IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 005922

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Simon McGregor
Deceased:	Jonathan Mark Townsend[1]
Date of birth:	30 September 1962
Date of death:	5 November 2021
Cause of death:	1a: Unascertained
Place of death:	91 The Crescent, Kensington, Victoria, 3031
Keywords:	PTSD, substance misuse, AOD treatment, Department of Veterans Affairs funding

[1] A pseudonym.

INTRODUCTION

1. On 5 November 2021, Jonathan Mark Townsend[2] was 59 years old when he died unexpectedly at the home he shared with his wife, Amanda Hewitt, at 91 The Crescent, Kensington, Victoria.

2. Jonathan and Amanda married in 1989 and together they had one son. Jonathan joined the Australian Navy aged 16 and served until he was 24 years old. In 2006, he was diagnosed with post-traumatic stress disorder (**PTSD**) related to incidents in the navy and deemed totally and permanently incapacitated.[3] Jonathan also described experiencing significant adverse childhood experiences.[4]

3. Jonathan went on to have multiple admissions to public and private psychiatric units for mental health issues and, in addition to PTSD, had been given the following diagnoses: alcohol use disorder, generalised anxiety disorder, major depressive disorder, with evidence of cluster B personality traits. He reported longstanding alcohol abuse, heavy use of diazepam, and multiple previous suicide attempts (the last one being approximately three years ago).[5]

4. Jonathan had been under the care of private psychiatrist Dr Astha Tomar since 2019, when he completed a detoxification and rehabilitation program at The Melbourne Clinic (**TMC**).[6] He had further admissions to TMC in 2020, and from 18 July to 21 August 2021 (Alcohol Detoxification and Rehabilitation Program), with ongoing contact with Dr Tomar through the TMC outpatient clinic. As Dr Tomar was no longer admitting inpatients, she arranged for another psychiatrist to do the referral to TMC for the 2021 admission and Jonathan engaged well during this stay.[7]

5. At what was her last appointment with Jonathan on 22 September 2021, Dr Tomar raised the unsustainable nature of Department of Veteran Affairs (**DVA**) funding, which partially covered the appointment costs but not 'out-of-pocket' costs associated with private psychiatry fees that would ordinarily fall to Jonathan to pay, nor Dr Tomar's considerable additional work in completing DVA documentation. Jonathan indicated he could not afford any out-of-

[2] A pseudonym. Pseudonyms have been used throughout to refer to the deceased and members of his family.
[3] Statement of Amanda Hewitt, Coronial Brief.
[4] Exhibit 3 – Memoir of Jonathan Townsend, Coronial Brief.
[5] Statement of Dr Astha Tomar dated 13 October 2022; RMH records.
[6] Jonathan's treatment at TMC and with Dr Tomar was funded by DVA.
[7] Statement of Dr Astha Tomar dated 13 October 2022.

pocket costs and would speak with DVA. Another appointment was booked for 27 October 2021, though it is unclear whether this appointment would incur out-of-pocket costs.[8]

6. On 28 September 2021, Dr Tomar was contacted by DVA after Jonathan complained to them about their fee structure. DVA indicated to Dr Tomar there was a process for a higher scheduled fee for veterans with complex issues and she stated she would discuss this with Jonathan at his next appointment.[9]

7. Jonathan attended the TMC Addictive Behaviour Day Group Program on 6, 13 and 20 October 2021 and was settled, engaged well and was recovery-oriented. No risks were identified.[10]

8. Amanda reported that on or around 18 October 2021, Jonathan was drinking excessively on his boat and on return home, tried to obtain an admission to TMC to commence detoxification.[11] A referral was required from his treating psychiatrist but Jonathan and Amanda believed Dr Tomar would not continue to work with him due to the DVA funding issue, so he tried to self-detox at home using diazepam to manage the withdrawal symptoms.[12] Amanda believed Dr Tomar had not provided a referral for a new psychiatrist, and this was now up to Jonathan and herself to organise.[13]

THE CORONIAL INVESTIGATION

9. Jonathan'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.

10. 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.

11. 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

[8] Statement of Dr Astha Tomar dated 13 October 2022.
[9] Statement of Dr Astha Tomar dated 13 October 2022.
[10] Statement of Dr Astha Tomar dated 13 October 2022.
[11] It is not known what efforts Jonathan made towards obtaining an admission to TMC.
[12] Statement of Amanda Hewitt, Coronial Brief.
[13] Email from Amanda Hewitt to Coroners Court dated 25 November 2021, p.2.

comments or recommendations in appropriate cases about any matter connected to the death under investigation.

12. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Jonathan's death. The Coronial Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

13. This finding draws on the totality of the coronial investigation into the death of Jonathan Mark Townsend including evidence contained in the coronial brief. 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.[14]

14. In considering the issues associated with this finding, I have been mindful Jonathan's human rights to dignity and wellbeing, as espoused in the *Charter of Human Rights and Responsibilities Act 2006*, in particular sections 8, 9 and 10.

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

Circumstances in which the death occurred

15. On 27 October 2021, Jonathan was still undergoing detoxification at home and did not attend his scheduled TMC Addictive Behaviour Day Group Program nor his scheduled appointment with Dr Tomar.[15] Dr Tomar recalled she may have phoned him and left a voicemail message around this date with the intention of informing him there was a different DVA fee structure that might mean he was not out-of-pocket, but did not hear from him again.[16]

16. On the evening of 27 October 2021, Jonathan was struggling to walk due to his heavy consumption of diazepam, so his wife helped him to bed. Sometime later he attempted to go to the bathroom and fell over. Amanda found him in bed and Jonathan advised her he had fallen and hurt himself.[17] Jonathan was then taken by ambulance to Royal Melbourne Hospital

[14] 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.

[15] Statement of Dr Astha Tomar dated 13 October 2022.

[16] Statement of Dr Astha Tomar dated 13 October 2022. Dr Tomar indicated there was nothing in the medical record to confirm she had phoned Jonathan about his missed appointment.

[17] Statement of Amanda Hewitt, Coronial Brief.

(**RMH**) Emergency Department. His primary diagnosis was a closed rib fracture and small right pneumothorax[18] and he was admitted under the care of the Trauma team on 28 October 2021.[19]

17. While at RMH, the Trauma team appropriately involved Consultation Liaison (CL) Psychiatry, Addiction Medicine and Social Work teams. Although Jonathan was never formally assessed by CL Psychiatry (due to not meeting their admission criteria), at the time they reviewed Jonathan's case on 29 October 2021, they noted his mental state was stable, with no management issues arising on the ward and that he denied current thoughts of suicide. CL Psychiatry appropriately recommended that Jonathan be reviewed by the Addiction Medicine team, collecting collateral[20] and re-referral to CL Psychiatrist if any acute mental health issues emerged, and that he otherwise seek psychological support through his general practitioner, if desired, upon discharge.[21]

18. Also on 29 October 2021, social worker Davina Cohen undertook a psychosocial assessment with Jonathan and Amanda (via telephone). Amanda expressed that she did not wish for Jonathan to be discharged home. Rather, she wanted him to go directly to a rehabilitation clinic due to his ongoing substance use issues. Amanda had contacted the Melbourne Clinic to discuss their inpatient rehabilitation availability. She was informed it may be a 2 week wait, however she was hopeful it could be much sooner as Jonathan was known to their service.[22] Ms Cohen was concerned about carer stress and documented that Jonathan was not safe for discharge until the Addictions Medicine and CL Psychiatry team spoke to both Jonathan and his wife, and the issues with his medication management and discharge destination were resolved.[23]

19. On 1 November 2021, Jonathan was reviewed by Addiction Medicine registrar Dr Jocelyn Chan. He was noted to have had a recent discharge from TMC about 4-5 weeks earlier, after which he had immediately resumed drinking with no community supports available. Jonathan requested an inpatient admission to The Melbourne Clinic as a bridge to being approved by the DVA for an outpatient program. Dr Chan considered this to be a reasonable plan in all the

[18] Jonathan also had a rapid pulse and cardiac arrythmia on arrival at ED but this resolved during the admission.
[19] Statement of Assoc Prof David Read dated 3 May 2024; RMH records.
[20] There was no evidence that the Trauma team had yet contacted Jonathan's wife nor Dr Tomar to obtain that collateral.
[21] Statement of Assoc Prof David Read dated 3 May 2024; RMH records.
[22] Statement of Assoc Prof David Read dated 3 May 2024.
[23] RMH records.

circumstances and the Trauma Service was asked to make a referral via the Intake Department at The Melbourne Clinic.[24]

20. On 2 November 2021, the Trauma team acknowledged the plan to refer Jonathan to TMC (but did not make a referral) and noted he was suitable for discharge.

21. On 3 November 2021, Trauma Resident Dr Katia Maccora documented: 'Will attempt to refer to Melbourne Clinic rehab, SW for crisis accommodation if delay.'[25] The same day, social worker Ms Cohen reviewed Jonathan and noted the Addictions Medicine team had requested the Trauma team refer him to TMC, with social work to explore crisis accommodation in case of delay in bed availability at TMC. Ms Cohen obtained additional information on the process for DVA approval of funding for TMC and provided this information to the Trauma Clinical Nurse Consultant (CNC). Ms Cohen also sourced crisis accommodation for three nights at Unison Housing and informed the Trauma CNC (and nurse-in-charge) the team would need to notify Unison Housing when day of discharge was confirmed. Jonathan was documented as being not safe for discharge as referral was still required to TMC, with discharge to Unison Housing, if needed, while awaiting bed availability at TMC.[26]

22. Around 7:00 am on 4 November 2021, the Trauma team reviewed Jonathan and indicated he was medically safe for discharge and requested the Addiction Medicine team organise the referral to TMC and DVA documentation, and Social Work manage access to crisis accommodation.[27] Social Work were notified and around 11:00 am, Ms Cohen phoned Amanda to see if crisis accommodation was still needed.[28] Amanda reported she was also told the referral to TMC had not yet been made due to confusion between Teams.[29] Amanda was distressed and stated she had not been contacted by any of the medical staff at RMH and neither herself nor her husband wanted him to come home.[30] Amanda expressed concerned about him moving to crisis accommodation because in the past this had led to an escalation in his alcohol consumption and overdose on his medications.[31]

[24] RMH records, p.84.
[25] Ibid, p.87.
[26] Ibid, p.88-89.
[27] Ibid, p.91.
[28] Ibid, p.92.
[29] Email from Amanda Hewitt to Coroners Court dated 25 November 2021, p.3.
[30] RMH records, p.92.
[31] Ibid.

23. Ms Cohen contacted TMC who indicated they would contact Dr Tomar but still needed a referral from RMH and a bed would take a couple of days. At around 4:00 pm, Dr Chan completed the referral to TMC and DVA documentation and phoned Amanda to inform her. Amanda expressed concern about the delay in making the referral and poor communication with her about her husband's discharge plan. She also indicated she was worried about Jonathan's alcohol and diazepam usage if he was discharged before admission to TMC.[32]

24. Around 4:05pm, Dr Maccora phoned Amanda to inform her that her husband could not remain at RMH while awaiting a bed at TMC and the options were that he move to crisis accommodation or return home.[33] As a bed at RMH was not possible, Amanda said her husband could return home and she would collect him at 8:00 pm.

25. Around 5:45pm, Dr Maccora was told by nursing staff that Jonathan did not want to go home with his wife that evening but would not explain the reason for this. Jonathan assured Dr Maccora he would go to a hotel while awaiting a bed at TMC. Dr Maccora considered Jonathan 'competent' and discussed the situation with a registrar, who was happy for him to be discharged to a hotel.[34] By the time Dr Maccora had phoned Amanda to update her, Amanda had spoken to Jonathan and planned to take him to stay on his boat with his dog to await the bed at TMC.[35]

26. An entry in the nursing progress notes at 8:15pm indicates that Jonathan was frustrated during the shift, saying 'no one is listening to me' and was upset at being discharged that evening; when questioned why he was upset at being discharged he stated that he was 'a danger to himself'. The entry by the nurse records that Trauma and the nurse-in-charge were informed of this, and a Trauma clinician reviewed him.

27. Nursing staff documented that Jonathan left the ward around 6:00 pm on 4 November 2021, before his wife was due to arrive at 8:00 pm, and without his medications and belongings. Dr Maccora and the nurse-in-charge were notified, but Dr Maccora was unable to contact Jonathan on his mobile phone. It appears Jonathan caught a taxi home and sometime before 8:15 pm, Amanda phoned the ward in distress that her husband had arrived home without his belongings, medications or discharge information.[36] She stated Jonathan was confused,

[32] RMH records, p.93.
[33] RMH records, p.94.
[34] RMH records, p.94.
[35] Statement of Assoc Prof David Read dated 3 May 2024.
[36] RMH medical record, p.95.

distraught and did not know what day it was when he arrived.[37] Amanda arranged to come to RMH to collect her husband's medications and belongings.[38] Nursing staff documented that the Trauma team were content with this plan.[39]

28. It is worth noting that when Jonathan left the ward without his belongings and medications, this was appropriately escalated to Dr Maccora and the nurse-in-charge. Dr Maccora and nursing staff made appropriate efforts to contact Jonathan to ensure he had safely arrived home.[40]

29. Jonathan went to bed at around 9:00 pm, after being assured by Amanda that she had obtained his medications. He initially appeared unsettled and worried he did not have enough medication, but appeared to Amanda to be asleep by about 11:30 pm.

30. On the morning of 5 November 2021, Amanda assumed her husband was sleeping in. She made an appointment for him with his GP and called TMC to arrange his admission. At around 9:40 am, she went into his room and discovered that Jonathan had passed away in his bed.[41] There were no suspicious circumstances, and no overt signs of an intentional overdose.[42]

Identity of the deceased

31. On 5 November 2021, Jonathan Mark Townsend, born 30 September 1962, was visually identified by his son, Conor Townsend.

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

Medical cause of death

33. Forensic Pathologist Dr Brian Beer from the Victorian Institute of Forensic Medicine conducted an autopsy on 10 November 2021 and provided a written report of his findings dated 15 March 2022.

[37] Email from Amanda Hewitt, p.3
[38] RMH records, p.95.
[39] Ibid.
[40] Ibid.
[41] Statement of Amanda Hewitt, Coronial Brief.
[42] Statements of FC Todd Eustice-Jones, DSC Jason Barry-Bassett, SC Stefan Najmeddine, Coronial Brief.

34. The post-mortem examination was not able to identify a discrete cause of death. This happens in approximately 6% of all Victorian cases, but in each such case, a second pathologist peer reviews the analysis before the forensic investigation is completed.

35. Dr Beer explained that the autopsy showed mild cardiac hypertrophy. There was mild to moderate coronary artery narrowing but no significant critical stenosis, no myocardial fibrosis, nor any acute infarction. There were no features to suggest hypertrophic or arrhythmogenic cardiomyopathy, and no evidence of myocarditis or an abnormal infiltrate within the myocardium. There was mild to moderate thickening of some blood vessels in the cardiac conduction system, but Dr Beer considered this was probably of no clinical significance. Jonathan's increased heart size is associated with an increased risk of sudden cardiac death due to cardiac arrhythmias but more typically with greater left ventricular wall thickness and myocardial fibrosis. Overall, there was no convincing evidence to indicate a cardiac related death.

36. There were minor scalp bruises and the rib fractures, most likely reflecting a collapse, but no physical injuries that would explain the death. Nor was there any other significant natural disease process present.

37. Toxicological analysis of post-mortem samples identified the presence of therapeutic drugs, but did not identify the presence of alcohol or any other common drugs or poisons.

38. The vitreous electrolytes and glucose were within normal range for post-mortem specimens, thereby ruling out ketosis and sudden acute sepsis.

39. The Quetiapine level was ~ 0.3 mg/L and the Citalopram level was ~ 0.09 mg/L, both of which are within reported 'non-toxic ranges'. Both Quetiapine and Citalopram may potentially cause prolongation of the heartbeat and lead to a fatal cardiac arrhythmia, but overall, the possibility of a fatal cardiac arrhythmia from these medications is regarded as being very low, although it cannot be excluded.

40. The level of Oxycodone detected (0.2 mg/L) was within reported widely overlapping non-toxic (0.04-0.9 mg/L), toxic (0.2-2.4 mg/L) and lethal ranges (0.1-53 mg/L), and so is also inconclusive as a standalone cause of death. Fatalities attributed to oxycodone alone have ranged from ~ 0.3-0.4 mg/L to 5 mg/L and 0.1 to 8.0 mg/L. Oxycodone has a similar narcotic potency to that of morphine and it is possible that much lower concentrations, such as those seen in heroin deaths, may cause fatal toxicity. There may, however, equally be habituation

effects due to chronic use of oxycodone, such that higher levels of the drug would be required to cause fatal respiratory depression.

41. The toxicology also showed low, non-toxic levels of benzodiazepine drugs (diazepam and its metabolite nordiazepam) and of zopiclone, which may have sedative effects and potentially add to the sedative effect of the oxycodone.

42. It is also now unclear if there was any interaction between the degree of heart enlargement and the drugs present, but that is possible.

43. Overall, the toxicology does not definitively suggest that mixed drug overdose was the mechanism of death, though this cannot be excluded, particularly noting the low levels of oxycodone that have been attributed to narcotic-related deaths in other cases and the presence of other sedative drugs here, albeit also at low levels.

44. Accordingly, Dr Beer provided an opinion that the medical cause of death was 1(a) unascertained, and I accept his opinion.

RMH REVIEW OF CARE

45. Associate Professor David Read, RMH Director of Trauma, reported on the findings of the RMH internal investigation into Jonathan's episode of care at RMH. The review acknowledged Jonathan's (and his wife's) desire for him to go straight from RMH to TMC and the high level of carer distress experienced by his wife, but that he was medically cleared for discharge. When a rehabilitation bed was not immediately available, the review considered appropriate controls were put in place by the treating team, such as referral to outpatient services and arrangement of crisis accommodation.[43]

46. Associate Professor Read noted that the key learning from this case was to consider opportunities for CL Psychiatry or another mental health clinician to become more involved in the care of trauma patients with co-morbid substance abuse and/or mental health issues.[44]

47. For my part, I also strongly support this action as a better way of ensuring holistic and safe care for these patients and ensuring that RMH meets *Standard 5: Comprehensive Care of the*

[43] Statement of Assoc Prof David Read dated 3 May 2024.
[44] Ibid.

National Safety and Quality Health Service Standards (*2021*).[45] I commend them for independently pursuing this prevention opportunity.

FAMILY CONCERNS

48. On Thursday, 25 November 2021, Amanda wrote to the Court to express some concerns she had regarding the care her husband received. The concerns centred on:

    a) Jonathan's ability as a veteran to access DVA funding for psychiatric and substance abuse treatment; and

    b) the decision to discharge Jonathan from RMH to home without his next detoxification placement yet being secured.

49. I pause at this point to observe that Victorian coroners can only examine matters that are proximate and causative, or contributory, to a death. Coroners do not investigate aspects of care that have not contributed to death. The limitations on the jurisdiction of the Coroners Court sometimes lead to the result that concerns raised by families are not able to be investigated because they are not sufficiently connected with the cause and circumstances of their loved one's death. In those circumstances, there may be other avenues available for the concerns to be addressed, such as contacting health services directly or appropriate investigatory bodies such as the Health Complaints Commissioner.

50. In the specific circumstances of Jonathan's case, where the medical cause of death remains unascertained, the extent my investigation has necessarily been curtailed. Nonetheless, and as a result of receiving the family's concerns, I directed the independent practitioners in the Health and Medical Investigation Team of the Coroners Prevention Unit (**CPU**)[46] to review the medical care Jonathan received in the days leading up to his passing.

51. The CPU reviewed all available evidence in Jonathan's case, including the coronial brief, medical records, the forensic pathologist's report and the family's concerns, but ultimately did not identify any opportunities for prevention.

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[45] Australian Commission on Safety and Quality in Health Care (2021). *National Safety and Quality Health Service Standards* (second edition).

[46] 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.

52. In relation to accessing DVA funding for further treatment, I accept that a pathway was available, but that subjectively neither Amanda nor Jonathan were aware of its existence. This is the basis of the recommendation I have made below.

53. In relation to the Jonathan's discharge from hospital, Associate Professor Nicolas Clark, RMH Head of Service for Addiction Medicine, explained that although the RMH were aware of Jonathan's history of suicidality, at no point did they consider he would have met criteria for non-voluntary care, so the correct clinical decision was to discharge him and clear that bed for the next patient.[47]

54. In relation to Jonathan's treatment and management once he did not require hospitalisation at RMH, it is now a matter of public record in Victoria that the demand for inpatient treatment for substance abuse disorders far exceeds the supply of available places, commonly resulting in patients having to wait a considerable period of time to access treatment.[48]

55. The Victorian Alcohol and Drug Association (**VAADA**) have reported that on any given day between 14 June and 15 July 2024, 4,615 people were waiting for AOD treatment in Victoria; and further, that between 2020 and 2024, treatment waitlists increased by 93%.[49] VAADA have noted that unlike other sectors, there has been no Royal Commission into AOD services, though the Royal Commission into Victoria's Mental Health System (**RCVMHS**) recommended moving to integrated treatment for people living with mental illness and substance use or addiction.[50]

FINDINGS AND CONCLUSION

56. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the *Briginshaw* gloss or explications.[51] Adverse findings or comments

[47] Statement of Assoc Prof Nicolas Clark dated 29 April 2024.

[48] Victorian Alcohol and Drug Association/Drug Policy Modelling Program, UNSW. (2024). *Care and Complexity: Towards a re-designed Victorian AOD Service System*. https://www.vaada.org.au/wp-content/uploads/2024/09/Care-and-Complexity-_Towards-a-re-designed-service-system.pdf

[49] Victorian Alcohol and Drug Association (n.d.) *Treatment delayed is treatment denied.* https://www.vaada.org.au/wp-content/uploads/2024/09/RES_Sector-Demand-Survey_FINAL_19092024.pdf

[50] Royal Commission into Victoria's Mental Health System (2021). *Final Report: Volume 3: Promoting inclusion and addressing inequities*. (see Recommendation 35: Improving outcomes for people living with mental illness and substance use or addiction)

[51] *Briginshaw v Briginshaw* (1938) 60 CLR 336 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…'.

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.

57. In the absence of a clear cause of death, it was not possible to identify specific prevention interventions in this case.

58. In terms of quality of care, RMH's management of Jonathan appears to have been reasonable, although the circumstances of Jonathan's death also highlight the challenges experienced by veterans in accessing the services of private psychiatrists, who are the gateway to private hospital-based substance abuse services.

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

    a) the identity of the deceased was Jonathan Mark Townsend, born 30 September 1962;

    b) the death occurred on 5 November 2021 at 91 The Crescent, Kensington, Victoria, 3031, from 1(a) unascertained causes; and

    c) the death occurred in the circumstances described above.

60. Having considered all of the circumstances, I am satisfied that Jonathan's death was the unintended consequence of the deliberate ingestion of prescription medications, albeit not in quantities necessarily sufficient to cause any overdose. His death can be best understood as the unintended consequence of the combined effects of those drugs in his system.

COMMENTS

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

61. As the cause of Jonathan's death was not able to be ascertained, I observe that this investigation has nonetheless made plain the need for substantial investment in the substance abuse sector in Victoria, to address the significant mismatch between demand and supply that sees actively help-seeking people unable to obtain treatment.

62. A corollary of this is that hospital staff need to have access to up-to-date, easily accessible information on the eligibility of a veteran for health services and the process for accessing such services.

RECOMMENDATIONS

Pursuant to section 72(2) of the Act, I make the following recommendation, adopting Recommendation 71 of the Royal Commission into Defence and Veteran Suicide:[52]

> That the Australian Government amend the Department of Veterans' Affairs fee schedule to mitigate the challenges faced by veterans in accessing health care, ensuring that:
>
> (i) at a minimum, the revised fee schedule aligns with that of the National Disability Insurance Scheme; and
>
> (ii) efforts to mitigate supply constraints are prioritised, such as non-fee-for-service components, additional loading, and/or incentive payments, including in areas with few health services for the populations being served.

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

Pursuant to section 73(1A) 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:

Amanda Hewitt, Senior Next of Kin

Michael Townsend, Brother

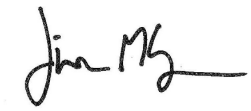
Daniel Lewis, Melbourne Health

Professor Glyn Davis AC, Secretary, Department of the Prime Minister and Cabinet

[52] Adopting the wording of *Royal Commission into Defence and Veteran Suicide* (Final Report, 9 September 2024) vol 1, p.138, Recommendation 71.

Senior Constable Benjamin Taualii, Coronial Investigator

Signature:



Coroner Simon McGregor

Date: 14 March 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 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.