IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2011 883

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the ***Coroners Act 2008***

I, PARESA ANTONIADIS SPANOS, Coroner,
having investigated the death of CASSILLA ELLEN DOOLEY
without holding an inquest:
find that the identity of the deceased was CASSILLA ELLEN DOOLEY
born 11 April 1976
and the death occurred on 7 March 2011
at Elizabeth Street Common Ground, 660 Elizabeth Street, Melbourne, Victoria 3000
from:

1 (a) MIXED DRUG TOXICITY (ETHANOL, METHADONE, DIAZEPAM AND RISPERIDONE)

Pursuant to section 67(2) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances**:

1. Ms Cassilla Ellen Dooley (referred to in this finding as 'Cassie' in accordance with the family's preference) was 34 years of age at the time of her death. She was in receipt of a disability support pension and resided at the Elizabeth Street Common Ground (ESCG). Cassie was the mother of a daughter who resided with the paternal grandparents. She had a 15 year history of mental illness, variously diagnosed as schizophrenia, schizoaffective disorder, polysubstance abuse and, borderline and anti-social personality disorder.

2. At approximately 4.50-5.00 pm on Monday, 7 March 2011, Cassie was taken to her room by a nurse and a staff member from ESCG as she appeared to be heavily intoxicated. The nurse assessed her as not requiring medical attention or emergency services, but directed that welfare checks be conducted by staff in the ensuing period.

3. A welfare check was conducted at approximately 6.10-15 pm and, as she did not respond, the master key was used to gain entrance to her apartment. Cassie was found unresponsive and an ambulance was called but Cassie unable to be revived.

INVESTIGATION

Medical investigations

4. An autopsy was conducted by Senior Forensic Pathologist Dr Matthew Lynch, from the Victorian Institute of Forensic Medicine (VIFM). Dr Lynch provided a detailed written report in which he summarised his autopsy findings as - evidence of recent and remote intravenous access at right elbow; hyperexpanded lungs with pulmonary oedema; enlarged fatty liver with chronic hepatitis C; gastric contents within upper airways but no evidence of bronchopneumonia; scattered bruises right upper arm, both lower limbs and both buttocks; and scars anterior left wrist suggestive of previous self-harm.

5. Noting the results of post-mortem toxicological analysis, Dr Lunch advised that the cause of death was 'mixed drug toxicity (ethanol, methadone, diazepam and risperidone)'. As to the mechanism of death he commented that "The presence of ethanol, methadone and benxodiazpeines can effect respiratory depression as a result of the synergistic effect of these agents and is the likely mechanism of death."

6. The toxicological analysis detected ethanol (alcohol) in post-mortem femoral blood at 0.33 gm/100ml and 0.38 gm/100mL in vitreous humour. Also detected in blood were methadone at ~0.4 mg/L, the sedative diazepam at ~0.2mg/L, hydroxyrisperidone (a metabolite of the atypical antipsychotic risperidone) at 32ng/mL and Δ9-tetrahydrocannabinol (THC) at ~3ng/mL. A metabolite of THC was also detected in urine at 270 ng/mL.

7. The toxicologist advised that blood alcohol concentrations (BAC) in excess of 0.15% can cause considerable depression of the Central Nervous System (CNS), that other drugs capable of depressing the CNS will increase the effects of alcohol and a BAC of ~0.40% can cause death in the absence of other contributing factors.

8. Department of Health records accessed by the toxicologist indicate that Cassie was a registered methadone recipient who was dosed with 40mg of methadone on 1, 2, 3, 5 and 7 March 2011 (date of death), but had missed her dose on 4 and 6 March 2011.

Police investigation

9. Cassie had resided at ESCG since 6 September 2010 and was one of its first tenants. ESCG essentially operates as a rooming house with additional services for severely disadvantaged people who are chronically homeless. It is a gazetted rooming house under the *Residential Tenancy Act 1997* (the RTA).

10. At approximately 7.45 pm on Friday, 4 March 2011, Cassie assaulted another resident and, was served with an immediate Notice to Leave (in accordance with the provisions for rooming houses in the RTA). The Notice required Cassie to be absent from the premises for a period of 48 hours.

11. The police were called to take Cassie to St Vincent's Hospital for an assessment but she was unable to be located. Cassie was subsequently served with the Notice at approximately 2.30pm the following day when she attended at ESCG.

12. Cassie was advised to attend the St Kilda Crisis Centre for assistance. They in turn called an ambulance some time after 6.30pm due to Cassie's presentation as she was noted to be very intoxicated. Cassie was conveyed by ambulance to the Alfred Hospital where she was admitted and stayed overnight. Cassie was monitored by a psychiatric nurse (at her request) and was discharged on 6 March 2010 at approximately 6.00am following a 'short' psychiatric assessment at which time no acute risk issues were identified.

13. Cassie attended ESCG but as the Notice was still operational she was asked to return the next day.

14. On Monday, 7 March 2011 Cassie was permitted to resume her tenancy at the ESCG following a meeting with representatives from Yarra Community Housing and Homeground.

15 At approximately, 4.20pm Cassie was noted to be stumbling and had fallen over on the ground floor of her residence. At approximately 4.50-5.00 pm, she was taken to her room by the registered nurse on duty and a support worker. CCTV footage available to the Court captured some of Cassie's movements during this period, including her being taken to her room on seventh floor.

16. The nurse assessed that Cassie did not require medical assistance or emergency services and that regular welfare checks were appropriate. There are differing accounts as to how often the welfare checks were to be conducted – the nurse states hourly and other staff state that the nurse said every two hours. A welfare check was conducted at approximately 6.10-15 pm and Cassie was found deceased.

The provision of mental health care to Cassie immediately before her death

17. With respect to the provision of mental health care services to Cassie, I examined her medical records, a statement of Dr Vicki Shephard (consultant psychiatrist, St Vincent's Mental Health) dated 26 August 2011, a statement of Dr Monica Cooper (who managed Cassie's opiate dependence) dated 29 August 2012 and a statement from Dr Alex Holmes (Consultant Psychiatrist, Inner West Area Mental Health Service) dated 30 May 2012 which was requested by the Court.

18. At the time of her death Cassie was the subject of a Community Treatment Order (CTO) and was being cared for by the Clarendon Homeless Outreach Psychiatric Service (CHOPS), St Vincent's Mental Health (and had been from 2005). Her care was in the process of being transferred to the Waratah Inner West Mental Health Service – with Homeless Outreach Psychiatric Service as the treating team (HOPS).

19. In the months preceding Cassie's death, her mental state was very unstable. Cassie was admitted to St Vincent's Hospital (and her CTO revoked) on 21 January 2011 for 10 days and then required a further admission on 9 February 2011 for 12 days.

20. HOPS was advised about the incident on 4 March 2011 and her admission to the Alfred Hospital. It was planned that as soon as Cassie was located they would facilitate an assessment, and admission if required. They were informed that Cassie would be returning to Elizabeth Street at 1.00pm on 7 March 2011 but were unable to attend that day due to there being no medication/script available. An appointment was booked with a consultant to review her on 9 March 2011.

21. Dr Monica Cooper managed Cassie's opiate dependency with methadone. She indicated that Cassie's opiate dependence and chronic schizophrenia were never fully stabilised, despite continuing medical and psychiatric services.

The ESCG accommodation

22. According to ESCG management, theirs is a 'normal apartment building where people have tenancy rights', not a mental health institution, hospital or registered health clinic. Additional services are provided including on-site case management, allied health and therapeutic support services during business hours and staffing of the front desk on a 24/7 basis.

23. ESCG was designed for people with significant barriers to stable housing and increased vulnerability caused by factors including mental health, physical health, drug and alcohol, family violence and disability. Cassie fitted the ESCG criteria as she had been chronically homeless over many years. Her risk assessment indicated that she was in the extreme category of risk in a number of areas. To deal with these risks, ESCG developed a comprehensive Mitigation Plan for Cassie that indicated what action should be taken when particular behaviours present. Records from ESCG reveal that Cassie was often substance affected on the premises and could be aggressive with other residents at times.

24. Overall, the available evidence suggests that Cassie was doing very well immediately after she took up residence at ESCG, and that she had reduced her drug use. However, according to some people around *'New Year 2011 other persons from the residence had a win on the pokies which was quite a lot of money and they went on a bit of a drug splurge using illicit drugs. The residents tend to share and Cassie became involved and stopped taking Methadone regularly at this time'.*

Provision of care immediately before Cassie's death

25. The evidence suggests that the registered nurse who took Cassie to her room shortly before her death made a professional judgment based on Cassie's presentation, history (the nurse knew her well), physical presentation and her advice that she had not consumed other (illicit) drugs.

26. I sought advice with respect to the nurse's assessment emergency physicians who are engaged as part of the Health and Medical Investigation Team. They advised that it was an unusual event for someone to die in these circumstances. They noted that Cassie could walk (albeit assisted), carry on a conversation and obey directions. Further, that Cassie's airway had not been obstructed in a manner that contributed to her death, and that as she was not displaying signs of coma (applying the Glasgow Coma Scale). They advised that placing her in a coma position was not a necessary response, and that even if Cassie had been placed in that position, she may have moved to another position at any time.

27. They concluded that decision taken by the nurse was within the scope of reasonable care. I accepted their advice on this matter.

Mention Hearing

28. A mention hearing was convened on 24 January 2012 to help me decide whether there was a need to hold an inquest as part of the investigation of Cassie's death. Cassie's sister Dr Paula Mitchell had requested that I conduct an inquest, and both she and Cassie's father, Mr Gary Mitchell were present at the mention hearing. Also represented at the mention were Homeground Services, as manager of ESCG.

29. Whilst the decision regarding Cassie's welfare in the hours before her death was made by a registered nurse, I raised concerns regarding the processes or guidelines that were in place at ESCG to assist workers in dealing with residents who presented poorly. At the hearing, Homeground Services advised that they were in the process of implementing a specific intoxication policy, a draft of which was subsequently provided to the parties.

30. The family wanted to understand why, given Cassie's significant and long standing drug an alcohol abuse, she succumbed on this occasion. I requested an additional expert toxicological report from Professor Olaf Drummer, VIFM. In that report, Professor Drummer advised that Cassie's '*missing methadone doses in her recent past would lower her tolerance to methadone and further increase the risk of depression of the central nervous* system.'

31. While the evidence does not support a finding that the discrepancy contributed to Cassie's death, it is problematic that there were two different versions with respect to the timing of Cassie's welfare checks. The nurse indicated hourly and was emphatic on this point, while the staff members who were to perform the welfare checks indicated two hourly and made a record along these lines in the communication log. It was and remains my view that such an inconsistency was unlikely to be resolved at inquest, and in all likelihood, represents poor communication between the parties and/or a misunderstanding.

32. However, the inconsistency demonstrates a need for a system that accurately records directions by health professionals to staff members at ESCG. At the mention hearing, I asked Homeground Services to consider a set of recommendations, drafted by the Court, for this purpose. I was subsequently advised that they accepted the proposed recommendations and intended to implement them. The recommendations form part of my findings.

33. Having considered all the evidence now available to me, I find that Ms Cassilla Ellen Dooley born on 11 April 1976 died as a result of 1(a) Mixed drug toxicity (ethanol, methadone, diazepam and risperidone).

34. The evidence does not support a finding that any want of clinical management and care on the part of the staff of any of the services involved with Cassie, caused or contributed to her death. More specifically, I find that the decision not to call emergency services or to provide medical assistance to Cassie in the hours immediately preceding her death, was reasonable and appropriate in the circumstances as known at the time.

RECOMMENDATIONS

Pursuant to section 72(2) of the **Coroners Act 2008**, I make the following recommendation(s) connected with the death:

1. That Homeground Services review the ESCG *Welfare Checks and Guideline* to ensure it is evidence based, appropriate and increases the safety of residents and ESCG and the Royal District Nursing Staff (RDNS), such review to include:

- RDNS and ESCG coming to a formal arrangement whereby the instigation of welfare checks is communicated clearly, based on a written recording of the order by the instigating staff member, and immediately available to all RDNS and ESCG staff who have to implement it.
- Ensuring that as a minimum standard for the implementation of a welfare check, the order should include the welfare check start time, frequency, intent of the check, the duration for which the welfare check order is to continue, and how the order is rescinded.
- Provision of training to all ESCG staff regarding the implementation of the *Welfare Checks and Guideline.*
- Ensuring that RDNS Homeless Person Program clinicians include education about the ESCG *Welfare Checks and Guideline* in their orientation to the ESCG facility, including their responsibilities.

Pursuant to rule 64(3) of the Coroners Court Rules 2009, I order that the following be published on the internet:

This Findings into Death Without Inquest, in its entirety.

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

- Dr Paula Mitchell
- Mr Gary Mitchell
- Dr Alex Holmes, Inner West Area Mental Health Services
- Ms Joanna Hill, Lander & Rogers

- Director, Office of Correctional Services Review
- Constable Matt Wilmot, Investigating Member.

Signature:

PARESA ANTONIADIS SPANOS
Coroner
Date: **4/09/2013**