IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2019 006677

**FINDING INTO DEATH WITH INQUEST**[1]

*Form 37 Rule 63(1)*

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

*Amended pursuant to section 76 of the **Coroners Act 2008** on 23 May 2023*[2]

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| Deceased: | Jennifer Gebert |
| Delivered on: | 22 May 2023 |
| Delivered at: | Coroners Court of Victoria,<br>65 Kavanagh Street, Southbank |
| Hearing date: | 11, 12 October 2022 |
| Findings of: | Coroner Paresa Antoniadis Spanos |
| Coroner's Assistant: | Acting Sergeant Darren Cathie, Police Coronial Support Unit |
| Representation: | Ms Fiona Ellis appeared on behalf of Western Health<br><br>Ms Deborah Foy appeared on behalf of Melbourne Health (NorthWestern Mental Health Service) |

[1] 'FINDING INTO DEATH WITHOUT INQUEST' amended to 'FINDING INTO DEATH WITH INQUEST' pursuant to section 76 of the *Coroners Act 2008* (Vic).
[2] This document is an amended version of the Finding into Death Without Inquest regarding Jennifer Gebert dated 22 May 2023. A correction to the title page has been made pursuant to section 76 of the *Coroners Act 2008* (Vic).

Key words: Mental health patient, compulsory treatment, Assessment Order, intoxication, observation, unascertained cause of death

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## INTRODUCTION

1. Jennifer Gebert was 49 years old when she died on 6 December 2019 in the Sunshine Adult Acute Psychiatric Unit (**SAAPU**), Sunshine Hospital.

2. At the time of her death, Ms Gebert ordinarily lived in Kurunjang with her mother and sister.[3]

3. Ms Gebert experienced a difficult childhood during which she was exposed to alcohol abuse, which she later mirrored in her own life. In her adult life, Ms Gebert disclosed to clinicians that she had also experienced family violence and sexual assault during her childhood and youth. She began using marijuana and other illicit substances at a young age.[4]

4. At the age of 16 years, Ms Gebert was involved in a physical altercation with her then boyfriend who sustained a fatal injury. Ms Gebert was subsequently charged and acquitted of manslaughter. This tragic event cast a shadow over the remainder of her life. Ms Gebert reportedly felt worthless because she had 'killed someone' and used drugs and alcohol as a way to cope with these feelings.[5]

5. Over the following years, Ms Gebert experienced ongoing and significant mental health symptoms for which she was prescribed various medications but struggled to adhere to prescribed treatment plans in the long-term. According to Michelle Gebert, her sister did not have a lot of faith in the mental health care system as she felt that those treating her did not understand what it was like to kill someone. From about her mid-30s, Ms Gebert had several hospital presentations and admissions to mental health facilities.[6]

## CIRCUMSTANCES PROXIMATE TO DEATH

6. Ms Gebert had been case-managed by the Mid West Area Mental Health Service Community (Outer) Team since 19 November 2016.[7]

7. Toward the end of 2019, she was referred to a Prevention and Recovery Care[8] (**PARC**) service for rationalisation and stabilisation of medications as it appeared that she was relapsing in

[3] Coronial Brief, page 20.
[4] Coronial Brief, pages 2, 22; Exhibit B, pages 635, 674, 680.
[5] Coronial Brief, pages 2-3.
[6] Coronial Brief, pages 3, 21-22.
[7] Coronial Brief, page 20.
[8] Burnside PARC is a program of Mid West Area Mental Health Service, which is operated by NorthWestern Mental Health Service, who also provide mental health services at Sunshine Hospital. The PARC is a 10-bed facility operated as a 'step-up' or 'step-up' unit for pre or post hospital care. Step-up refer to patients who need more care/support or respite than can be provided in a home environment but for who are no so unwell that they require an admission to an acute

terms of her dependence on substances. At the time, there was a four-week waitlist for admission to a PARC service. Her clinical team used this period to assist Ms Gebert to reduce her alcohol intake and support her with detoxification in the community so that she could participate in the PARC program when a place became available.[9]

8. On 21 November 2019, Ms Gebert began residing at the PARC in Burnside and engaged well with the program and staff.[10]

9. Michelle Gebert spoke to her sister on 27 November 2019 while she was at the PARC. She noted that the plan was to transfer Ms Gebert to a three-month program at a different treatment centre. She described Ms Gebert as:[11]

> *... positively happy but was worried about the length of the alcohol detox program they were talking about for her. She didn't express any self-harm issues resulting from her worry about the three-month program. She was going to have a meeting with staff about it after I left.*

10. On 4 December 2019, Michelle Gebert text messaged her sister to arrange to take her to visit their mother, but Ms Gebert did not reply to the messages. Michelle Gebert later saw her sister standing at a bus stop in Deer Park and assumed she would be taking the bus to their mother's house. She spoke to Ms Gebert a short time later at which time Ms Gebert said she was on her way to Melton to do her weekly medication pickup.[12]

11. Later that day, Ms Gebert returned to the PARC in an intoxicated state. She disclosed to staff that she had consumed four pre-mix vodka drinks (375mL UDL cans at 4.5% alcohol, equivalent to about 6.4 standard drinks). This was in breach of the PARC's zero tolerance policy. Ms Gebert was subsequently informed that she would be discharged back into the community the following day. In consideration of her intoxicated stated, PARC staff decided Ms Gebert should remain at the PARC overnight and be discharged the following morning.[13]

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mental health inpatient unit. Step-down refers to patients who may benefit from an intermediate step between discharge from an acute mental health inpatient unit and returning home. PARC is staffed 24-hours per day and clinical services are provided by a consultant psychiatrist, registrar, mental health nurse, and allied health clinicians. Each patient has a single bedroom with an ensuite. The lounge, kitchen, and dining facilities are communal spaces. Patients are essentially free to come and go: Coronial Brief, pages 18-19.

[9] Patients with significant substance use disorders who require supervised withdrawal or rehabilitation and/or would be unable or unwilling to abstain from ongoing substance misuse do not meet the criteria for treatment at a PARC: Coronial Brief, pages 19, 21.

[10] Coronial Brief, page 21.

[11] Coronial Brief, page 4.

[12] Coronial Brief, page 4.

[13] Coronial Brief, pages 9, 21; Exhibit B, page 673.

12. At discharge planning the following morning, 5 December 2019, Ms Gebert stated that she did not intend to return to live with her mother and sister and did not consent for any clinical information to be provided to them. She planned to go to a motel in Deer Park. She reported that she was suicidal and planned to drink alcohol and to overdose on Phenergan (promethazine). She later changed her mind about going to a motel and said she would run away to the bush instead. Ms Gebert also expressed deep disappointment and shame about her relapse with alcohol and anger at being discharged.[14]

13. The PARC consultant psychiatrist subsequently determined Ms Gebert was not safe to discharge to the community and placed her on a compulsory Inpatient Assessment Order.[15] [16]

14. An ambulance transported Ms Gebert to Sunshine Hospital Emergency Department (**ED**) where she arrived at about 10.30am. Ms Gebert's stay in the ED was captured by Closed-Circuit Television (**CCTV**) footage[17] and I will refer to that footage below.

15. Upon initial assessment, Ms Gebert was noted to be drowsy but otherwise had normal nursing observations. Her Glasgow Coma Scale[18] (**GCS**) score was 13 on arrival. The medical notes record Ms Gebert as having reported consuming a 375mL bottle of vodka (37.5% alcohol, equivalent to about 11 standard drinks) earlier that morning.[19]

16. At 11.05am, nursing notes record Ms Gebert as appearing intoxicated with slurred speech, smelling of alcohol. As she was unable to be breathalysed, Ms Gebert was allowed to sleep.[20]

17. At 11.41am, the Emergency Mental Health Clinician noted Ms Gebert's plan to consume alcohol and overdose on promethazine, and that she could not guarantee her safety, nor could she engage in safety planning. She documented a plan for the Consultant Psychiatrist to review Ms Gebert and admit her to the SAAPU.[21]

[14] Coronial Brief, page 21; Exhibit B, pages 673-674.
[15] An Assessment Order enables a person to be compulsorily taken to, and detained in, a designated mental health service and examined by an authorised psychiatrist to determine whether the treatment criteria apply to that person: section 28 of the *Mental Health Act 2014* (Vic).
[16] Coronial Brief, pages 9, 21-22, 29.
[17] Exhibit C.
[18] The Glasgow Coma Scale is a clinical scale used to measure a person's level of consciousness. Scores can range from 3 (completely unresponsive) to 15 (responsive).
[19] Coronial Brief, page 9, 21; Exhibit B, pages 609, 613, 673.
[20] Coronial Brief, page 9; Exhibit D.
[21] Coronial Brief, page 9; Exhibit B, page 610.

18. At 11.56am, the ED Alcohol and Other Drug Clinician noted that Ms Gebert's risk of withdrawal would be low given her two-week residence in the PARC with reduced access to alcohol during that time.[22]

19. At 12.45pm, Ms Gebert went to the toilet and although observed to have an unsteady gait, was able to walk there unassisted.[23]

20. At 12.58pm, Ms Gebert was breathalysed, and her blood alcohol concentration (**BAC**) was documented as being 0.159%.[24]

21. At 3.20pm, medical notes record Ms Gebert as remaining drowsy but rousable when spoken to. Her GCS score remained at 13. Ms Gebert required intranasal oxygen for transient mild hypoxia, which returned to normal over the following hours in the ED.[25]

22. At about 3.30pm, Ms Gebert was seen by the Emergency Medical Officer and had some bloods taken.[26] The full blood examination and biochemistry measurements were normal apart from a mildly raised mean cell volume, which was consistent with Ms Gebert's history of alcohol dependency.[27] This sample was subsequently tested at the Victorian Institute of Forensic Medicine (**VIFM**) after her death and indicated a BAC of 0.16 g/100mL. This information was unknown to clinicians during Ms Gebert's ED stay.[28]

23. At 4.00pm, Ms Gebert was seen by the Emergency Mental Health Clinician and Consultant Psychiatrist. The Inpatient Assessment Order was subsequently extended, and it was planned to admit Ms Gebert to the SAAPU once she was medically cleared.[29]

24. At 4.30pm, nursing staff documented that Ms Gebert was observed to be fully awake and looking for her phone.[30] CCTV footage captured Ms Gebert in the ED, walking unaided to fetch a cup of water.[31]

[22] Coronial Brief, page 9; Exhibit B, page 611.
[23] Coronial Brief, page 9; Exhibits C and D; Clarification of time at Transcript, page 67.
[24] Coronial Brief, page 9; Exhibit D.
[25] Coronial Brief, page 10; Exhibit D.
[26] Exhibits D and E.
[27] Coronial Brief, page 10.
[28] Transcript, pages 76-78.
[29] Coronial Brief, page 10, 22, 30; Exhibit B, pages 610, 632.
[30] Exhibit D.
[31] Exhibit C.

25. Between 5.00pm and 5.18pm, CCTV footage captured Ms Gebert exiting her ED cubicle and walking unaided to the rubbish bin on three occasions. At 5.20pm, she fetched another cup of water.[32]

26. Between 5.15pm and 5.45pm, Ms Gebert was reviewed by the ED Consultant. She was noted to be alert and orientated, her observations were normal, and her GCS score had improved to 15. Ms Gebert had requested diazepam from a nurse but as there was no evidence of alcohol withdrawal, it was determined there was no current need for benzodiazepines. The Consultant cleared Ms Gebert medically for transfer to the psychiatric unit, completing a 'Safe Consumer Transfer Medical Checklist'.[33]

27. At 5.55pm, CCTV footage captured Ms Gebert walking unaided to the rubbish bin yet again.[34]

28. Between 6.00pm and 6.45pm, a mental health clinician escorted Ms Gebert to the SAAPU. Upon admission to the SAAPU, she was noted to somewhat unsteady on her feet and smelling of alcohol. Routine observations were ordered to be documented hourly.[35]

29. At about this time, Ms Gebert also disclosed she had taken some pills containing codeine given to her by a friend *"a couple of hours ago"*. When her personal belongings were searched as a safety precaution, there was no evidence of pills or empty medication packaging.[36]

30. At about 6.30pm, Ms Gebert telephoned her sister, Michelle Gebert, to let her know where she was. Michelle Gebert later recalled her sister was difficult to understand because of her badly slurred speech. Ms Gebert acknowledged she had been drinking. Michelle Gebert stated that had she been informed of her sister's transfer to hospital from the PARC, she would have attended the ED or hospital to support her sister and help calm her.[37]

31. At about 7.20pm, a Hospital Medical Officer attempted to review Ms Gebert, but she was unable to fully participate as she was still intoxicated, and her speech was slurred. The treatment plan was to extend the Assessment Order. Diazepam was to be given if clinically indicated for symptoms of alcohol withdrawal. A urine drug screen was ordered. Ms Gebert's observations were normal but there was a note about an unsteady gait due to being under the

[32] Exhibit C.
[33] Coronial Brief, page 10, 32; Exhibit B, page 611.
[34] Exhibit C.
[35] Coronial Brief, page 14; Exhibit B, pages 628, 638.
[36] Coronial Brief, page 11; Exhibit B, page 638.
[37] Coronial Brief, page 4-5; Transcript pages 40-41; Exhibit B. However, in oral evidence Michelle Gebert noted that her reference to helping her sister settle down was in reference to a previous admission when restraints had been required and Ms Gebert had been distressed, which was not the case during this admission: Transcript, pages 52-53.

influence. Hourly observations were ordered.[38] Ms Gebert's regular medications, amitriptyline and risperidone, were withheld that night due to their sedative effect as she was still intoxicated.[39]

32. At about 8.00pm, Ms Gebert was escorted to and from the kitchen to make a coffee. The medical notes record that Ms Gebert was *"very sedated"* and *"unable to stand"*, so she was taken back to her room.[40]

33. At 8.30pm, physical vital observations of Ms Gebert were taken and documented as normal.[41]

34. At 9.00pm, 10.00pm, 11.00pm, and 12.00am, Ms Gebert was noted to be in bed, sleeping and breathing.[42]

35. When nursing staff conducted the hourly check at 1.00am the next morning, 6 December 2019, Ms Gebert was found unresponsive in bed. A code blue was called, and cardiopulmonary resuscitation was commenced. Sadly, Ms Gebert could not be revived and was verified deceased at 1.47am.[43]

## INVESTIGATION AND SOURCES OF EVIDENCE

36. This finding draws on the totality of the coronial investigation into the death of Ms Gebert's including evidence contained in the coronial file comprising the inspection report and toxicology report from the VIFM, an extract of the medical records, and statements from Ms Gebert's sister and the health services involved in her treatment proximate to death.

37. All of this material, together with the inquest transcript, will remain on the coronial file.[44] In writing this finding, I do not purport to summarise all the material and evidence but will only refer to it in such detail as is warranted by its forensic significance and the interests of narrative clarity.

[38] Coronial Brief, page 14; Exhibit B, pages 626, 634-637.
[39] Coronial Brief, pages 14, 33.
[40] Coronial Brief, pages 11, 14; Exhibit B, page 628.
[41] Coronial Brief, page 14; Exhibit B, page 628.
[42] Coronial Brief, pages 11, 14; Exhibit B, page 628.
[43] Coronial Brief, pages 11, 14.
[44] From the commencement of the *Coroners Act 2008* (Vic) (**the Act**), that is 1 November 2009, access to documents held by the Coroners Court of Victoria is governed by section 115 of the Act. Unless otherwise stipulated, all references to legislation that follow are to provisions of the Act.

## PURPOSE OF A CORONIAL INVESTIGATION

38. The purpose of a coronial investigation of a *reportable death*[45] is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[46] Ms Gebert's death clearly falls within the definition of reportable death, specifically section 4(2)(d) of the Act which includes (relevantly) a death of a person who immediately before death was a patient within the meaning of the *Mental Health Act 2014* (Vic).

39. The 'cause' of death refers to the 'medical' cause of death, incorporating where possible the 'mode' or 'mechanism' of death. For coronial purposes, the 'circumstances' in which death occurred refers to the context or background and surrounding circumstances but is confined to those circumstances sufficiently proximate and causally relevant to the death, and not all those circumstances which might form part of a narrative culminating in death.[47]

40. The broader purpose of any coronial investigations is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of recommendations by coroners, generally referred to as the 'prevention role'.[48]

41. Coroners are empowered to report to the Attorney-General in relation to a death; to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.[49] These are effectively the vehicles by which the coroner's prevention role can be advanced.[50]

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[45] The term is exhaustively defined in section 4 of the Act. Apart from a jurisdictional nexus with the State of Victoria a reportable death includes deaths that appear to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from an accident or injury; and, deaths that occur during or following a medical procedure where the death is or may be causally related to the medical procedure and a registered medical practitioner would not, immediately before the procedure, have reasonably expected the death (section 4(2)(a) and (b) of the Act). Some deaths fall within the definition irrespective of the section 4(2)(a) characterisation of the 'type of death' and turn solely on the status of the deceased immediately before they died – section 4(2)(c) to (f) inclusive.

[46] Section 67(1).

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

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

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

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

42. Coroners are not empowered to determine the civil or criminal liability arising from the investigation of a reportable death and are specifically prohibited from including in a finding or comment any statement that a person is, or may be, guilty of an offence.[51]

## IDENTITY OF THE DECEASED

43. On 6 December 2019, Jennifer Gebert, born 13 June 1970, was visually identified by her mother, Vicki Parker, who signed a formal Statement of Identification to this effect.

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

## MEDICAL CAUSE OF DEATH

45. Forensic Pathologist, Dr Victoria Francis, from the VIFM, conducted an examination on 11 December 2019 and provided a written report of her findings dated 13 May 2020.[52]

46. The post-mortem examination revealed natural disease processes in the form of pulmonary emphysema, mild myocardial fibrosis, and some hepatic steatosis. Dr Francis noted that none of these findings were considered sufficient to have caused death in the described circumstances. Nor was there any evidence of significant violence or injury causing or contributing to her death.

47. Dr Francis noted alveolar haemorrhage and fat emboli in the small pulmonary vessels, findings often seen in the setting of cardiopulmonary resuscitation.

48. Routine toxicological analysis of ante-mortem samples collected at 4.33pm[53] on 5 December 2019[54] detected ethanol[55] (at a concentration of 0.16 g/100mL), diazepam[56] and nordiazepam, nitrazepam,[57] amitriptyline[58] and nortriptyline, hydroxyrisperidone,[59] and promethazine.[60]

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[51] Section 69(1). However, a coroner may include a statement relating to a notification to the Director of Public Prosecutions if they believe an indictable offence may have been committed in connection with the death. See sections 69(2) and 49(1).
[52] Coronial Brief, pages xiv-xxiv; Transcript, pages 8-17.
[53] Likely about 3.30pm: Exhibit D.
[54] Coronial Brief, pages xxv-xxxvii.
[55] A blood alcohol content in excess of 0.15 g/100mL can cause considerable depression of the central nervous system affecting cognition and capable of producing adverse behavioural changes.
[56] Diazepam is a sedative/hypnotic drug of the benzodiazepines class. Metabolites of diazepam include nordiazepam, temazepam, and oxazepam.
[57] Nitrazepam is a sedative (hypnotic drug).
[58] Amitriptyline is a tricyclic antidepressant indicated to treat major depression, panic disorder, neuropathic pain, and enuresis.
[59] Paliperidone (9-hydroxyrisperidone) is an active metabolite of risperidone which is used as an antipsychotic.
[60] Promethazine is an antihistamine.

49. Toxicological analysis of post-mortem samples[61] detected ethanol (0.04 g/10mL), codeine,[62] diazepam and nordiazepam, nitrazepam and 7-aminonitrazepam, amitriptyline and nortriptyline, hydroxyrisperidone, pregabalin, promethazine, and paracetamol.[63]

50. Dr Francis explained that amitriptyline, pregabalin, and promethazine may increase the QT interval. It is recognised that people with schizophrenia have an increased risk of death thought to be almost twice the risk of the general population. While a natural disease process may be identifiable in some people, a proportion of these deaths have no identifiable medical or toxicological cause of death. It is possible in these cases that death may be due to altered autonomic physiology, and possible interactions with psychotropic medications.

51. Post-mortem biochemistry showed no significant electrolyte abnormality within the limits of interpreting post-mortem specimens.

52. There was a vitreous glucose level of 6.8 mmol/L. Dr Francis explained that glucose levels normally decrease in the post-mortem period.

53. C-reactive protein was not elevated. C-reactive protein is a molecule that increases in the blood stream in response to inflammation, particularly infections.

54. Post-mortem microbiology showed *Escherichia coli* in the blood enrichment culture. There was no significant micro-organism growth in the left and right lung swabs or urine sample. Viral nucleic acids were not detected in the left and right lung tissue specimens. Dr Francis considered these results to be non-contributory.

55. Dr Francis considered that these combined toxicology results appeared insufficient, even in combination, to have caused Ms Gebert's death. There was no suggestion from the described circumstances or scene photographs that positional asphyxia or any mechanical asphyxia in the setting of combined alcohol and drug intoxication played any major role in her death.

56. In Dr Francis's opinion, the cause of death remained unascertained following completion of a full post-mortem examination or autopsy and ancillary investigations.

57. She noted that causes of death where there is a negative autopsy include cardiac arrhythmic disorders, seizure disorders, and metabolic disorders. Ms Gebert did not have a history of

[61] Coronial Brief, pages xxv-xxxvii.
[62] Codeine possesses 10-17% of the analgesic activity of morphine. Codeine is an effective antitussive and anti-diarrhoeal agent.
[63] Paracetamol is an analgesic drug.

seizures and a first seizure causing death would be unusual. Some other cardiac arrhythmic disorders such as long QT syndrome, Brugada, and Catecholaminergic polymorphic ventricular tachycardia may run in families.

58. Dr Francis provided an opinion that the medical cause of death was *"1(a) Unascertained"*.

59. I accept Dr Francis's opinion.

## FOCUS OF THE CORONIAL INVESTIGATION

60. As is often the case in this jurisdiction, the focus of the coronial investigation and inquest into Ms Gebert's death was on the circumstances in which the death occurred. More specifically the focus of this inquest was:

    (a) further elucidation of the medical cause of death, if possible;

    (b) an assessment of Ms Gebert's suitability for transfer from the Sunshine Hospital ED to the SAAPU;

    (c) consideration of the adequacy of communications between staff from the PARC, Sunshine Hospital ED, and SAAPU with Ms Gebert's family about her admission, discharge, and transfer between facilities, and any relevant policies or procedures; and

    (d) consideration of the manner of recording a patient's instructions about their consent or withdrawal of consent to provide family members with information about their clinical management and care, admission, discharge, and transfer.

## FURTHER EVIDENCE REGARDING MS GEBERT'S CAUSE OF DEATH

### Whether Ms Gebert had ingested medication after her admission

61. During the coronial investigation, a question was raised as to whether Ms Gebert had ingested a drug or medication during her stay in either the ED or the SAAPU. Nursing notes recorded her disclosure she had taken an unknown quantity of unknown pills containing codeine about two hours previously, which would have been at about 5.00pm.[64]

[64] Exhibit B, page 638.

62. While the ante-mortem sample collected at 4.33pm did not detect codeine, the post-mortem sample did, including paracetamol, and several combinations of paracetamol and codeine are available in pharmacies in Australia, currently only on prescription.

63. In Court, Michelle Gebert was shown excerpts of CCTV footage of her sister from about 4.30pm to 6.00pm during which Ms Gebert can be seen fetching a glass of water and putting something in the rubbish bin.[65] To Michelle Gebert's eye, the footage indicated that her sister had swallowed some medication and, moreover, that her sister's condition had clearly deteriorated, stating *"... just consciousness, she's just not as with it as she was ... looks under the influence of something to me."* She indicated she had observed Ms Gebert deteriorate in that manner previously after taking pills and medication.[66]

64. In oral evidence, Dr Gary Ayton, Director Emergency Medicine at Sunshine Hospital, confirmed that a patient's belongings are not routinely searched unless there is a good reason, including that they are at high risk of injury to themselves or others, which was not the case with Ms Gebert.[67]

65. Dr Ayton was unable to say whether Ms Gebert had ingested tablets after transfer to the SAAPU. If this did occur, he considered that it would account for her increasing drowsiness overnight as he would not expect continued drowsiness from a single ingestion of alcohol at about 9.00am that morning.[68]

66. According to Mr Peter Kelly, Director Operations at NorthWestern Mental Health, Ms Gebert's belongings were searched as per standard admission practice. No illicit substances, alcohol, or medications were found. Her low level of risk meant that a body search was not conducted.[69]

67. In her oral evidence, Dr Francis noted that toxicological analysis of the ante-mortem and post-mortem samples suggested that Ms Gebert ingested some paracetamol with codeine sometime after 4.30pm.[70]

68. However, Dr Francis noted that the levels of the drugs detected in toxicology analysis did not raise a concern. This included the level of codeine, which did not contribute significantly to

[65] Transcript, pages 38-40; Exhibit C. Ms Gebert goes to the rubbish bin three times between 5.00pm and 5.18pm and then once more at 5.55pm
[66] Transcript, page 40.
[67] Transcript, pages 69-70.
[68] Coronial Brief, page 13.
[69] Coronial Brief, page 15.
[70] Transcript, page 15.

death, although it could have contributed to Ms Gebert's drowsiness, but Dr Francis was unsure as to how much this would have affected her.[71]

69. To assist my investigation regarding possible causes of Ms Gebert's death, I obtained a report from Dr Dimitri Gerostamoulos, Head of Forensic Sciences and Chief Toxicologist at the VIFM, dated 28 November 2022. He noted that the VIFM routinely tests samples from deceased persons for a number of drugs and poisons. Any positive finding will be reported if it is above the laboratory's limit of reporting for that specific drug. It is important to note that if the drug is not included in the routine scope of testing, the pathologist or toxicology laboratory will need to be alerted to ensure it is tested for in an appropriate specimen.[72] For example, the VIFM does not routinely test for novel psychoactive substances and would need to be alerted to the possibility of the use of such substances in order to test for them.

70. Dr Gerostamoulos explained the difference between ante-mortem and post-mortem samples, which will affect concentrations of drugs detected. He noted that Ms Gebert's ante-mortem result for alcohol was 0.16 g/100mL at 4.33pm. However, the post-mortem sample collected at 12.44pm on 6 December 2019, indicated it was 0.04 g/100mL. He noted that the alcohol concentration had decreased over time as it had been eliminated by normal metabolic processes.

71. In terms of drugs, he noted, *"The timeframe of drug elimination will depend on the half-life of the respective drug and whether or not some of the drugs were administered in hospital as part of the treatment prior to death".* In response to a question as to whether it could be determined when Ms Gebert had ingested promethazine, he noted that the concentration of promethazine in ante-mortem blood was 0.08 mg/L and 0.3 mg/L in post-mortem blood. Dr Gerostamoulos explained that promethazine exhibits post-mortem redistribution after death, which leads to increased blood concentrations. He was unable to rule out ingestion of promethazine in hospital or prior to admission.

**Premature deaths in mental health patients**

72. In his statement, Mr Kelly outlined his observations of premature mortality of persons living with severe and enduring mental illness. He explained that over a roughly 15-year period as Director Operations he had compiled a database of premature deaths involving people living with severe and enduring mental illness. He identified 184 people who had died prematurely

[71] Transcript, pages 14-16.
[72] See list of routinely tested drugs and poisons at Coronial Brief, pages xxviii-xxx.

with an average age of 45.5 years. For 21 of those cases, the cause of death remained unascertained or undetermined on completion of autopsy and ancillary tests. The remaining deaths were associated with cardiac/ respiratory diseases and cancer, likely impacted by lifestyle factors.[73]

73. He also referred to a small sub-group of patients who had died suddenly, unexpectedly, and prematurely in acute inpatient psychiatric units over recent years, one of which Ms Gebert's death. Based on analysis of the database, Mr Kelly testified about a *"perfect storm"* of preconditions, suggested by the data, including the following:[74]

    (a) acute mania of florid psychosis, often driven behaviours over the preceding 72 hours with little or no sleep;

    (b) morbid obesity;

    (c) poor respiratory function;

    (d) underlying and often undiagnosed cardiac disease;

    (e) obstructive sleep apnoea, diagnosed and undiagnosed; and

    (f) use of sedating medications, which may cause respiratory depression.

74. He noted that while some patients are unwilling or unable to cooperate with medical directions to assess these issues during their admission, some are also admitted without ever having previously undergone proper medical investigations or treatment for what are often longstanding conditions.[75] In oral evidence, Mr Kelly opined that people with a severe and enduring mental illness receive suboptimal medical care in the community and primary healthcare due to a wide range of factors such as homelessness, itinerancy, health literacy, and logistical reasons.[76]

75. Mr Kelly specified the underlying risk factors for sudden or premature death that applied to Ms Gebert. She had a BMI if 34 kg/m², which meant she was 'obese' according to World Health Organization Class I. She was a smoker (although she was reported to have cut down recently), had pulmonary emphysema, and had been diagnosed with schizophrenia. He also

[73] Coronial Brief, page 15; Transcript pages 102-105.
[74] Coronial Brief, page 16.
[75] Coronial Brief, page 16.
[76] Transcript, page 105.

noted that life expectancy of patients with schizophrenia was much lower than the general population.[77]

76. Mr Kelly's statement annexed a research article[78] and presentation[79] based on the statistics he had compiled.

**Discussion about possible causes of Ms Gebert's death**

77. Dr Francis gave evidence at the inquest about her post-mortem findings outlined above. She was asked about the meaning of 'negative autopsy' and 'limitations of autopsy'. Dr Francis explained that a negative autopsy was one in which there were no toxicological or anatomical findings that to which the cause of death could be attributed. She noted that some natural disease phenomena that can cause death cannot be seen in the post-mortem examination. These include seizures and cardiac arrhythmic disorders. However, Dr Francis noted that Ms Gebert did not have a known history of seizures, and that while there were some while there were some abnormal changes seen in Ms Gebert's heart and lungs, there was nothing sufficient to attribute it to the cause of death.[80]

78. Following the inquest, I asked Dr Francis for statistics regarding the number of deaths where the cause of death is recorded as 'unascertained' despite autopsy and ancillary testing being conducted. Dr Francis informed me:[81]

> *… between 10-20% cases have an unascertained cause of death. The majority of these are most likely to have an underlying natural cause of death for which no anatomical abnormality was identifiable at autopsy. There may be a proportion of cases in which toxicology may have contributed to the death but the results of extensive postmortem testing are unable to elucidate the role that these substances may have had in the death.*
>
> *There is a proportion of cases in which the circumstances are conflicting or uncertain and the role of contributing factors is impossible to differentiate. These may include suspicious deaths and/or restraint related deaths.*

[77] Coronial Brief, page 16.
[78] Suggett, J. et al. (2020). Natural cause mortality of mental health consumers: A 10-year retrospective cohort study. *International Journal of Mental Health Nursing*, which appears at Coronial Brief, page 76.
[79] Dying more than 30 years earlier than the general population, which appears at Coronial brief, page 67.
[80] Transcript, pages 13-14.
[81] Email from Dr Victoria Francis, dated 19 May 2023. Dr Francis was unable to provide data on the number of deceased with an unascertained cause of death following autopsy having a significant mental illness.

*With the exception of heavily decomposed remains, ALL cases with the cause of death ascribed as "unascertained" will have a technical review by another pathologist to ensure that the report is correct and reasonable.*

79. In oral evidence Dr Francis agreed with Mr Kelly there was an increased risk of mortality in people with schizophrenia, as noted in her report at paragraph 6. She explained that a prolonged QT interval, which is a measurement on an electrocardiogram (**ECG**), can be considered a potential contributor to death as it can potentially cause sudden cardiac death, as can some psychiatric medications. Unfortunately, these cannot be visualised in a post-mortem examination or autopsy.[82] [83]

80. Dr Francis agreed with Mr Kelly that Ms Gebert had a number of risk factors that would put her at risk of cardiac disease. She also agreed with the article cited by Mr Kelly that it was a reasonable proposition that a dual diagnosis of schizophrenia and substance use disorder had a higher mortality rate than each diagnosis alone.[84]

81. Ultimately, Dr Francis stated she suspected cardiac abnormality was the *most likely* cause of Ms Gebert's death. Dr Francis added that in her opinion, Ms Gebert's death was most likely from natural causes, although she could not entirely rule out a possibility that the detected drugs contributed directly or indirectly.[85]

**MS GEBERT'S TRANSFER FROM THE ED TO SAAPU**

82. Michelle Gebert expressed concern that her sister was not observed appropriately at the SAAPU, that she should have remained at the ED where she would have been observed more closely or at least more frequently.[86]

83. While she conceded that the SAAPU would be an appropriate place for patients about whom there were no medical concerns, she disputed her sister was such a patient.[87] As noted above, after viewing the CCTV footage, Michelle Gebert was of the opinion that her sister had in fact deteriorated while in the ED (attributable by her to her sister having taken substances while

[82] Transcript, pages 16-17.
[83] In the email dated 19 May 2023, Dr Francis noted she was unable to provide data on the number of deceased with an unascertained cause of death following autopsy having a significant mental illness.
[84] Transcript, page 24.
[85] Transcript, pages 17, 25.
[86] Coronial Brief 5-6, Transcript 34.
[87] Transcript, pages 36-37.

in the ED) and that this as more likely to be appreciated by ED staff than in staff in the SAAPU where she was in a single room and on hourly observations.[88]

84. During her oral evidence, Michelle Gebert was taken to the 'Nursing Engagement Record', which recorded Ms Gebert's engagement with staff and/or observations at 6.45pm, 7.00pm, 7.30pm, 8.05pm, 8.10pm, 8.30pm, 9.00pm, 10.00pm, 11.00pm, and 12.00am. Between 8.05pm and 8.10pm, that record indicates that Ms Gebert was escorted to the kitchen for a coffee, but was then observed to be unable to stand and appeared very sedated so she was taken back to her room. Following this occurrence, her vital sign observations were normal at 8.30pm. However, Michelle Gebert was of the strong belief that her sister being unable to stand indicated that her condition had deteriorated as she had been able to walk around unaided while in the ED.[89]

85. Dr Ayton considered that Ms Gebert was provided *"appropriate care"* during the seven and a half hours she was in the ED. He described her *"maximum sedation"* as occurring at about 1.20pm, after which she improved over the following hours. Dr Ayton considered that Ms Gebert's oxygen levels and sedation had substantially improved by 5.15pm to a level *"which would not be expected to pose clinical risk"*.[90] This was confirmed by the Emergency Consultant, who completed a 'Safe Consumer Transfer Medical Checklist' form which indicated that Ms Gebert was medically cleared for transfer.[91]

86. In oral evidence, Dr Ayton confirmed that Ms Gebert was not breathalysed again after the first reading. However, he noted that he did not think it was warranted thereafter because 0.16% *"of itself is not what we'd consider a danger and we'd expect it to go down over time."*[92]

87. Dr Ayton also pointed to the nursing observations at 4.30pm and 5.15pm that Ms Gebert was fully awake and requesting diazepam. He also noted that the CCTV footage demonstrated that Ms Gebert could and did walk around unaided.[93]

88. Dr Ayton explained that the decision to transfer a mental health patient to the SAAPU is made by the Emergency Mental Health team and the Consultant Psychiatrist,[94] not the ED

[88] Transcript, pages 44-48.
[89] Transcript, pages 57-58; Exhibit B, page 628; Exhibit F.
[90] Coronial Brief, page 12.
[91] Coronial Brief, pages 12, 32: Transcript 77.
[92] Transcript, page 79.
[93] Coronial Brief, page 12.
[94] They are a part of the NorthWestern Mental Health Service.

Consultant.[95] However, the ED Consultant then completes a 'Safe Consumer Transfer Medical Checklist', confirming a patient is medical stable.[96]

89. It was noted the Consultant Psychiatrist had recorded the following plan in respect of Ms Gebert: *"Admit to IPU [inpatient psychiatric unit] once medically cleared (↓ BAC [lower blood alcohol concentration] and can engage for thorough mental state examination)."*

90. Dr Ayton's understanding of this note was that the primary reason for Ms Gebert being in the ED was her intoxication, and once she could meaningfully engage in mental health examination, she would be transferred.[97] It was not a requirement that Ms Gebert be totally sober before transfer.[98]

91. In response to a question as to whether Ms Gebert should have continued to be observed in the ED, Dr Ayton explained:[99]

> *Prolonged observation in a busy, stressful emergency department tends to be very stressful for patients, particularly mental health patients, and is associated with considerable risk of patients absconding and completing suicide.*
>
> *The clinicians consider the risks and benefits of emergency department care versus care in a dedicated mental health facility. If there appears to be a low clinical risk of medical issues as in Ms Gebert's case at the time of transfer, then transfer to a dedicated mental health facility is preferable.*

92. In oral evidence, Mr Kelly described the decision to transfer Ms Gebert to the SAAPU as a *"collaborative decision".* Ms Gebert had been seen by an Emergency Mental Health Clinician and a Psychiatrist and later reviewed again by an ED Consultant Physician and a Consultant Psychiatrist, and there was *"no dissent"* regarding the plan to transfer Ms Gebert. Mr Kelly stated he was, *"…comfortably satisfied that Ms Gebert's transfer to SAAPU was appropriate under the circumstances."* He denied that she had been transferred too hastily, noting that she had been in the ED for over eight hours and by the time of transfer her GCS score was 15, having risen from 13 when she first arrived in the ED.[100]

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[95] Coronial Brief, page 12.
[96] Coronial Brief, page 12.
[97] Transcript, pages 72-74; Exhibit B, pages 610, 632.
[98] Transcript, page 81.
[99] Coronial Brief, page 12.
[100] Transcript, pages 108-109.

93. Mr Kelly further stated that that after her arrival at the SAAPU, there was no indication that Ms Gebert's *"physical observations required a MET call, or a code blue, or need any other changes to observations. The physical observations were all within normal physiological parameters."* There was, of course, an option to provide more frequent observations, which may be required based on risk and vulnerability factors, but in Ms Gebert's case the Medical Officer considered one-hourly observations were appropriate. If staff had concerns about Ms Gebert's condition, for example concern about her breathing, that concern could have been escalated and a medical officer called, or a MET or code blue could have been called.[101]

**COMMUNICATION BETWEEN SERVICES AND MS GEBERT'S FAMILY**

94. In her statement and oral evidence, Michelle Gebert expressed concern that she was not contacted by either the PARC or the hospital as to her sister's discharge and admission respectively.[102] She accepted that Ms Gebert had informed staff she did not consent to her family being contacted and that her wishes should be honoured. However, she asserted that Ms Gebert had called her later that evening and that indicated that she had changed her mind.[103]

95. With all due respect to Michelle Gebert, this does not follow. The fact that Ms Gebert called her sister later in the evening to talk to her is not at all inconsistent with her express refusal of consent for staff to provide clinical information to her family. It is entirely consistent with her wish to control the flow of information from clinicians to her family and to control her own narrative.

96. Dr Ayton confirmed that no contact had been made with Ms Gebert's family because contact would ordinarily be left to the mental health team *"when in doubt"*.[104]

97. Ms Gebert made it clear to staff on 5 December 2019 that she did not consent for any clinical information to be provided to her mother and sister.[105] There had been occasions in the past when she had not wanted her family to be informed and occasions when she did.[106]

[101] Transcript, pages 116-118. See also Exhibit F, recording Ms Gebert's vitals between 11.05am and 8.30pm. Mr Kelly was satisfied that the vitals taken at 6.45pm and 8.30pm were within normal range: Transcript, page 124.
[102] Coronial Brief, pages 4-6; Transcript, pages 34, 41.
[103] Transcript, pages 34-35, 49, 56.
[104] Transcript, pages 75, 83.
[105] Coronial Brief, page 21; Transcript, pages 109-110; Exhibit B, page 671.
[106] Transcript, page 49; Exhibit B, page 677, 1253.

98. In oral evidence, Mr Kelly noted that Ms Gebert had expressed disappointment and shame about relapsing,[107] which I inferred to mean was a possible reason as to why she did not want her family informed. He also explained that although Ms Gebert initially refused consent to PARC staff, as they are part of the same health services as the SAAPU, staff from the SAAPU were also bound by that refusal.[108]

99. Counsel for NorthWestern Mental Health Service referred me to section 11(1)(e) of the *Mental Health Act 2014*, which states that persons receiving mental health services should have their rights, dignity, and autonomy respected and promoted. As such, Ms Gebert's refusal of consent to staff to provide clinical information to her family properly prevented them from doing so. In addition, which Mr Kelly also noted, a breach of confidence in this respect may threaten a patient's therapeutic relationship with their treating team.[109]

100. I note the Psychiatric Medical Officer who reviewed Ms Gebert at the SAAPU indicated she planned to obtain *"collateral [information] from family"* and the Consultant Psychiatrist planned to *"inform family"*.[110] It is trite to observe that clinicians can (and often do) obtain information with family without disclosing clinical information other than the fact that a person is being treated by their service.

**FINDINGS AND CONCLUSION**

101. The applicable standard of proof for coronial findings is the civil standard of proof on the balance of probabilities, with the *Briginshaw* gloss or explications.[111]

102. Moreover, the effect of the authorities is that Coroners should not make adverse comments or findings against individuals or institutions, unless the evidence provides a comfortable level of satisfaction that they departed materially from the standards of their profession and in so doing, caused, or contributed to the death.

103. It is axiomatic that the material departure from applicable standards be assessed without the benefit of hindsight, on the basis of what was known or should reasonably have been known at the time, and not from the privileged position of hindsight. Patterns or trajectories that may

[107] Transcript, page 109.
[108] Transcript, page 110.
[109] Transcript, pages 110, 139-140.
[110] Transcript, page 55; Exhibit B, pages 632, 637.
[111] Briginshaw v Briginshaw (1938) 60 C.L.R. 336 especially at 362-363. "*The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences…".*

be appreciated at a later time or may even obvious once the tragic outcome has come to pass are to be eschewed in favour of a fair assessment made while standing in the shoes of the individual or institution whose conduct is under scrutiny.

104. Having applied the applicable standard of proof to the available evidence, I find that:

(a) The identity of the deceased was Jennifer Gebert, born 13 June 1970.

(b) The death occurred on 6 December 2019 at the Sunshine Adult Acute Psychiatric Unit, Sunshine Hospital, 176 Furlong Rd, St Albans, Victoria.

(c) The medical cause of Ms Gebert's death remains unascertained despite a full post-mortem examination or autopsy and ancillary investigations.

(d) Although formally unascertained, based largely on Dr Francis' evidence, the cause of Ms Gebert's death was *most likely* due to a cardiac abnormality.

(e) The available evidence suggests Ms Gebert ingested paracetamol and codeine after 4.30pm. While I am unable to find that these drugs contributed significantly to her death, they are likely to have increased her drowsiness.

(f) While there is no evidence that Ms Gebert also ingested another drug which is not routinely tested for at the Victorian Institute of Forensic Medicine, the *possibility* cannot sensibly be excluded.

(g) Ms Gebert had a long history of mental ill health and substance dependence on the background of experiencing traumatic events as a child and teenager. Shortly before her death, she was admitted to Burnside Prevention and Recovery Care where she initially engaged well. Sadly, she relapsed and returned to the service in an intoxicated state, which was in breach of the service's policy and triggered her discharge.

(h) Ms Gebert was appropriately made subject to an Assessment Order under the *Mental Health Act 2014* when she expressed suicidal intent and could not guarantee her own safety.

(i) Ms Gebert was then taken to Sunshine Hospital Emergency Department where she was initially assessed to have a Glasgow Coma Scale score of 13 and a blood alcohol concentration of 0.159%. She was clearly intoxicated on arrival and could not meaningfully engage in a mental state examination. It was appropriate for Ms Gebert

to remain in the Emergency Department until she was fit for transfer to the psychiatric unit.

(j) While in the Emergency Department, Ms Gebert was medically assessed on at least three occasions and her clinical condition improved. Her Glasgow Coma Scale score increased to 15 (normal) and CCTV footage shows her ambulating and negotiating her way around the Emergency Department unassisted. Her vital signs were normal, apart from mean cell volume, which was consistent with chronic alcohol abuse.

(k) The 'Safe Consumer Transfer Medical Checklist' indicating Ms Gebert was medically cleared and safe for transfer, was in order at the time it was completed.

(l) Without the benefit of hindsight, the video footage showing Ms Gebert's physical condition toward the end of her stay in the Emergency Department does not display a deterioration in her clinical condition which was or should have been appreciable to clinical staff and, in any event, her vital signs and other assessments remained normal.

(m) Given Ms Gebert's medical stability, and following her transfer, I am satisfied that the order for hourly observations in the Sunshine Adult Acute Psychiatric Unit was appropriate. Despite her obvious intoxication, Ms Gebert's condition and vital signs remained stable and there was no indication for escalation of her care or that a deterioration or death was imminent.

(n) There was nothing in Ms Gebert's presentation while in the Emergency Department or the Sunshine Adult Acute Psychiatric Unit which would have led anyone to consider that she was at risk of imminent death whether from a cardiac abnormality or drug related death.

(o) The available evidence therefore does not support a finding that there was any want of clinical management or care on the part of the clinical staff at Sunshine Hospital or the Sunshine Adult Acute Psychiatric Unit that caused or contributed to Ms Gebert's death.

105. I convey my sincere condolences to Ms Gebert's family for their loss.

**PUBLICATION OF FINDING**

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

**DISTRIBUTION OF FINDING**

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

Michelle Gebert, senior next of kin

Robert Gebert, senior next of kin

Melbourne Health (NorthWestern Mental Health Service) (care of DTCH Lawyers)

Western Health (care of HWL Ebsworth)

Office of the Chief Psychiatrist

Senior Constable Dion Martin, Victoria Police, Coroner's Investigator

Signature:


Coroner Paresa Antoniadis Spanos

Date: 22 May 2023

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.