IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2020 1831

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 63(1)
Section 67 of the Coroners Act 2008

Deceased:	**NICHOLAS LOPES**
Delivered on:	17 November 2021
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing date:	17 November 2021
Findings of:	**KATHERINE LORENZ, CORONER**
Counsel assisting the Coroner:	**Dylan Rae-White, Coroner's Solicitor, Coroners Court of Victoria**
Other matters:	*Person detained under the Mental Health Act*

HER HONOUR:

INTRODUCTION

1. Nicholas Lopes was born on 16 December 1993. He died at 26 years of age after absconding from escorted leave from a St Vincent's Hospital Mental Health (**SVMH**) inpatient ward on 12 February 2020.

THE CORONIAL INVESTIGATION

2. Mr Lopes' death was reported to the coroner both because his death was 'unnatural' and he was considered to be 'in care' because he was a patient detained in a mental health service within the meaning of the *Mental Health Act 2014* pursuant section 3(1) of the *Coroners Act 2008* (**the Act**) and so fell within the definition of a reportable death under the Act. When a person dies 'in care' an inquest into the death is mandatory (unless it is a death from natural causes). The Act recognises that people 'in care' are vulnerable and affords them protection by requiring that the circumstances of their death are investigated by a coroner, irrespective of the medical cause of death, and by mandating that as part of that investigation there should be an inquest or formal public hearing.

3. After reviewing all the material, I determined that the circumstances of Mr Lopes' death were adequately revealed by the coronial brief and the other documents gathered as part of my investigation, which meant that the investigation could be concluded. I also determined that no witnesses were required to give evidence at the inquest.

4. A coroner independently investigates 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. Coroners make findings on the balance of probabilities, not proof beyond reasonable doubt.

5. Victoria Police assigned a Coroner's Investigator for the investigation. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses and submitting a coronial brief of evidence. The brief includes statements from a friend of Mr Lopes, treating physicians, the forensic pathologist who examined him and investigating officers, as well as other relevant documentation.

6. The Court also obtained Mr Lopes' medical records.

7. Coroner Spanos directed this coronial investigation until my appointment as a coroner on 8 February 2021, when I assumed the responsibility for it.

BACKGROUND

8. Mr Lopes was born six weeks prematurely. His parents both had intellectual disabilities and serious physical health conditions. He completed his primary education with a teaching and integration aide.

9. Mr Lopes was removed his parents' care at age 13 when he was placed into a care arrangement by DHHS. From aged 14 he attended school for children with intellectual disability from which he was frequently absent. He completed his education in 2009 at age 16.

10. His father died in 2009 from Parkinson's disease. His mother died in 2010 from Emphysema. Mr Lopes spent periods in juvenile detention and jail and lived a largely itinerant lifestyle. He attempted to maintain a relationship with his older brother Scott, who was also in and out of jail, but his brother did not reciprocate. Mr Lopes had various friends in the Melton area who would look out for him, including Kelly Linnell who would become Mr Lopes' next of kin during his multiple hospital admissions.

11. Mr Lopes' medical history included treatment resistant schizophrenia and antisocial personality disorder. He had an intellectual disability, the cause of which was not known.

12. Mr Lopes began using substances at a young age, including cannabis, heroin and methamphetamine. His first public mental health contact was in 2007 when was admitted to a mental health ward at the Royal Children's Hospital after expressing suicidal ideation in the context of his parents' health deteriorating (age 14). In 2013 he was diagnosed with schizophrenia by the Northern Crisis Assessment and Treatment Team (**CATT**) following which he had a six-month admission to Thomas Embling Hospital for management of schizophrenia.

13. Treatment often included long-acting injection antipsychotic medications and, from 2015, electroconvulsive therapy (**ECT**). He had a history of absconding during his admissions, typically to use substances. On some occasions he returned of his own volition and on others he was returned by police.

14. In July 2019 Mr Lopes was admitted to Broadmeadows Hospital psychiatric inpatient unit following release from prison.

15. On 5 August 2019, he was discharged on a community treatment order (**CTO**) under the *Mental Health Act 2014* (Vic) and referred for follow up at the Harvester Clinic.

16. On 12 August 2019, he attended at the Sunshine Hospital Emergency Department after he had been found wandering in a car park, threatening security guards, yelling that people with shot guns were following him and expressing a belief that his parents had been killed by police. Whilst in the Sunshine Hospital Emergency Department, he had to be physically restrained and sedated due to his level of agitation and following an attempt to hang himself.

17. Following his attendance at Sunshine Hospital, he was admitted to the SVMH inpatient ward, where he remained until his death.

18. During his admission to the SVMH, Mr Lopes had ongoing delusions. The delusions were larger largely persecutory in nature, regarding the mafia and how they were out to get him. He had multiple additional delusional beliefs including that his parents were alive and that he had many children and a grandiose delusion that he had wealth and fame.

19. He had auditory hallucinations with persecutory content relating to an organisation wanting to kill him. He had an unstable mood with impulsive outbursts and aggressive and violent episodes. He recurrently threatened the safety and lives of other patients and staff.

20. Mr Lopes had issues of vulnerability due to his psychosis, the adverse effects of illicit drugs on his mental state, impulsivity with self-harm, aggressive and violent behaviour towards others, absconding and non-adherence to treatment. For his safety and that of others he was managed in the extra care unit (**ECU**).

21. He was initially treated on antipsychotic injection zuclopenthixol and this was changed to antipsychotic injection paliperidone due to extra-pyramidal side effects[1]. He was also prescribed mood stabiliser sodium valproate, benzodiazepine lorazepam regularly with additional as needed, and oral antipsychotic olanzapine as needed but would sometimes refuse oral medications.

22. On 30August 2019, the Mental Health Tribunal (**MHT**) made an inpatient Treatment Order (**TO**) for 26 weeks with the expiry date of 27 February 2020.

23. On 29 October 2020, Mr Lopes applied to the MHT for his TO to be revoked. On 14 November 2019, the MHT upheld the TO for 15 weeks with an expiry date of 26 February 2019. In November 2019 the MHT approved a course of 12 ECT treatments, which was ceased after the seventh as it was ineffective in reducing his psychotic symptoms.

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1 Extrapyramidal side effects include acute dystonic reactions (oculogyric crisis, torticollis, lock jaw, laryngeal spasm), akathisia, parkinsonism (rigidity, bradykinesia, tremor) and tardive dyskinesia.

24. Mr Lopes expressed his frustration with being in hospital generally and especially in the ECU. At times he expressed that he preferred jail to hospital.

25. During his admission to SVMH, Mr Lopes absconded on four previous occasions:

    a. Between 14-18 September 2019, Mr Lopes absconded during his first 'trial' day in the Low Dependency Unit (**LDU**). He slept rough and was brought back by police and readmitted with on-going delusions. He reported using methamphetamine and cannabis;

    b. Between 27-30 November 2019, he absconded while awaiting anaesthetic to wear off in the recovery area after ECT, and was returned by police;

    c. Between 11-16 December 2019, he absconded from the airlock of the ward, reported using alcohol, methamphetamine and cannabis and self-presented to Sunshine Hospital seeking admission as he believed SVMH were trying to kill him; and

    d. On 20 December 2019, he left as staff were entering the ward, reported drinking a slab of beer with others. He denied drug use after returning within a few hours.

26. During his admission, due to the risk to Mr Lopes' safety and that of others and his level of vulnerability, independent accommodation was deemed an inappropriate discharge option. A referral was made to the Secure Extended Care Unit (**SECU**) which was declined. Another referral was later made to SECU and a date for assessment was pending at the time Mr Lopes's death. An NDIS referral was made and an NDIS coordinator appointed, with a plan to explore suitable long-term accommodation options once an NDIS funded package was approved. Referrals were made to the SVMH Senior Forensic Clinician and neuropsychologist but it was unclear whether these assessments had occurred at the time of Mr Lopes's death. An application for guardianship was being prepared and a referral to the Victorian Dual Disability Service was being considered, though had not yet been made at the time of Mr Lopes' death.

27. Mr Lopes frequently expressed frustration being in hospital and stated that he preferred jail. Attempts were made to provide less restrictive treatment with numerous trials on the LDU to allow him to interact on the larger ward and attend groups. Mr Lopes was sometimes aggressive and violent and did not comply with directions to return to ECU.

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

28. At 5.20pm on 12 February 2020, Mr Lopes was reviewed by consultant psychiatrist Dr Susan Ong and Nurse Ken Maher. Mr Lopes requested discharge and wanted to seek

accommodation via the Salvation Army, but this was declined. He expressed frustration that his medication made him gain weight and said that he had lost weight previously by using drugs. He declined a referral to a dietician. He continued to display behaviours of vulnerability. He asked to go to the shop to buy cigarettes and hot chips and agreed to cooperate with his nurse if he was permitted to go on leave.

29. At 6.30pm, Nurse Maher took Mr Lopes on escorted leave. Mr Lopes ran towards and boarded a tram towards the city, saying "don't chase me" and "sorry uncle" as Nurse Maher tried to convince him to return[2]. Nurse Maher immediately phoned the ward to let the ward know that Mr Lopes had absconded. Nurse Maher then returned to the ward, phoned police and faxed documentation to police at 8.38pm. Nursing observation charts documented Mr Lopes to be on the ward at 6.00pm and absent without leave at 7.00pm.

30. On 13 February 2020, SVMH notified Mr Lopes' nominated next of kin, Ms Kelly Linnell that Mr Lopes had absconded.

31. On 14 February 2020, Mr Tony Duric was parking his vehicle at a multi-level car park at 300 Flinders Street Melbounre. At approximately 9.35am, Mr Duric was getting his bag from the back of his vehicle and noticed a man lying inside the small generator/vent room. The small door to the room was open. Mr Duric observed that the man had foam coming from his mouth and his arm was in the air. Mr Duric knew the man was deceased. At approximately 9.45am, Mr Duric telephoned emergency services and waited for them to arrive.

32. Police and ambulance attended and found multiple syringes scattered throughout the room and other drug paraphernalia. Police seized two small zip-lock bags containing what they believed was methyl amphetamine.

33. The details of Mr Lopes' movements between absconding and his death two days later are largely unknown. At some point, he entered a car park in the CBD and used heroin, resulting in his death.

[2] Mr Lopes had chronic delusions that staff and patients were related to him.

FURTHER INVESTIGATIONS

34. At my direction, this case was reviewed by the Mental Health and Disability Investigations Team, a part of the Coroner's Prevention Unit (**CPU**)[3]. I asked CPU to review the treatment provided to Mr Lopes by SVMH proximate to his death.

35. CPU noted that affording Mr Lopes leave was an appropriate part of his treatment plan aimed at preparing him for discharge. While withholding leave may sometimes be required as a short-term strategy in response to identified risks, in the long term it would only serve to potentially prolong admission and negatively impact clinical progress and compliance by increasing feelings of containment, aggression, dependence and institutionalisation.

36. CPU reported that there was no evidence of any indication, prior to his leave on 12 February 2020, that Mr Lopes had intent or a plan to abscond. His request for leave was considered reasonable in the circumstances and would not have been expected to raise suspicion.

37. While a desire to use illicit substances was the likely precipitant for Mr Lopes choosing to abscond, CPU considered that withholding leave would not have changed this risk. It was noted that Mr Lopes was offered Alcohol and Other Drug services during his admission but had declined these. Despite being an involuntary patient, he could not be compelled to participate in these services.

38. CPU considered that Nurse Maher acted appropriately in response to Mr Lopes absconding, explaining that he would not have been expected to follow Mr Lopes due to the risks of being alone in an uncontrolled environment. Further, he appropriately contacted the SVMH immediately following the event. CPU also noted that police were notified and appropriate documentation provided in a timely manner.

39. CPU concluded that the clinical treatment and management by SVMH of Mr Lopes proximate to his death, including the decision to grant escorted leave and response to him absconding, appeared appropriate. They did not identify any missed prevention opportunities.

40. I accept and adopt CPU's conclusion.

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[3] 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.

INQUEST

41. After reviewing all the material, I determined that the circumstances of Mr Lopes' death were adequately revealed by the coronial brief and the other documents gathered as part of my investigation, which meant that the investigation could be concluded. I also determined that no witnesses were required to give evidence at the inquest.

IDENTITY

42. On 14 February 2020, Mr Nicholas Lopes was identified by his fingerprints.

43. Identity was not in dispute and required no further investigation.

CAUSE OF DEATH

44. On 18 February 2020, Dr Matthew Lynch, a senior forensic pathologist practising at the Victorian Institute of Forensic Medicine, performed an examination and provided a written report of his findings dated 19 February 2020. In that report, Dr Lynch concluded that the cause of Mr Lopes' death was "1(a) mixed drug toxicity."

45. Toxicologist analysis detected morphine (the principal metabolite of heroin), codeine (often found as an impurity in heroin) lorazepam, olanzapine and hydroxyrisperidone.

46. The prescription medications were not in excess of therapeutic use and it is likely they were administered to Mr Lopes prior to him absconding.

47. The toxicologist noted that these results, namely the presence of morphine and codeine, are consistent with the recent use of heroin. Multiple use of drugs that depress the central nervous system, such as opioids and opiates, benzodiazepines and antipsychotics will increase the risk of death. The toxicologist reported that the combination of drugs detected in Mr Lopes' body was consistent with excessive and potentially fatal use.

48. I accept and adopt Dr Lynch's opinion as to Mr Lopes' medical cause of death.

FINDINGS

Having investigated the death of Nicholas Lopes and having held an Inquest into his death, I make the following Findings pursuant to s 67(1) of the Coroners' Act 2008 (Vic):

49. The identity of the deceased is Nicholas Lopes, who was born on 16 December 1993, and who died between 12 to 14 February 2020 at level 2, 300 Flinders Street, Melbourne, Victoria.

50. Mr Lopes was under a temporary treatment order pursuant to the Mental Health Act 2014. As such, I find that he was 'in care' immediately before his death pursuant to the definition contained within section 3 of the Coroners Act 2008 (Vic).

PUBLICATION

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

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

Ms Kelly Linnell

Senior Constable Little, Coroner's Investigator

St Vincent's Hospital

Dr Neil Coventry, Chief Psychiatrist

Signature:

KATHERINE LORENZ

CORONER

Date: 25 November 2021

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.