IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 002138

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Catherine Fitzgerald
Deceased:	Tania Louise De Jong
Date of birth:	15 June 1974
Date of death:	23 April 2023
Cause of death:	1(a) Mixed drug toxicity (morphine, codeine, venlafaxine, amitriptyline and zopiclone)
Place of death:	South Eastern Private Hospital, 313 Princes Highway, Noble Park, Victoria, 3174
Key words:	Mixed drug toxicity, voluntary inpatient mental health care, day leave

INTRODUCTION

1. On 23 April 2023, Tania Louise De Jong was 48 years old when she died at South Eastern Private Hospital. At the time of her death, Ms De Jong lived at Officer, Victoria.

2. Ms De Jong was separated and had three children. Her medical history included migraines and previous diagnoses of depression, anxiety and bipolar disorder. She had a known history of prescription medication and alcohol misuse, but had reportedly abstained from alcohol for several months prior to her death.

THE CORONIAL INVESTIGATION

3. Ms De Jong'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.

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

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

6. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Ms De Jong's death. The Coroner's Investigator conducted inquiries on my behalf and submitted a coronial brief of evidence.

7. This finding draws on the totality of the coronial investigation into the death of Tania Louise De Jong 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.[1]

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

Circumstances in which the death occurred

8. In March 2023, Ms De Jong attended her general practitioner, Dr Di Zhao, and complained of worsening anxiety in the setting of her marriage breakdown. She reported racing thoughts, feelings of being overwhelmed, impulsivity, and risky behaviours, and queried whether she was suffering from attention deficit hyperactivity disorder. She also expressed disagreement with an earlier diagnosis of bipolar disorder. Dr Zhao noted that Ms De Jong's counsellor had recently observed a sudden and severe decline in Ms De Jong's mood.

9. Dr Zhao referred Ms De Jong to South Eastern Private Hospital (**SEPH**) for a planned voluntary inpatient admission to review her medication, diagnoses and treatment. Dr Zhao recorded the reason for referral as "urgent assessment and clarification of diagnosis, and prompt initiation of appropriate treatment, +/- any inpatient treatment like TMS". The only reference to alcohol or drug use was an indication that Ms De Jong "was a heavy drinker, but has not had any alcohol for several months". Dr Zhao noted that Ms De Jong's separation from her husband and the process of sorting out child custody and financial arrangements had been a "significant stressor" for her over the past two years.

10. Ms De Jong was pre-admitted to SEPH by a Mental Health Intake Officer on 30 March 2023. Her presenting complaint was documented as "Depression and Anxiety with a past medical history of migraines". Alcohol misuse was the only risk factor identified during the triage process, although Ms De Jong reported having been sober since July 2022.

11. On 31 March 2023, Ms De Jong was admitted to SEPH as a private patient and underwent a psychiatric assessment. Her drug and alcohol history was recorded as previous alcohol dependence with abstinence from alcohol since July 2022, with no current alcohol or drug use. It was noted that her mental health issues commenced in 2006 after her first child was born, and she had a previous inpatient admission at another facility in 2016. Ms De Jong

[1] 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.

reported some suicidal thoughts and her HoNOS score[2] was 20. She described her husband, children and friends as part of her strengths and supports.

12. From 1 to 9 April 2023, a clinical risk assessment was completed twice per day and Ms De Jong was assessed as being at "low risk" throughout this period.[3] She denied any self-harm or suicidal ideation. Nursing staff were required to make visual observations every 60 minutes. In this period, Ms De Jong was granted unsupervised day leave five times without incident. She continued to receive psychological counselling, medical reviews and received ECT.

13. On 9 April 2023, Ms De Jong was granted unsupervised day leave from 8:00 am to 3:00 pm to have Easter lunch with her husband, Andrew De Jong, and her children. On the way to the house, she stopped at a friend's house saying she wanted to drop off a card. She returned to the car with an envelope. While at Mr De Jong's house, she said she was going to take a bath, as she was unable to have baths in hospital. A short time later, Mr De Jong found her in the bathroom "on the floor, groggy and speaking but not making sense". Mr De Jong assessed that she was "clearly under the influence of something". He let her rest and gave her dinner. Mr De Jong then drove her back to the hospital and ensured she went inside.

14. On her return to SEPH, the afternoon nursing staff noted that Ms De Jong was "elevated" in mood. She had a lengthy conversation with the Associate Nurse Unit Manager and disclosed that she had injected herself with cocaine mixed with water. Nursing staff notified the hospital coordinator and treating psychiatrist. Ms De Jong's unsupervised leave was cancelled, and she was asked to undergo a drug test. It was documented that "all contraband and paraphernalia" were taken from her.

15. Ms De Jong's behaviour became increasingly erratic on 10 April 2023. Nursing staff observed that she was not oriented to time, was laughing and giggling at inappropriate times, and was screaming and yelling loudly in her room. Her treating psychiatrist prescribed olanzapine to assist with her symptoms and her scheduled ECT was withheld. Nursing observations were

[2] Health of the Nation Outcome Scales, a tool used in mental health to assess the severity of a patient's psychiatric symptoms. The score is a sum of individual ratings across 12 scales, with each scale scoring from 0 (no problem) to 4 (severe problem). A higher total score means a patient is experience more symptoms and/or symptoms of greater severity.

[3] The 'Daily Risk Assessment Tool' requires clinical staff to assess risk as across multiple categories, including suicidality, self-harm, aggression, absconding and substance abuse, as either Intensive, High, Moderate, Low or Past History. The tool also prompts consideration of whether the information obtained is reliable, and whether the risk levels are highly changeable.

increased to every 15 minutes and her risk was assessed to be "moderate to high". Ms De Jong reported feeling low due to her behaviour and her husband knowing about her addiction.

16. On 11 April 2023, the psychiatrist noted Ms De Jong was settled after a protracted period of confusion and possible elation secondary to cocaine use. He adjusted her medication, withheld her scheduled ECT for 12 April 2023, and approved accompanied leave.

17. On 12 April 2023, Ms De Jong went on accompanied leave from 8:30 am to 3:30 pm to complete a driving course. Shortly after returning to SEPH, Ms De Jong signed herself out from 3:30 pm to 8:00 pm.

18. On 13 April 2023, Ms De Jong was reviewed by her psychiatrist. She disclosed her intravenous cocaine use on 9 April 2023 and reported that she had been experiencing hallucinations since that day. Ms De Jong also underwent a psychological assessment on this day and explained that she felt "embarrassed and horrible" in relation to her drug use during leave. She stated that there had been an argument with her husband about her drug use after he had witnessed it, and that it was the first time she had used the drug and obtained it while on day leave.

19. Ms De Jong recommenced ECT on 14 April 2023 and adjustments were made to her medication. On 17 April 2023, Ms De Jong reported ongoing hallucinations when reviewed by the psychiatrist, but stated they were only occurring in bed when waking from sleep. She denied thoughts of self-harm or suicidal ideation. Fifteen minute observations and twice daily clinical risk assessments continued.

20. Ms De Jong continued treatment from 18 to 22 April 2023 without incident. She often used ground leave (to smoke) without incident and from 19 April her observations were changed back to 60 minute intervals.

21. On 23 April 2023, Ms De Jong went on supervised leave with her father, Doug Peterson, leaving the hospital at about 11:30 am. Mr Peterson drove Ms De Jong to a shopping centre in Officer, where she attended a pharmacy while he left the car to find a bathroom. Upon Ms De Jong's return to the car, she became agitated and appeared to believe her father was "spying on her". Mr Peterson then drove Ms De Jong to her home, where she took "something out of the letter box, like an envelope or something". Ms De Jong also entered her bedroom

and asked her father to wait in the car while she searched for something. She returned to the car approximately 5 minutes later.

22. Mr Peterson and Ms De Jong then attended her child's football match, where she spoke to her husband, Andrew De Jong, and the children. During the afternoon, she advised Mr De Jong that she had hit her head in the days prior and passed out. After the match, Mr Peterson drove Ms De Jong back to SEPH. As they neared SEPH, Ms De Jong asked her father to stop the car on Heatherton Road. Ms De Jong got out of the car in the service lane and Mr Peterson observed her walk up to the front door of the hospital and thought she appeared to be waiting for someone. Mr Peterson drove away and did not observe her walk inside.

23. Closed circuit television (**CCTV**) captured Ms De Jong returning to SEPH at about 3:00 pm carrying a large black backpack. Ms De Jong brought the backpack to her room prior to participating in a bag search by nursing staff. However, nursing staff only conducted a bag check of "a small handbag" she had with her, and not the backpack.

24. At about 6:30 pm, Ms De Jong told nursing staff that she had accidentally hit her head on the bathroom sink the night before. The treating clinician was advised, and Ms De Jong was commenced on routine neurological observations with no injuries or issues observed.

25. At about 9:30 pm, the night shift nurse attended Ms De Jong's room to conduct a visual observation. Ms De Jong was in the bathroom at the time and the staff member did not visually check her, but spoke to her through the closed bathroom door.

26. At 10:27 pm, the same nurse, attended Ms De Jong's room for hourly observations. When he opened the door, he observed Ms De Jong "face-planted on her bed, in a standing position", wearing pants, but with no clothing on her upper body. For privacy reasons, he did not enter the room. The nurse went to the staff bathroom and staff dining rooms, and at 10:35 entered the nurse's station, where he informed the nurse in charge (**NIC**) that Ms De Jong did not have a top on and required assistance.

27. At 10:27 pm, the NIC attended Ms De Jong's room and found Ms De Jong to be unresponsive. She immediately pressed the nurse call bell for assistance, followed by the emergency buzzer at 10:40 pm. Staff commenced cardiopulmonary resuscitation (**CPR**) at 10:45 pm and called 000.

28. Ambulance Victoria members arrived on scene at 11:06 pm and continued advanced life support measures, however they were unable to revive Ms De Jong and she was declared deceased at 11:32 pm.

29. Police attended and investigated the scene. They observed used and unused syringes, assorted drug paraphernalia and empty zip-lock 'deal' bags, as well as evidence of intravenous drug use on Ms De Jong's body. A mobile phone and iPad were seized and an examination of the electronic devices revealed communications with others in a group regarding drug taking and purchasing. Police did not identify any suspicious circumstances or signs of third-party involvement in Ms De Jong's death.

Identity of the deceased

30. On 27 April 2023, Tania Louise De Jong, born 15 June 1974, was visually identified by her father, Douglas Peterson.

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

Medical cause of death

32. Forensic Pathologist Dr Sarah Parsons from the Victorian Institute of Forensic Medicine conducted an autopsy on 2 May 2023 and provided a written report of her findings dated 13 June 2023.

33. The post-mortem examination revealed focal small vessel dysplasia in the heart of uncertain significance and scarring of the left kidney.

34. Toxicological analysis of post-mortem blood samples identified the presence of morphine and its metabolite codeine,[4] venlafaxine and its metabolite desmethylvenlafaxine,[5] zopiclone,[6]

[4] Morphine is a narcotic analgesic indicated for moderate to severe pain.
[5] Venlafaxine is indicated for the treatment of depression.
[6] Zopiclone is a cyclopyrrolone derivative used in the short-term treatment of insomnia.

amitriptyline and its metabolite nortriptyline,[7] topiramate,[8] ondansetron[9] and paracetamol.[10] Ethanol (alcohol) and cocaine were not detected.

35. On the day of Ms De Jong's death, she was administered amitriptyline, topiramate, Dulcolax, lithium, quetiapine, zopiclone, clonidine, venlafaxine, and valproate by hospital staff.

36. Urine was unavailable for the detection of specific heroin markers, but in the absence of hospital administration of morphine, Dr Parsons opined that the presence of morphine and codeine could have derived from heroin use. It does not appear that Ms De Jong was ever administered morphine at SEPH. Codeine was administered in the form of Panadeine Forte on either 22 or 23 April 2023, however the records are difficult to read.

37. Dr Parsons explained that many of the drugs detected in Ms De Jong's system have the effect of depressing the central nervous system (**CNS**), which can lead to CNS and respiratory depression.

38. Dr Parsons provided an opinion that the medical cause of death was "1(a) Mixed drug toxicity (morphine, codeine, venlafaxine, amitriptyline and zopiclone)".

39. I accept Dr Parsons' opinion.

FURTHER INVESTIGATIONS AND REVIEW OF CARE

40. Following Ms De Jong's death, SEPH conducted an internal review and produced a Serious Adverse Patient Safety Event (**SAPSE**) report. Dr Zhao and Aurora Health Care (the operator of SEPH) both provided statements as part of the coronial investigation.

Serious Adverse Patient Safety Event report

41. The SAPSE report addressed the events leading up to Ms De Jong's death and identified the following as potential issues with Ms De Jong's admission:

[7] Amitriptyline is a tricyclic antidepressant indicated for major depression, panic disorder, neuropathic pain, and enuresis.
[8] Topiramate is an effective anticonvulsant.
[9] Ondansetron is indicated for post-operative nausea and vomiting due to chemotherapy.
[10] Paracetamol is an analgesic drug available in many proprietary products either by itself or in combination with other drugs such as codeine and propoxyphene.

a) Per their policy, day leave is not to be granted within the first 24 hours of admission and is not to be granted to patients under 15-minute observations;

b) Ms De Jong's pharmacological management;

c) The psychiatrist did not review Ms De Jong in person following her admitting to intravenous cocaine use and a subsequent change in mental state the next day, and;

d) Inconsistencies in the documentation by nursing staff regarding visual observations, level of risk and leave approval.

42. However, the SAPSE report concluded that the above four issues did not contribute to Ms De Jong's death, noting that most of these issues occurred several days or weeks prior to Ms De Jong's death and were not sufficiently proximate such that they could have caused or contributed to her death. The documentation inconsistencies were regarded as minor in nature and not contributory. Similarly, Ms De Jong's medication regime was reviewed and was found to be satisfactory. I agree with these conclusions.

43. As part of the SAPSE process, Ms De Jong's family were invited to participate and submitted questions and concerns as follows:

a) When did Ms De Jong return to the ward on 23 April 2023? Did she immediately return to the ward or did she attend the smoking area first?

b) Why was Ms De Jong not required to 'sign in' upon returning to SEPH, when she was required to 'sign out' for day leave?

c) When did the first visual observation of Ms De Jong occur following her return from day leave on 23 April 2023?

d) Family members felt uncertain about the responsibilities and requirements of the person accompanying Ms De Jong on day leave as the 'responsible adult'.

e) Ms De Jong's husband recalled an instance when Ms De Jong had been on leave earlier in her admission when she purchased cans of Coca-Cola. When questioned about this, she stated "it didn't matter as the staff didn't check her bags when she returned from leave".

f) The family questioned what medications Ms De Jong was on, specifically what was required daily, twice a day, and three times a day. They questioned why she was able to miss her tablets that were required three times a day when on leave.

44. A common theme that emerges from the SAPSE report is that SEPH staff did not have experience, training, or skills to recognise and treat patients with substance abuse issues. This lack of awareness may have contributed to the staff's inability to recognise Ms De Jong's deterioration, and hampered opportunities for them to escalate her care appropriately.

45. These observations are unsurprising as SEPH is not a facility that is equipped to admit patients with substance abuse issues and/or treat drug withdrawal. The hospital's admission policy relevantly states, "Mental Health Exclusion criteria includes patients with a primary diagnosis of alcohol and/drug dependency". In the statement provided by Aurora Health Care, it was noted that Ms De Jong would not have been admitted to SEPH if they were aware of her substance abuse issues prior to her admission.

46. SEPH became aware of potential substance abuse issues when Ms De Jong disclosed her intravenous use of cocaine on 9 April 2023. In accordance with their own policies at the time, once SEPH became aware of her drug use, staff reviewed her case and reviewed whether she could remain as a patient. A decision was made to allow her to remain at the facility. I note that this decision was made using information provided by Ms De Jong, who claimed that her use of cocaine was the first time she had used illicit substances. This does not appear to have been an accurate representation of the extent of her drug use. Having regard to the quantity of drug paraphernalia located in her room after her death, as well as the evidence of drug use prior to admission, I am satisfied that Ms De Jong's drug use was far more significant than she disclosed to SEPH.

47. In her statement, Dr Zhao noted that she was unaware of Ms De Jong's illicit drug use. This was reflected in the referral she made to SEPH. Dr Zhao explained that she recommended SEPH for Ms De Jong as it was convenient to her home address and near her husband's home where here children were living. She additionally believed that SEPH "had the necessary expertise and facilities to diagnose and treat anxiety and mood related disorders".

48. Having regard to the SEPH Admission Policy, it is clear that Ms De Jong would not have been admitted if the extent of her drug use was known. I make no criticism of Dr Zhao's management of Ms De Jong or referral to SEPH, as she was not aware of Ms De Jong's drug

use at that time. Similarly, SEPH staff were unaware of Ms De Jong's drug use and there was therefore no reason not to admit her for treatment.

49. I note that Aurora Health Care has now implemented (or is currently implementing) several recommendations arising from the SAPSE review, namely:

    a) including drug and alcohol experience in future staff recruitment processes;

    b) providing specific drug and alcohol training to all mental health staff and hospital contractors;

    c) requiring twice weekly reviews of comprehensive care plans and progress notes by a Nurse Unit Manager and Allied Health team member to ensure that appropriate care planning is in place;

    d) amending the Clinical Escalation policy to add escalation of critical information to the hospital's on-call executive team member;

    e) updating the Escalation of Mental Health Deterioration policy to improve awareness among staff;

    f) introducing written guidelines for the 'responsible adult' regarding accompanied leave;

    g) developing a new Patient Leave form that provides a checklist prompting staff to undertake post-leave bag searches, document the time of return and post-leave debriefing with the 'responsible adult' and the patient;

    h) updating the Visual Observations policy to standardise the observations process, including environmental scans;

    i) conducting Code Blues in a simulation lab environment with after-action critiques and debriefing;

    j) reviewing the mental health admission packs;

    k) conducting risk assessment training with after-action critiques and debriefing, and;

    l) conducting education regarding comprehensive documentation.

50. These improved training and hiring practices may assist staff to identify patients who have a concomitant substance abuse issue. It is not uncommon for mental illness and substance abuse disorders to coexist in patients accessing inpatient mental health treatment, so a greater ability to recognise an undiagnosed substance abuse issue is important.

51. I note that self-reporting of substance abuse is often inaccurate, so more rigorous procedures regarding day leave, clarification of the role of the 'responsible adult' and bag searches may provide an earlier indication of unknown drug issues.

52. Having regard to SEPH's admitted lack of experience, skills, and expertise to deal with patients suffering from substance abuse, I recommend that SEPH also consider implementing a policy whereby any determination to discharge or continue treatment of a patient discovered to be using drugs should also include a requirement to seek advice from an appropriately qualified drug and alcohol clinician, should that expertise be unavailable in-house.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Tania Louise De Jong, born 15 June 1974;

    b) the death occurred on 23 April 2023 at South Eastern Private Hospital, 313 Princes Highway, Noble Park, Victoria, 3174, from mixed drug toxicity (morphine, codeine, venlafaxine, amitriptyline and zopiclone); and

    c) the death occurred in the circumstances described above.

54. Having considered all the circumstances, I am satisfied that Ms De Jong's death was the unintended consequence of the deliberate ingestion of drugs.

RECOMMENDATIONS

Pursuant to section 72(2) of the Act, I make the following recommendations:

(i) I recommend that SEPH implement a policy whereby any determination to discharge or continue treatment of a patient discovered to be abusing drugs/alcohol should include a requirement to seek advice from an appropriately qualified Alcohol and Other Drugs (AOD) Clinician.

I convey my sincere condolences to Ms De Jong's family for their loss.

Pursuant to section 73(1) 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:

Andrew De Jong, Senior Next of Kin

Aurora Health Care

Detective Senior Constable Josh Gordon, Victoria Police, Coroner's Investigator

Signature:

Coroner Catherine Fitzgerald

Date : 11 December 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.