IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 006991

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Ingrid Giles
Deceased:	Joseph David Jones
Date of birth:	23 November 1946
Date of death:	6 December 2022
Cause of death:	1(a) Unascertained - natural causes
Place of death:	1200 Dana Street, Ballarat Central, Victoria, 3350
Keywords:	IN CARE; SCHIZOPHRENIA; NATURAL CAUSES; GRAMPIANS HEALTH; TEMPORARY TREATMENT ORDER

INTRODUCTION

1. Joseph David Jones (**Mr Jones**) was 76 years old when he died on 6 December 2022. At the time of his death, Mr Jones resided at the Steele Haughton Residential Unit in Ballarat. This is an aged care and mental health facility. At the time of his death, Mr Jones was an involuntary psychiatric patient under a Temporary Treatment Order, which was issued on 31 November 2022.[1]

2. Dr Ramesh Chandra, Consultant Psychiatrist at Grampians Mental Health Services, provided a statement to the Court detailing Mr Jones' care and treatment. Mr Jones had a long-standing diagnosis of schizoaffective disorder, with multiple relapses and admissions to psychiatric facilities due to non-adherence to medications. His relapses were in the form of manic and psychotic symptoms. He was treated with a combination of antipsychotic and mood stabilising medications. Due to his non-adherence to medications and repeated relapses, Mr Jones was treated with the help of long-acting antipsychotic injections (Haloperidol, Zuclopenthixol, and Paliperidone) and subject to both inpatient and community orders.

THE CORONIAL INVESTIGATION

3. Mr Jones's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury. The death of a person in care or custody (as Mr Jones' was, due to his status under the *Mental Health Act 2014*) is a mandatory report to the coroner, even if the death appears to have been from natural causes.

4. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

5. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

[1] Issued under section 46 of the *Mental Health Act 2014* (the Act in force at the time of Mr Jones' death).

6. Then-Deputy State Coroner Jacqui Hawkins initially held carriage of the investigation into Mr Jones' passing. I took carriage on 27 October 2023 for the purposes of finalising the investigation and making findings.

7. There is a requirement under section 52(2)(b) of the Act to hold an Inquest into the death of a person who was in custody or care immediately prior to passing, though pursuant to section 52(3A) of the Act, the coroner is not required to hold an Inquest if the coroner considers the death was due to natural causes. I exercise my discretion under this provision not to hold an Inquest in the present case on the basis that Mr Jones's passing was due to natural causes and there are no further issues I have identified that require the hearing of *viva voce* evidence.

8. This finding draws on the totality of the coronial investigation into the death of Joseph David Jones. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[2]

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

9. On 29 November 2022, Mr Jones was admitted to the acute psychogeriatric unit due to a relapse of schizoaffective disorder on the background of medication non-adherence. His care was transferred from the residential unit to the psychogeriatric unit due to increased care needs, risk, and refusal to take medications. Tests indicated Mr Jones had been non-compliant with his oral medications.

10. Mr Jones was commenced on a short course of regular intramuscular (**IM**) olanzapine 10mg injections daily to improve his mental state.

11. Mr Jones was reviewed by Dr Chandra and registrar Dr Vineet Eranna on 30 November and 2 December 2022. He was found to be thought-disordered and expressing persecutory delusions, hallucinatory behaviour, irritable mood, impaired judgment, and poor insight. Repeated Valproate blood levels were scheduled and he was continued on IM olanzapine and as-needed (**PRN**) quetiapine.

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[2] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

12. Mr Jones's physical health was reviewed by medical officer Dr Stephanie McLennan throughout his admission. Mr Jones denied experiencing any shortness of breath, chest pain, or palpitations. He was reportedly difficult to perform physical examinations on due to his refusals and he exhibited some challenging behaviours on the unit.

13. On 6 December 2022, Mr Jones was found unresponsive by nursing staff. Emergency Services were contacted and CPR was performed for approximately 30 minutes. Mr Jones was declared deceased at 6:20am.

IDENTITY OF THE DECEASED

14. On 6 December 2022, Joseph David Jones, born 23 November 1946, was visually identified by his carer, Dawn Sebastian, who signed a formal statement of identification to this effect.

15. Identity is not in dispute and requires no further investigation.

MEDICAL CAUSE OF DEATH

16. On 8 December 2022, Forensic Pathologist Dr Paul Bedford from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination. Dr Bedford reviewed the medical notes of Ballarat Group Practice, post-mortem computed tomography (**CT**) scan, and the Victoria Police Report of Death Form 83, and provided a written report of his findings.

17. Dr Bedford noted that Mr Jones had a medical history of congestive cardiac failure, atrial fibrillation, chronic obstructive pulmonary disease, diabetes, asthma, and mental health issues.

18. The post-mortem CT scan indicated mild cerebral atrophy but no acute changes. There were renal cysts and vascular calcifications including the coronary arteries. Emphysema with bullae was identified.

19. No suspicious circumstances were identified, and Dr Bedford was of the view the death was due to natural causes.

20. Toxicological analysis of post-mortem samples identified the presence of aripiprazole,[3] hydroxyrisperidone,[4] olanzapine,[5] valproic acid,[6] bisoprolol,[7] metformin,[8] and paracetamol.

21. Dr Bedford confirms that none of the drugs identified were present in concerning levels, and it is clear from the evidence that the drugs apparent upon toxicological testing were prescribed to Mr Jones prior to death.

22. Dr Bedford provided an opinion that the medical cause of death was 1 (a) unascertained-natural causes.

23. I accept Dr Bedford's opinion.

FINDINGS AND CONCLUSION

24. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    a) the identity of the deceased was Joseph David Jones, born 23 November 1946;

    b) the death occurred on 06 December 2022 at 1200 Dana Street, Ballarat Central, Victoria, 3350, from unascertained- natural causes; and

    c) the death occurred in the circumstances described above.

25. Having considered all of the circumstances, I find that Mr Jones died of natural causes.

26. Having investigated the care provided to Mr Jones in the lead-up to his passing, I consider that the care and treatment provided by Grampians Health was appropriate, noting that Mr Jones was a complex patient who presented with acute mental health issues and multiple medical comorbidities, and who displayed challenging behaviours to his treating team.

I convey my sincere condolences to Mr Jones's family for their loss.

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[3] A third-generation antipsychotic drug with partial agonist activity at dopamine D2-receptors and 5-HT1A receptors and antagonist activity at 5-Ht2A receptors.
[4] Benzisoxazole derivative and active metabolite of risperidone indicated for schizophrenia.
[5] Atypical antipsychotic drug.
[6] Indicated for epilepsy and as an adjunct in mania and schizophrenia where other therapy is inadequate.
[7] Synthetic beta-blocker indicated for hypertension.
[8] Antidiabetic drug used to treat maturity onset diabetes.

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 *Coroners Court Rules 2019*.

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

Colin Cropley, Senior Next of Kin

Anoop Lalitha, Ballarat Health Services (Grampians Health)

Signature:

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Coroner Ingrid Giles

Date: 28 March 2024

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 investigation. 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.