his death?

    b) Second, if a similar scenario were to arise today, would the care provided to a patient in Mr SWX's circumstances be different? Are there any further opportunities to prevent future deaths in similar circumstances?

146. In conducting this analysis, I emphasise that, in the coronial jurisdiction, adverse findings or comments against individuals in their professional capacity, or against institutions, are not to be made solely with the benefit of hindsight, but 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.

147. Overall, as I will explicate further, I am satisfied that Mr SWX was subject to: (i) monitoring under a deficient visual observations regime; (ii) inadequate physiological monitoring; and (iii) administration of multiple sedative and antipsychotic medications without a pharmacist review, which was a lost opportunity for clinicians to receive advice on Mr SWX's medication regime *in toto*. I will expand upon this below.

148. In arriving at such conclusion, I do not purport to place blame on any individual clinician involved. Rather, I consider that any deficiencies in care are properly attributed to Mercy Health as an organisation, including by way of failing to provide adequate guidance to assist its staff to identify and implement appropriate monitoring and review practices.

**Did any aspect of the care provided to Mr SWX by clinicians at Werribee Mercy Hospital cause, or contribute, to his death?**

*Medication regime*

149. The question of Mr SWX's medication regime and its potential contribution to his death was considered in the expert report of Clinical and Forensic Toxicologist, A/Prof Gunja.

150. A/Prof Gunja observed that the post-mortem toxicological results largely confirmed the presence in blood of those medications that Mr SWX had been prescribed while at WMH, with none particularly elevated suggesting acute drug overdose.[56] Nonetheless, A/Prof Gunja concluded that the regimen of medications administered to Mr SWX "*could have contributed to [his] death*".

[56] As noted in the statement of Dr Banerjee, this includes some medications which had been prescribed earlier but subsequently ceased, for example, codeine is present in Panadeine Forte and morphine is an active metabolite of codeine: CB-41.

151. A/Prof Gunja explained that while all medications prescribed to Mr SWX were prescribed within therapeutic dosing ranges, as a concurrent regime they had "*the potential to cause profound sedation and increase the risk of cardiac arrhythmias, particularly in an obese individual*." While there is "*no concrete evidence of arrhythmia having occurred*," A/Prof Gunja considered that this remained "*a distinct possibility*" in the absence of anatomical pathology, trauma or acute drug overdose. On this basis, A/Prof Gunja provided an opinion that, "*Concurrent anti-psychotic drugs, as well as the cumulative effect of multiple sedative medications, with the addition of buprenorphine on the day prior, could have contributed to [Mr SWX's] death*."

152. In submissions made following the Inquest, Counsel for Mercy Health stated that, whilst it is conceded that there were shortfalls in physiological monitoring and potentially a shortfall in the manner of visual observations, it is contended that the medication regimen was subject to review. Counsel submitted, *inter alia*, that Mr SWX's treating psychiatrist, Dr Banerjee, reviewed and altered his medication regimen on Friday 18 August 2017, Monday 21 August 2017 and Tuesday 22 August 2017.

153. Counsel submitted that, at its highest, the opinion of A/Prof Gunja rises to "*sudden cardiac death from cardiac arrhythmia remains a distinct possibility*", likely contributed to by his medication regimen. Mercy Health did not seek to argue the opinion of A/Prof Gunja in this regard.

154. I remain concerned that Mr SWX's medication regimen was not subject to specialist pharmacist review during his in-patient stay. I note that in 2020, Mercy Health appointed a dedicated pharmacist and assistant to the psychiatric inpatient unit so that all medication charts are now reviewed on a regular basis with immediate feedback if concerns relating to prescribing are identified, which I will refer to further below.

*Visual observations*

155. At the time of Mr SWX's death, the Mercy Health *Psychiatric Inpatient Unit Visual Observations and Engagement Procedure* provided that all patients in ICA were to be

subject to 15-minutely visual observations.[57] Although the policy did not provide clear instructions regarding how observations were to be caried out, the Visual Observation chart in use at the time specified that where a patient was asleep, clinicians "*must*" document at least two of the following indicators:

a) A – Regular respiratory movements;

b) B – Change in sleeping position; and

c) C – Audible respiratory sounds.[58]

156. On the day of Mr SWX's death, the Visual Observation chart records that nurses observed that Mr SWX was sleeping from 2.30pm until 6pm, the final check recorded before Mr SWX was discovered unresponsive 30 minutes later. In all but potentially one observation at 2.45pm (which is unclearly notated), the Visual Observation chart records that Mr SWX was observed to present with 'A – Regular respiratory movements' and 'C – Audible respiratory sounds'.

157. However, as noted above, in its internal review, Mercy Health identified that at the relevant time of Mr SWX's death, it was common practice for staff to regularly record that a patient had been observed with '*audible respiratory sounds*' even though the staff member had not opened the door, and audible respiratory sounds could not usually be heard through a closed door.

158. Mercy Health also conceded that the policy in place at that time did not provide clear instructions regarding the need for staff to open the door in order to perform visual observations to the standard required in order to properly ensure patient wellbeing Moreover, it noted that the design of the doors in place at the time may have discouraged staff from proper monitoring practices, as the doors were "*not favourable for quiet and clear visual observations*."

[57] CB-289 – CB-292.
[58] MR-692.

159. I note that no evidence was provided as to whether or not the nurse responsible for conducting checks on Mr SWX in the period leading to his death did in fact open Mr SWX's door, or rather subscribed to the common practice described by Mercy Health in carrying out checks through a closed door.[59] Further, while Mercy Health staff believed that Mr SWX was likely observed by staff at 6.15pm, the Visual Observation chart did not record any observation at that time.

160. In the absence of any evidence to the contrary, and noting that Mercy Health has conceded the general inaccuracy of Visual Observation charts from this time, I consider that it is possible that Mr SWX was not subject to an adequate regime of visual monitoring in the period leading to his death, from 2.30pm until 6.30pm on 22 August 2017.

161. This is because, by the time that Mr SWX was discovered unresponsive at 6.30pm, it is possible that clinicians had not completed visual observations to an appropriate professional standard since 2.30pm that afternoon.

162. In submissions made following the Inquest, Counsel for Mercy Health acknowledged this "*possibility*", and that such a material departure from professional standards "*may*" may have contributed to Mr SWX's death, while emphasising that there was insufficient evidence available to make any finding that the manner or frequency in which visual observations were conducted did, in fact, contribute to Mr SWX's death. I accept Mercy Health's submissions in this regard.

163. Further, I note that Mercy Health has since updated its policies, and that the current *Mental Health Inpatient Unit Engagement & Observations Procedure* provides that, "*When a person is sleeping, or appearing to be sleeping … [i]t highly likely that staff will need to enter the person's bedroom to ensure the accuracy of [visual observations].*"[60] Mercy Health has also replaced all doors in the ICA such that they are now quiet and simple to open.

[59] A statement from the nurse who recorded relevant observations from 3.30pm until 6pm on 22 August 2017 states that throughout his shift, nursing staff "did visual checks … every 15 minutes using the visual observation chart" but does not provide any detail of what this involved.
[60] AM1-93.

*Physiological monitoring*

164. At the time of Mr SWX's death, the Mercy Health *Adult Observation and Response Chart Procedure (Excluding Maternity)* provided that physiological monitoring should occur at the frequency specified by the patient's monitoring plan, and at a minimum of daily for patients in the psychiatric unit.

165. The Mercy Health *Psychiatric Inpatient Unit Visual Observations and Engagement* did not provide guidance on the frequency or quality of physiological observations.

166. Nonetheless, there is evidence to suggest that it would be reasonable to expect that a patient in Mr SWX's circumstances, who was being administered multiple antipsychotics and benzodiazepines and displaying symptoms of sedation, should be subject to regular physiological monitoring including vital signs and ECGs.

167. A/Prof Gunja considered that when patients are being administered large amounts of antipsychotics and benzodiazepines, it is reasonable to expect they should be subject to physical observations at least three times per day (including heart rate, blood pressure, oxygen saturation and temperature).

168. In a statement dated 12 June 2019, Mercy Health Clinical Services Director of Mental Health Services A/Prof Stevenson provided an alternative view on the expected professional standards for physical monitoring. A/Prof Stevenson posited that when a patient has been prescribed multiple sedating medications that are not a part of their usual medication regime and presents with symptoms of sedation, he would expect that morning physical observations be routinely conducted and that the results of these physical observations would be used to guide the frequency of further observations through the course of the day.[61]

169. A/Prof Stevenson stated that, in general, four-hourly observations would be preferable for a patient presenting with signs of sedation secondary to the commencement of multiple

[61] CB-57 – CB-58.

psychiatric medications and that if physical observations were stable throughout the day, they could be ceased overnight to avoid waking the patient.[62]

170. In Mr SWX's case, there is evidence that while he displayed clinical signs of sedation on every day throughout his admission, physical observations were not even consistently recorded on a daily basis, with no observations completed on 21 August 2017, the day before he died. There was no evidence in the medical record that vital signs were attempted on 21 August 2017 nor an explanation as to why they were not conducted.

171. In submissions made following the Inquest, Counsel for Mercy Health stated that it is accepted that no vital sign observations were undertaken on 21 August 2017 and that they should have been undertaken. Counsel emphasised, however, that there was no cogent evidence to suggest that undertaking such vital signs on 21 August 2017 would have altered the outcome. In this respect, Counsel noted that while Mr SWX was tachycardic on 18 and 19 August 2017, his vital signs were unremarkable on 20 and 22 August 2017. I accept Mercy Health's submissions in this regard.

172. In relation to ECGs, A/Prof Gunja stated that he would expect a patient in Mr SWX's circumstances who was receiving sedating medications to receive ECGs at least daily.[63] A/Prof Gunja explained that visual observations alone are insufficient in such circumstances, as a patient may appear asymptomatic before sudden deterioration. Further, ECGs are critical in enabling staff to weigh the risk of QT prolongation and cardiac arrythmia caused by the synergistic effect of multiple antipsychotic medications, against any therapeutic benefits of medication.

173. A/Prof Stevenson accepted the opinion of A/Prof Gunja that it is best practice to conduct daily ECGs in patients on high doses of antipsychotic drugs. However, he considered that where an ECG had been conducted and did not indicate any lengthening of a QTc interval, it was generally "*not practicable*" to conduct further ECGs in the context of an acute

[62] CB-57 – CB-58.
[63] CB-301.

psychiatric unit, and noted that clinicians are generally guided in determining the frequency of ECGs by a person's co-morbid medical history.[64]

174. Upon reviewing the available evidence, I note there is no evidence that staff considered requesting a further ECG during the final four days of Mr SWX's life. Even noting the practical challenges raised by A/Prof Stevenson, in light of the opinion of A/Prof Gunja, I consider that it could reasonably be expected that clinicians would at least consider a further ECG, or further ECGs, in the context of the medication regime prescribed to Mr SWX.

175. In submissions made following the Inquest, Counsel for Mercy Health accepted that an ECG would "*ideally*" be conducted on a daily basis, but emphasised that "*this ideal requires contextualisation*" to the situation where Mr SWX presented an "*extreme risk*" to staff and co-patients on his history and current presentation. While I acknowledge and accept that there may have been practical difficulties in performing an ECG in the circumstances as stated, I consider that, at the very least, clinicians should have considered this option (and documented same).

176. Counsel for Mercy Health further submitted that in circumstances where Mr SWX's ECG on 18 August 2017 did not reveal a prolonged QTc interval, it would be "*pure speculation*" to conclude that in the context of a normal QTc on 18 August 2017, a subsequent ECG/s would have revealed a prolonged QTc. I accept Mercy Health's submissions in this regard.

177. Finally, as acknowledged by Mercy Health in its RCA, I consider that Mercy Health failed to provide adequate care due to the lack of documented attempts to take blood during the first four days of the admission, and the failure to escalate the challenges in obtaining blood samples.

178. In submissions made following the Inquest, Counsel for Mercy Health stated that it accepted that bloods were not taken from Mr SWX and that they should have been taken during his admission. However, Counsel stated that it was "*mere speculation*" as to what

[64] CB-306.

they may have revealed, particularly with reference to an electrolyte imbalance. I accept Mercy Health's submissions in this regard.

179. Further, I note that since the time of Mr SWX's death, Mercy Health has effected substantial updates to its policies intended to ensure that patients being administered large amounts of antipsychotics and benzodiazepines receive both regular, and comprehensive, physiological monitoring, as well as pharmacist review. These policy updates are discussed further below.

**If a similar scenario were to arise today, would the care provided to a patient in Mr SWX's circumstances be different? Are there any further opportunities to prevent future deaths in similar circumstances?**

180. The CPU observed that since the internal review of Mr SWX's death, and more recently the commencement of the *Mental Health and Wellbeing Act 2022* (**MHWA**) that has classified so-called 'chemical restraint' as a restrictive intervention, Mercy Health has undertaken and is continuing to progress considerable reform in relation to providing care to patients who are receiving sedating medications for behavioural reasons in psychiatric inpatient units.

181. As a result of these reforms, the CPU considers that medical practitioners and nurses at WMH psychiatric unit are now better-supported to undertake safe prescribing and monitoring of a person for the purposes of chemical restraint.

182. Prior to outlining the specific reforms implemented, it is relevant to first set out the new legislative framework for the use of chemical restraint, as well as the outcomes of the inquest into the passing of Jacob Kennedy.

*The Mental Health and Wellbeing Act 2022 (Vic)*

183. In Victoria, the use of chemical restraint has been subject to significant reform as the result of new provisions included in the MHWA which for the first time regulates chemical restraint as a restrictive intervention.

184. Chemical restraint is defined in section 3(1) of the MHWA as '*the giving of a drug to a person for the primary purpose of controlling the person's behaviour by restricting their freedom of movement but does not include the giving of a drug to a person for the purpose of treatment or medical treatment*'.

185. While chemical restraint was not regulated *per se* at the time of Mr SWX's death, the CPU considered that it is likely that if the same scenario arose today, certain prescribing to Mr SWX during his admission to WMH would now fall within this legislated definition, noting that A/Prof Stevenson acknowledged that psychiatric medications were prescribed "*in order to address [Mr SWX's] psychiatric symptoms and behavioural and risk issues*",[65] and thus were not only for therapeutic purposes but also for behavioural control in the context of acute behavioural disturbance.

186. I am satisfied that, in light of his presentation and the noted prescribing rationale, and in light of A/Prof Gunja's opinion in which he describes Mr SWX's prescribing regime as '*an attempt to control Mr SWX's behaviour and agitation*',[66] certain of the sedative and anti-psychotic drugs prescribed and administered to Mr SWX during his treatment by WMH would today fall under the definition of '*chemical restraint*'.

187. Under the new legislative framework, services must take steps to minimise the use of restrictive interventions such as chemical restraint, and chemical restraint may only be authorised if it is the least restrictive option. To determine if there is no less restrictive option available, a person authorising the use of restrictive interventions must have regard, to the greatest extent possible in the circumstances to:

    a) the likely impact of the use of the restrictive intervention on the person, considering the person's views and preferences, and any past experience of trauma;

    b) the person's views and preferences relating to the use of restrictive interventions (including views and preferences expressed in an advance statement of preferences

[65] CB-58.
[66] CB-299.

of the person or expressed by the person's nominated support person, if they have one); and

c) the person's culture, beliefs, values and personal characteristics.

188. Importantly, the MHWA also sets out specific requirements for monitoring of a person who is chemically restrained. Under these provisions:

a) A Registered Nurse (**RN**) or medical practitioner must continually observe the person for not less than 1 hour after chemical restraint is administered;

b) A RN or medical practitioner must clinically review the person as often as is appropriate, having regard to the person's condition but not less frequently than ever 15 minutes; and

c) An authorised psychiatrist (or if not practical, a registered medical practitioner) must examine the person as often as is appropriate, having regard to the person's condition, but not less frequently than every 4 hours.

189. In April 2024, the Chief Psychiatrist introduced a guideline[67] to assist designated mental health services to meet their obligations and understand the Chief Psychiatrist's expectations of best practice when using restrictive interventions, including chemical restraint. It states that continuous observation can be either at arm's length or with the person being always within the vision of the observer, with the rationale for the decision about the type of observation to be documented in the nursing care plan. Observations should include (but are not limited to) breathing, level of movement, alertness and responsiveness, levels of agitation, the need to continue the restrictive practice and the status of the consumer established through direct conversation.

190. The Chief Psychiatrist's Guideline refers to a 2013 Department of Health Guideline, the *Nursing observation through engagement in psychiatric inpatient care*, for further information on the role of the RN in relation to observing the person. The Office of the

[67] Department of Health (April 2024) *Chief Psychiatrist's Guideline: Restrictive Interventions*. Victorian Government. https://www.health.vic.gov.au/chief-psychiatrist/chief-psychiatrists-restrictive-interventions.

Chief Mental Health Nurse has confirmed in correspondence to the Court that it is currently in the process of developing a new suite of guidelines to support nurses to provide care in alignment with new legislation, including revising the '*Nursing observation through engagement in psychiatric inpatient care'*. I am hopeful that the revised guideline will provide specific guidance on visual observations of patients receiving chemical restraint.

191. In relation to the requirement for clinical review, the Chief Psychiatrist's Guideline specifies that the review must contain both objective and subjective information about the person from direct contact with them. The review must include the person's vital signs (with escalation of any concerns in a timely manner) but does not provide specific guidance in relation to the nature of physical monitoring when chemical restraint is used.

192. The Chief Psychiatrist's Guideline devolves responsibility to local services for the development of her own policies, protocols and guidelines to support clinicians to comply with their obligations in relation to the MHWA, particularly in relation to restrictive interventions such as chemical restraint.

*Learnings from the Inquest into the passing of Jacob Kennedy*

193. In his findings in relation to the passing of Jacob Kennedy (COR 2017 0595), Coroner Olle recommended both the Medical Board of Australia (**MBA**) and the Nursing and Midwifery Board of Australia (**NMBA**), as supported by the Australian Health Practitioner Regulation Agency (**Ahpra)** develop policies and protocols in relation to the use of sedating medications in inpatient psychiatric units. The recommendations focused on prescribing and administering sedatives, monitoring sedated patients, and the use of an oximeter as a monitoring tool for sedated patients; they were therefore of relevance to the current case.

194. Ahpra acknowledged the case of Jacob Kennedy raised important issues and stated that National Boards do not generally develop clinical practice guidelines and that this would usually be the remit of the National Health and Medical Research Council **(NHMRC**), and specialist colleges and nursing organisations. The MBA and NMBA have declined to develop guidelines but sought the permission of the Court to share the case with medical practitioners and nurses through their respective newsletters, which was granted.

195. Coroner Olle also made recommendations directed at the health service involved in Jacob's care regarding vital signs observations and monitoring, which were duly acknowledged.

196. I recognise that any further initiatives developed in response to the recommendations emerging from the Finding into the passing of Jacob Kennedy will be informed by the broader suite of reforms that have occurred in response to the new legislative regime.

*Changes to Mercy Health policy, procedure and practice*

197. As recommended in the Chief Psychiatrist's Guideline, Mercy Health is currently in the process of aligning existing procedures, and developing new procedures, to support the provision of further guidance to staff in relation to, *inter alia*, chemical restraint. In a statement to the Court provided in September 2024, A/Prof Stevenson noted that:

    a) The *Psychiatric Inpatient Unit Visual Observations and Engagement Procedure* was in the process of being enhanced to incorporate agitation and sedation monitoring scales, track and trigger escalation points, monitoring guidelines (physiological observations) and escalation processes. This was expected to be completed within the next 6 months but will firstly undergo a pilot.

    b) The *Pharmacological Management of Acute Behavioural Disturbance Procedure (2024)* has been updated to provide improved guidance in relation to dosing, in accordance with best practice pharmacological approaches to sedation. This procedure also provides general guidance which was already in place at the time of Mr SWX's death, with regard to choice of medication, precautions, potential interactions, and monitoring.

    c) The updated *Electrocardiogram (ECG) Monitoring of Inpatients prescribed Neuroleptic Medications Procedure (2024)* highlights the risks of cardiac events with the use of antipsychotic drug polypharmacy and mandates the use of ECGs for monitoring. Inpatients prescribed three or more antipsychotic medications (includes the use of PRN antipsychotic medication) must have ECG monitoring, ideally weekly, while patients who are treated in the ICA and are prescribed high dose polypharmacy (two antipsychotic medications and any other psychotropic

medications such as lithium) must have ECG monitoring conducted if and when the person's mental state allows an ECG to be performed.

d) Mercy Health is currently developing a tool that will provide more nuanced assessment of sedation than the existing Glascow Coma Scale and provide a track and trigger for escalation of physiological observations, including oxygen saturation. The inclusions of these measures and processes in the revised *Engagement and Observations Procedure* will provide an important safeguard for future WMH patients when chemical restraint is authorised.

e) In order to support the objective to minimise the use of restrictive interventions, all ICA patients at WMH are now subject to targeted Multidisciplinary Team huddles where agitation and sedation are specifically addressed. According to A/Prof Stevenson, the effectiveness of huddles has been facilitated by the recruitment of three Clinical Nurse Consultants and the huddle process appears to have improved the oversight and management of complex patients, such as Mr SWX.

Internal review – current developments in implementation of recommendations

198. In addition to those initiatives described above, Mercy Health has also progressed specific reforms in response to those learnings identified as part of its internal review. In response to learnings (a), (b) and (c) which related to safe prescribing practices, Mercy Health has made several updates to its *Medication management and prescribing* procedure in order to:

a) Ensure improved clarity in regard to the *Best Possible Medication History Taking procedure;*

b) Include olanzapine as a high-risk medication; and

c) Simplify the number of procedures required to be consulted by clinical staff.

199. In 2020, Mercy Health also appointed a dedicated pharmacist and assistant to the psychiatric inpatient unit so that all medication charts are now reviewed on a regular basis with immediate feedback if concerns relating to prescribing are identified.

200. In response to learning (d) which related to a need for improved escalation processes in circumstances where mental health clinicians were unable to complete blood sampling, Mercy Health advised that the mental health unit "*continue[s]*" to have a strong relationship with the Medical, Subacute and Palliative Care Program, and that escalation procedures are set out within the *Referral of Adult Inpatients for General Medicine Consultation* procedure. While the CPU noted that a similar procedure was already in place at the time of Mr SWX's admission, and did not result in an effective process of escalation in that instance, it was hopeful that the enhanced focus on physical monitoring arising as a result of the new legislative regime would encourage greater compliance in this respect.

201. In response to learning (e) which related to delays in the resuscitation team accessing the Mental Health Building, Mercy Health advised that a tour of the mental health building is now included in orientation to all new clinical staff upon commencement.

202. Finally, in response to learning (f) which related to inadequacies in visual monitoring, Mercy Health indicated that the previously heavy, noisy doors in the ICA were replaced in August 2024 and now have a much larger viewing window and are simple and quiet to open.

203. While Mercy Health considered the feasibility of monitoring high risk patients using sensor devices, the leadership team ultimately determined this initiative would not be pursued on the basis that sensor technologies were unreliable, there was a risk of false positives, and implementing a technological strategy may deter staff from face-to-face engagement which remained the gold standard for monitoring.

*Conclusion*

204. Overall, the CPU was satisfied that WMH has undertaken and is continuing to progress significant reforms which will improve the management of complex patients like Mr SWX, who present with challenging behaviours and who are prescribed substantive sedative and antipsychotic medications, and to address those specific issues identified in the Mercy Health internal review.

205. The CPU further noted that the issue previously identified in relation to clinicians conducting observations through the door has been resolved such that the capacity for visual observation is now greatly improved and the door is no longer noisy when opened; detailed guidance on the physical monitoring of sedated patients is in the process of being developed; a pharmacist has been allocated to the psychiatric inpatient unit; multidisciplinary team discussions now occur for patients in ICA where sedation is used for agitation; and a procedure exists to ensure patients receiving antipsychotic drug polypharmacy receive appropriate ECG monitoring.

206. As a result of these improvements, the CPU was satisfied that medical practitioners and nurses at WMH psychiatric unit are now appropriately supported to undertake safe prescribing and monitoring of a person for the purpose of chemical restraint.

207. The CPU did not identify any further opportunities for prevention or issues that would be the subject of appropriate recommendations.

208. I accept and adopt the advice of the CPU in this regard.

## ADDITIONAL FAMILY CONCERNS

209. During the Inquest, Mr SWX's family raised three additional areas of concern in relation to the care and management provided to Mr SWX by WMH. A response in relation to each issue was provided in a further statement by Dr Michael Lograsso (**Dr Lograsso**), Director of Medical Services at Mercy Mental Health and Wellbeing Service, dated 30 April 2025. These issues are dealt with in turn below.

### Involvement of Mr SWX's sisters as legal guardians

210. Mr SWX's family raised concerns in relation to whether WMH had adequately complied with any requirements to consult with his sisters, in their capacity as legal guardians.

211. As noted above, Mr SWX's sisters were appointed by the Victorian Civil and Administrative Tribunal (**VCAT**) as joint limited guardians on 4 August 2017 and had powers and duties under this order, including to make decisions concerning medical or other health care.

212. In a supplementary statement on behalf of Mercy Health, Dr Lograsso noted that WMH was not made aware at the time of his admission that Mr SWX had a guardianship order in place, and noted this information was not contained in any paperwork available at the time, including previous discharge summaries or documents from other services. However, as soon as WMH became aware of the guardianship order upon contact by Mr SWX's sister and guardian on 19 August 2017, WMH staff provided Mr SWX's guardian with an update and recorded their status as guardian on relevant admission documents.

213. Dr Lograsso noted that further contact with Mr SWX's guardian occurred on 20 August 2017, when she requested information about Mr SWX's treatment plan, and on 21 August 2017 when a medical officer provided information about the current state of the admission and plans. On 21 August 2017, Mr SWX's sister raised concerns regarding treatment without consent and an explanation was provided regarding treatment under the then-applicable *Mental Health Act 2014*.

214. Finally, Dr Lograsso noted that following Mr SWX's death, a plan was made on the morning of 22 August 2017 to liaise with Mr SWX's next of kin to arrange a family meeting.

215. I consider that, as part of the admission process, it would have been best practice to ask about the existence of any orders in place. However, in Mr SWX's case, this may not have been effective, as Mr SWX was unlikely to have been well enough to provide such information himself and there was likely no one present at the time of transfer who would have been aware of the existence of any orders (noting that Mr SWX was accompanied only by Serco guards).

216. The then-applicable *Mental Health Act 2014* and guidelines existing at that time provided relevant principles as follows:

    a) A psychiatrist/clinician should have reasonable regard to the views of carers (and if relevant, guardians) and inform them about decision making and reasoning under the *Mental Health Act 2014* and the use of that Act for compulsory care; and

b) Principle 11.1(k) of the *Mental Health Act 2014* stated: *carers (including children) for persons receiving mental health services should be involved in decisions about assessment, treatment and recovery, whenever this is possible*.

217. While WMH provided some information to Mr SWX's sisters, and noted certain of their concerns in contemporaneous clinical notes, I consider that its engagement with them was limited. Given Mr SWX's culturally and linguistically diverse background, his precarious immigration status and limited engagement with clinicians, there was likely to be significant value in including his sisters in his treatment planning, particularly in relation to addressing Mr SWX's behaviours of concern.

218. I consider that, irrespective of the legal status of Mr SWX's sisters as guardians, there was a missed opportunity to engage them more closely in Mr SWX's care, to consider more closely their views on his treatment, and to provide a trauma-informed, culturally-responsive approach to his care. A pertinent comment will follow.

219. However, I note in this regard that Mercy Health confirmed that it has "*take[n] on board*" the issues identified regarding culturally-responsive care, and that Mercy Health's legal obligations to Mr SWX's sisters as his guardians must be construed in light of Mr SWX being a compulsory patient under the *Mental Health Act 2014* at all relevant times.

**Adequacy of the emergency response**

220. Mr SWX's family also raised concerns with regard to the adequacy of WMH's emergency response, following the discovery of Mr SWX in an unresponsive state at approximately 6.30pm on 22 August 2017. In particular, Mr SWX's family stated that they observed that the resuscitation team arrived to the room without all appropriate equipment, and were required to leave the room to obtain necessary equipment, causing further delays in treatment.

221. In his supplementary statement, Dr Lograsso acknowledged that there had been some delays in the emergency response, as a result of difficulties accessing the new Mental Health building, as identified and addressed by the RCA. However, taking these delays into account, Dr Lograsso noted that the Code Blue team had still arrived within 3 minutes of

the Code being called. In addition, Dr Lograsso noted that the patient file described clinical delays due to a lack of immediate IV access[68] and intubation.[69]

222. In relation to the additional delays described by Mr SWX's family, Dr Lograsso noted that he was unable to comment on whether or not the resuscitation team was further delayed as a result of arriving to the room without all necessary equipment. In this respect, Dr Lograsso noted that he was not aware of any CCTV footage available of this incident, as there are no CCTV cameras in patient-facing areas, and that the clinician who led the resuscitation team had not made any comments about equipment delaying the resuscitation.

223. Mr SWX's family also raised concerns that Mr SWX was only discovered unresponsive as the result of the family attending for a visit. In response, Dr Lograsso acknowledged that Mr SWX was located at approximately the same time that family arrived, but considered that it was unclear whether he was observed at that time in response to the family's arrival or otherwise as the result of a delayed observation.

224. On the evidence available, and noting the passage of time, I consider it is not possible to determine whether there may have been further delays in treatment as a result of the resuscitation team arriving without all necessary equipment. Similarly, it cannot now be determined on the state of the evidence whether Mr SWX was discovered as the result of his family arriving, or alternatively, due to scheduled observations which had been delayed.

225. I acknowledge that the circumstances of Mr SWX being found unresponsive would have been extremely distressing to his family, and would undoubtedly have raised a number of questions for them. However, I consider that, in terms of the adequacy of the emergency response: (i) there is no evidence that any issues with available resuscitation equipment would have changed the outcome for Mr SWX; (ii) the known delays associated with the emergency response have been appropriately identified and responded to by Mercy

[68] Dr Lograsso noted that IV therapy was not supported in that mental health unit, and so no patient would have immediate access. Such patients would be managed in a general medical ward.
[69] Dr Lograsso noted this was due to the presence of vomitus.

Health;[70] and (iii) the issue of improved processes regarding observations has also been comprehensively addressed by Mercy Health and is canvassed elsewhere in this finding.

**Failure to take blood samples**

226. Mr SWX's family further queried why WMH clinicians were unable to successfully take blood from Mr SWX, despite multiple reported attempts.

227. In a supplementary statement on behalf of Mercy Health, Dr Lograsso noted that medical records document two reasons, as follows:

    a) During the first few days of his admission, Mr SWX reportedly refused to comply with requests and was uncooperative and unpredictable;

    b) On 22 August 2017, a Registered Nurse recorded that during a phlebotomy, "*no blood came out*" and documented a suggested reason of dehydration.

228. Dr Lograsso acknowledged that the latter explanation "*should not have been the case in circumstances where [Mr SWX] was noted to be eating and drinking well*" that day, but that he was otherwise unable to speculate as to the reason why blood was unable to be taken at that time.

229. I accept that it is not possible in the circumstances to make any finding on this issue given the passage of time, and noting that nurses may encounter difficulties when taking blood for a number of reasons. Further, regardless of the specific cause of difficulties in this instance, I am satisfied that the core issue has been appropriately resolved through improving processes of escalation.[71]

[70] The associated recommendation made at the time of the internal review was for 'a tour of the mental health building to be added to the medical staff orientation program to ensure timely access to required areas. Swipe card access to be activated upon employment', which was marked as completed. As of September 2024, Mercy Health reports that this is included in orientation to all new clinical staff upon commencement.

[71] The associated recommendation made at the time of the internal review was for 'Review of process of escalation to general medical staff for patients with complex medical problems and when specialist mental health staff are unable to complete blood sampling', the outcome of which was noted to be that 'discussions on how to strengthen pre-existing referral pathways have commenced'. As of September 2024, Mercy Health noted that the mental health program has a strong relationship with the medical, subacute and palliative care programs that is supplemented by the *Referral of Adult Inpatients for General Medicine Consultation* (2020) to ensure a clear referral process and that if phlebotomy is challenging, pathology services are asked to assist.

230. Finally, as previously discussed, I note there is no evidence to find that any failure to take blood caused or contributed to Mr SWX's death, noting submissions by Counsel for Mercy Health that it would be "*mere speculation*" as to what any blood tests may have revealed, particularly with reference to an electrolyte imbalance.

## FINDINGS AND CONCLUSION

231. Having investigated the death of Mr SWX, and having held an Inquest in relation to Mr SWX's death on 5 February 2025 at the Coroners Court of Victoria at Melbourne, I make the following findings, pursuant to section 67(1) of the *Coroners Act 2008*:

    a) the identity of the deceased was Mr SWX, born [redacted] 1985;

    b) the death occurred on 22 August 2017 at Werribee Mercy Hospital, 300 Princes Highway, Werribee, Victoria, 3030, from 1(a) aspiration of gastric contents and 1(b) combined drug toxicity; and

    c) the death occurred in the circumstances described above at paragraphs [73] to [98].

232. Having considered all of the evidence, along with the submissions made following the Inquest, I find that there were several aspects of Mr SWX's care that were deficient during his period as an involuntary inpatient at Mercy Werribee Hospital from 16-22 August 2017.

233. These include a deficient visual observations regime, lack of appropriate physiological monitoring, and insufficient engagement with Mr SWX's family in his care.

234. Moreover, as opined by the Court's expert, Associate Professor Gunja, I find that Mr SWX had suboptimal monitoring, observations and investigations performed during the 72-hour period prior to his death.

235. I consider that it was critical to ensure appropriate monitoring, observations and investigations were undertaken in the context of Mr SWX's medication regime, which involved the concurrent administration of multiple sedative and antipsychotic agents. While these medications were periodically reviewed by his treating psychiatrist, and each individual medication was within therapeutic limits, the regime as a whole was not subject

to a pharmacist review during his in-patient stay. I find that this represented a lost opportunity to identify and respond to the attendant risks of Mr SWX's prescribing regime.

236. I find these deficiencies to be of great concern, in circumstances where Mr SWX was a highly vulnerable member of our community – as a person subject to compulsory treatment under the then-applicable *Mental Health Act 2014* and who faced imminent deportation, away from his family and his home of 18 years, and who was receiving a high number of sedating and antipsychotic medications.

237. Moreover, I consider that it is *possible* that the cumulative impact of these deficiencies in care may have led to Mr SWX's death.

238. Overall, however, taking into account all evidence before me, I consider there is insufficient evidence to make a finding on the requisite standard – *the balance of probabilities* – that these deficiencies did *indeed* cause Mr SWX's death. In this respect, I note in particular that each of Mr SWX's medications were within a common range of doses, that his medication regimen was subject to review on three occasions, and that it cannot be established on the balance of probabilities that the visual observations taken on the afternoon of his death were below standard, nor that additional physiological monitoring would have identified deterioration and thus have prevented his death.

239. Finally, while noting my deep concern in regard to the care provided to Mr SWX, I must acknowledge the efforts of Mercy Health on the significant reforms undertaken since the time of his death, including in response to the implementation of new legislation regulating the use of chemical restraint and restrictive interventions more broadly. I am hopeful that as the result of these initiatives, and subject to the comments below, future patients presenting with complexities such as Mr SWX will have an optimised level of care.

## COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

### Expanded role of the Office of the Chief Psychiatrist

1. As noted earlier in this finding, given the cause of his death, I limited the scope of my investigation to the care and treatment provided to Mr SWX while he was a patient at Werribee Mercy Hospital. This meant that certain of the concerns of Mr SWX's family members in relation to his access to healthcare and treatment while in state and federal custody were not examined in detail in the Inquest proceedings.

2. However, I note that under the new *Mental Health and Wellbeing Act 2022*, the Office of the Chief Psychiatrist (**OCP**) has an expanded role in relation to specialist mental health services provided in custodial settings. I am hopeful that the OCP will consider exploring thematically some of those issues raised by Mr SWX's family, including the potential impacts of separation regimes on access to mental health care within custodial settings, and/or providing any relevant guidelines on this issue.

### Access to culturally-responsive care

3. The Coroners Prevention Unit (**CPU**), in assessing the care provided to Mr SWX by Werribee Mercy Hospital, opined that clinicians did not adequately consider Mr SWX's needs in delivering culturally competent care, and his particular vulnerability upon his admission given that he was facing imminent deportation to Eritrea, in circumstances in which his family were able to remain in Australia.

4. The CPU opined, and I agree, that the need for culturally competent care in this context should have incorporated both trauma-informed and family-centred practices, however, there is no evidence that this was actively considered by clinicians beyond limited contact with Mr SWX's sisters.

5. The relevant Mercy Hospital policy in this regard simply notes a requirement for staff to '*Respect patient's and clients' values, preferences, expressed needs, beliefs, cultural needs,*

*family situation and lifestyle*', as well as a requirement not to provide health services in a non-discriminatory manner.

6. Noting that Mercy Health has stated that it is committed to providing responsive and accessible services that meet the needs of the diverse communities it serves, I make comment that Mercy Health consider the need for further guidance and training to its staff on concrete ways in which it can best accommodate the needs of patients and their families who come from culturally and linguistically diverse backgrounds. This should also include guidance on the particular considerations that can attend upon patients from refugee communities who have come to Australia following experience of conflict and violence, and the importance in this connection of trauma-informed practice.

**Challenge of working with patients exhibiting acute behavioural disturbance and concurrent need to ensure staff safety and upholding of patients' rights**

7. Significant challenges are posed to staff and clinicians in providing care to patients exhibiting, at times, acute behavioural disturbance including violent or aggressive behaviours.

8. It ought to go without saying that all hospital staff members deserve to feel safe and supported while at work. I recognise that certain of Mr SWX's behaviours, when he was acutely unwell, may have raised concerns for the safety and wellbeing of those caring for him.

9. In these circumstances, there is a significant responsibility for healthcare providers, such as Mercy Health, to facilitate a working environment in which its staff feel supported to provide a high quality of care and treatment, without compromising their personal safety or wellbeing. This must be done in a manner that simultaneously upholds the human rights of vulnerable patients, including the right to access healthcare, without discrimination, and the right to be treated with dignity at all times.

10. To this end, I am optimistic that the suite of organisational changes made by Mercy Health since Mr SWX's passing, when applied in the context of a new *Mental Health and Wellbeing Act 2022*, will mean improved safety for staff and patients alike, including a

reduced reliance on restrictive measures such as chemical restraint, optimised patient monitoring, and better care for vulnerable patients.

## ACKNOWLEDGEMENTS

I convey my sincere condolences to Mr SWX's family for their immeasurable loss. I recognise the devastation they have faced in the wake of the death of a son, brother and uncle that they loved and cared for deeply in the face of the complex issues he faced over many years. I consider it to be a tragedy that Mr SWX, who arrived in Australia as a young refugee, in search of safety and a better life, died in such circumstances.

Moreover, I recognise the significant passage of time since Mr SWX's death, and acknowledge that the distress experienced by Mr SWX's family may have been further amplified as the result of the long investigation into his death that has taken place. I also thank Mr SWX's family for raising significant concerns of care with the Court and for contributing so valuably to the coronial investigation. I acknowledge the fierce love and ongoing support they provided to Mr SWX despite the challenges he faced in his life, and thank them for the eloquent and heartfelt words delivered through their coronial impact statement.

I acknowledge the work of my former colleague Coroner Olle who previously had carriage of this investigation and who worked tirelessly to progress it prior to me assuming carriage of these proceedings. I also extend my gratitude to the Coroner's Assistant, Ms Kajhal McIntyre, the Registry staff (including Family Liaison Officers), the Coronial Investigator and in particular the Coroners Prevention Unit for the invaluable assistance all have rendered in these proceedings. I also thank legal representatives for Mercy Health for the proactive, considered and helpful approach to this investigation.

## ORDERS AND DIRECTIONS

Pursuant to section 73(1B) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

[redacted], Senior Next of Kin

[redacted], Family member

Mercy Health

Western Health

Victorian Department of Health

Commonwealth Department of Home Affairs

International Health and Medical Services

The Department of Justice and Community Safety (inclusive of Corrections Victoria and Justice Health)

Correct Care Australasia

St Vincent's Correctional Health Service

Forensicare

Office of the Chief Psychiatrist

Office of the Chief Mental Health Nurse

Detective Sergeant Chris Madden, Coronial Investigator

Signature:

**INGRID GILES**
**CORONER**

**Date: 24 July 2025**

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an inquest. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.

**Annexure A - Table included in expert report of A/Prof Gunja dated 26 April 2020 summarising all psychotropics administered during Mr SWX's admission to WMH**

**Table 1**: Psychotropics administered to Mr SWX , 17th – 22nd August

| Date | Drug | Type of psychotropic | Total daily dose (mg) |
|---|---|---|---|
| 17 August | Olanzapine | Anti-psychotic | 20 |
| | Quetiapine | Anti-psychotic | 200 |
| | Chlorpromazine | Anti-psychotic | 100 |
| | Diazepam | Sedative | 20 |
| | Lorazepam | Sedative | 2 |
| 18 August | Zuclopenthixol | Anti-psychotic | 400 |
| | Chlorpromazine | Anti-psychotic | 400 |
| | Olanzapine | Anti-psychotic | 20 |
| | Lorazepam | Sedative | 4 |
| | Clonazepam | Sedative | 2 |
| 19 August | Chlorpromazine | Anti-psychotic | 500 |
| | Olanzapine | Anti-psychotic | 30 |
| | Temazepam | Sedative | 20 |
| | Clonazepam | Sedative | 4 |
| | Lorazepam | Sedative | 4 |
| 20 August | Chlorpromazine | Anti-psychotic | 400 |
| | Olanzapine | Anti-psychotic | 20 |
| | Clonazepam | Sedative | 4 |
| | Lorazepam | Sedative | 4 |
| 21 August | Chlorpromazine | Anti-psychotic | 600 |
| | Olanzapine | Anti-psychotic | 30 |
| | Clonazepam | Sedative | 4 |
| | Lorazepam | Sedative | 6 |
| | Temazepam | Sedative | 40 |
| | Buprenorphine | Opiate | 8 |
| 22 August | Chlorpromazine | Anti-psychotic | 100 |
| | Olanzapine | Anti-psychotic | 10 |
| | Buprenorphine | Opiate | 8 |
| | Pregabalin | Anxiolytic | 75 |