IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2014 000430

FINDING INTO DEATH WITHOUT INQUEST

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

I, PHILLIP BYRNE, Coroner, having investigated the death of CHRISTOPHER JOHN DOKOS without holding an inquest:
find that the identity of the deceased was CHRISTOPHER JOHN DOKOS
born on 6 February 1968
and that the death occurred between 17 and 19 January 2014
at 23 Ramu Parade, West Heidelberg Victoria 3081

from:

I (a) COMPLICATIONS OF HEAT STROKE IN A MAN WITH SCHIZOPHRENIA.

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

1. Mr Christopher John Dokos, 45 years of age at the time of his death, resided with his partner, Ms Katrina Baron, at 23 Ramu Parade, West Heidelberg.
2. Mr Dokos' medical history included hypertension, type 2 diabetes mellitus and hyperlipidaemia. He was a smoker and had a long history of schizophrenia that was being treated with the antipsychotic drug Clozapine.
3. On 19 January 2014, Mr Dokos' parents attended her house to conduct a welfare check and from the outside the premises observed Ms Baron lying inside the house near the front door.
4. Emergency Services were called and the Metropolitan Fire Brigade, police and paramedics arrived shortly after. They forced entry into the house and observed Ms Baron lying on top of a washing basket with her feet towards the door. Paramedics confirmed that Ms Baron was deceased. Police subsequently located Mr Dokos in a bedroom towards the rear of the house and

he too was confirmed to be deceased. Mr Dokos and his partner were last seen by a neighbour on 17 January 2014 at around 5.50pm.

5. The matter was reported to the Coroner who ordered an autopsy which was undertaken at the Victorian Institute of Forensic Medicine (VIFM) by Dr Heinrich Bouwer. After exhaustive investigation including biochemistry, histopathology, toxicology and radiology, Dr Bouwer advised he found no physical traumatic injuries that could have caused or contributed to death. He further commented that "heat stroke related deaths in people with schizophrenia are a rare but well recognised phenomenon..." He noted vitreous urea level was raised, suggesting dehydration. I accept his advice that Mr Dokos' untimely death was due to:

   I(a) COMPLICATIONS OF HEAT STROKE IN A MAN WITH SCHIZOPHRENIA

   I am entirely satisfied there was no third party involvement or suspicious circumstances.

6. Toxicological analysis revealed the presence of the antipsychotic Clozapine.

7. The circumstances of the finding of the bodies of Ms Baron and Mr Dokos were somewhat unusual which raised concerns in the minds of police who first attended. Appropriately, the Homicide Squad were invited to have input into the investigation. However in the final analysis after the autopsy results became available, it was clear there were no suspicious circumstances surrounding the deaths. For completeness I add that the families of Ms Baron and Mr Dokos are apparently satisfied that the deaths of the couple are not suspicious.

8. The untimely deaths of Ms Baron and Mr Dokos occurred at the time of the extraordinary heat wave during which the whole of Victoria sweltered in almost unprecedented temperatures. The period was aptly described in the Australian Government Bureau of Meteorology Annual Climate Statement 2014 as:

   "One of the most significant multi-day heatwaves on record..."

   The highest temperatures experienced in Melbourne peaked at 43.9 degrees on both the 16 and 17 days of January 2014. In other parts of the State the temperature reached 45 degrees on three days during the heatwave.

9. Heatwave plan for Victoria – Protecting health and reducing harm from heatwaves provides a technical definition based on a concept of a "heat health temperature threshold". The plan provides:

   "Once forecast average temperatures are predicted to reach or exceed the heat health temperature threshold for a specific weather forecast district, the department will issue a

heat health alert for that district. The alert notifies departmental program areas, hospitals, local government, agency partners and service providers of forecast heatwave conditions that are likely to impact on human health". (my emphasis)

Acting on that direction the Department of Health (as it was then titled), under the hand of the Chief Health Officer, issued an alert on 9 January 2014, which was updated on 17 January 2014 relating to the period of Monday 13 January – Saturday 18 January 2014.

10. When one examines the Department of Health Heatwave Plan for Victoria, the stated aim is to "protect the health of Victorians in a heatwave, specifically those most at risk of heat-related health impacts." The document recognises that various categories of people are at heightened risk; for instance people who have a mental illness, particularly those on anti-psychotic medication, or overweight or obese (see appendix 1). It is noted that people who fall into more than one at-risk group are likely to be even more susceptible to extreme heat.

11. As the Department distributed the alert to hospitals I have assumed Austin Health, a tertiary hospital, received the alert. How widely that information was disseminated/conveyed to the various parts of that very large public hospital is somewhat unclear to me. Having regard to the potential impact upon patients suffering from schizophrenia and on anti-psychotic medication like Clozapine failure to disseminate the contents of the alert to the mental health component of Austin Health would be problematic.

12. At the relevant time North East Area Mental Health Service (NEAMHS) did not, as Associate Professor Newton conceded, have in place a specific heatwave plan. The deficiency was identified during Austin Health's internal review following the deaths of Ms Baron and Mr Dokos.

13. In response to further questions put to Austin Health on my behalf Associate Professor Newton provided an "additional response", (in effect a supplementary statement) advising details of the new guideline developed and promulgated by Austin Health. A copy of the guideline titled "Extreme Weather: Alert and Response" was provided to the Court.

14. The document contains a section titled Communication Strategy a process to ensure dissemination of the guideline to all staff. I annex it to this finding.

15. I include in this finding an additional comment made by Associate Professor Newton as to important refinements to practices and procedures adopted to ensure more effective management of mental health patients during heatwave conditions. He advised:

"All relevant directorates within the MHCSU at Austin Health have confirmed that registers of those clients identified to be vulnerable to extremes in temperature are in place. The guideline is structured to include responsibilities at all levels throughout the MHCSU".

16. I received a letter dated 28 July 2014 from Ms Linda Baron, sister of Ms Baron, in which she levelled strident criticism of those organisations responsible for the care, treatment and management of her sister and Mr Dokos. Her position is encapsulated in the following short excerpt from her letter of concerns where Ms Linda Baron stated:

"...these unexpected deaths were a culmination of the negligence and lack of support the mentally ill suffer". (my emphasis)

17. In light of the reference to negligence I think it incumbent on me to say something about the role of the coroner. For a variety of reasons, there is a broad misunderstanding in the general community about our role. Often parties are left with an unfulfilled expectation because those adversely affected by an act or omission alleged to have occurred look to the coroner to directly lay or apportion blame/fault. Often the implied attribution of fault is lost on the lay party who expected more direct, strident denouncement of the party against whom an adverse finding is made.

18. Keown v Kahn[1] a decision of the Victorian Court of Appeal represents a landmark judgement which, in my opinion, provided much needed guidance to Victorian (and other) coroners. His Honour Mr Justice Callaway adopting a statement contained in the report of the Brodrick Committee (UK) Report[2] said:

"In future the function of an inquest should be simply to seek out and record as many of the facts concerning the death as public interest required, without deducing from those facts any determination or blame."[3]

19. Again quoting the Brodrick Committee (UK) Report, His Honour noted:

"In many cases, perhaps the majority, the facts themselves will demonstrate quite clearly whether anyone bears any responsibility for the death; there is a difference between a form of proceeding which affords to others the opportunity to judge an issue and one which appears to judge the issue itself."[4]

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[1] (1999) 1 VR 69
[2] Report of the Committee on Death Certification And Coroners (1971) (UK) ("The Brodrick Report" Cmnd. 4810)
[3] (1999) 1 VR 69, 75
[4] (1999) 1 VR 69, 75

20. So while not laying or apportioning blame a Coroner should endeavour to establish the CAUSE, or CAUSES, of a death; the distinction is fine but real. As Callaway J.A. described it in Keown v Kahn:

> *"In determining whether an act or omission is a cause or merely one of the background circumstances, that is to say a non-causal condition, it will sometimes be necessary to consider whether the act departed from a norm or standard or the omission was in breach of a recognised duty, but that is the only sense in which para. (e) mandates an inquiry into culpability. Adopting the principal recommendation of the Norris Report, Parliament expressly prohibited any statement that a person is or may be guilty of an offence. The reasons for that prohibition apply, with even greater force, to a finding of moral responsibility or some other form of blame: the proceeding is inquisitorial; the conclusion would be more indeterminate than a conclusion about legal responsibility; and there would be no prospect of a trial at which the person blamed might ultimately be vindicated by an acquittal."*[5]

21. I have found the dichotomy between finding cause of death on one hand and finding or apportioning fault, blame or culpability on the other, difficult to articulate. Quite recently, in a judgement of the New Zealand Court of Appeal I saw as good an explanation of the conundrum as I have seen. In the Coroners Court v Susan Newton & Fairfax New Zealand Ltd [6] (a judgement delivered 30th November 2005) reference is made to Laws of New Zealand, Coroner's. At paragraph 28 under the heading of "blame", the following statement appears:

> *"It is no part of the coroner's function to apportion blame for the death. The coroner must however be able to go beyond the mere cause of death if the coroner is to serve a useful social function, and must establish so far as is possible, the circumstances of the death. The implicit attribution of blame may be unavoidable in order for the coroner to ascertain or explain how the death occurred in the wider events that were the real cause."*[7](my emphasis)

22. In his judgement in Keown v Kahn, Callaway J.A. referred to the Norris Report upon which the 1985 Coroners Act was largely founded and observed.

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[5] (1999) 1 VR 69, 76
[6] [2006] NZAR 312
[7] [2006] NZAR 312, 320

"A coroner is not concerned with questions of law of that kind. Instead the coroner is to find the facts from which others may, if necessary, draw legal conclusions."[8]

23. Consequently, no matter what findings I make, I will not be determining whether management was negligent per se. Having said that I will consider whether care/management departed from a norm or standard, or there was some omission in relation to treatment in breach of a recognised duty that represents a causal factor in the death.

24. In her letter of concerns, Ms Linda Baron suggests Ms Baron and Mr Dokos "were possibly poisoned by their anti-psychotic Clozapine medication." I have satisfied myself that the prescribing of Clozapine to Ms Baron and Mr Dokos was within clinical guidelines. Toxicological analysis of a post-mortem blood sample does not support the claim that Ms Baron and Mr Dokos were "poisoned" by Clozapine.

25. I am further satisfied that the monitoring of both Ms Baron and Mr Dokos was within the strict requirements of the Highly Specialised Drugs Program and complied with the Austin Health Clozapine Treatment and Shared Care Program.

26. Ms Linda Baron maintains that the provision of service to Ms Baron and Mr Dokos was fragmented with a "disconnect" between their general practitioner and NEAHMS. While various aspects of care and treatment were undertaken by different entities, I do not accept there was a "disconnect". The Clozapine Treatment and Shared Care Program Procedure details the roles and responsibilities of various clinicians within the program. Associate Professor Newton describes it as a "partnership model".

27. In his letter/statement of 29 July 2014 Associate Professor Newton refers to some of the reviews/consultations that occurred as part of the management of Mr Dokos under the NEAMHS Clozapine Shared Care Program. In October Mr Dokos was reviewed by his consultant psychiatrist, he was noted to present with blunted affect but was not depressed or experiencing psychotic symptoms. While Ms Linda Baron describes the shared responsibilities as "a disconnect" I am not persuaded that is correct. The program, as its title suggests, involves the input of various clinicians, presumably with a sharing of information.

28. It is clear from the medical records that there was a reasonable level of communication between the entities providing service to the couple.

29. In her letter to the Court, Ms Linda Baron raises the issues of:

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[8] (1999) 1 VR 69, 75

- The housing of mental health patients;
- The lack of information flowing to family

The first of those matters is, as Ms Baron concedes, beyond the scope of the Coroner's Court.

30. As to the second matter, over a decade ago, I made some observations about family involvement in the management of mental health patients. I said:

> *"For some time there has been a concern that professionals responsible for the care and treatment of psychiatric patients do not pay due heed to the expressed concerns of family members and other carers who, due to their closeness and contact with the patient, are able to observe even subtle changes, let alone significant deterioration in condition. This concern was taken up and addressed in "New Directions for Victoria's Mental Health Services – the Next Five Years" published in September 2002. One of the six "Key Directions" was strengthening support to carers and improving carer involvement. The circumstances of this death demonstrate the wisdom of such strategy. Having said that there are quite complex issues which are often difficult to accommodate."*[9]

31. It would appear issues of privacy and confidentiality hindered the adoption of such a position; finding the appropriate balance has been somewhat elusive. However, the "new" Mental Health Act 2014 has, in some instances, provided family with more involvement.

32. In a Ministerial Foreword to a document titled A New Mental Health Act for Victoria under the heading of Recovery Framework it was proposed that the new Mental Health Act will:

> *"Recognise the importance value and challenges of the role undertaken by carers and families and encourage greater opportunities for partnership for partnership between carers, consumers and clinicians".*

For completeness I annex the Carers and families section of the Mental Health Act 2014 handbook.

33. I turn to address what I see as the principal issue; the adequacy, or otherwise, of the support/monitoring/checking (call it what you may) of the couple by NEAMHS during the week leading to their deaths. I have carefully examined the Austin Health Extreme Weather Guideline. The purposes of the guideline are set out. They are designed to "reduce risks and enhance safety to consumers" in the event of extreme weather conditions; they include:

[9] Kevin Thomas Hassard (dec'd) 591/02

- Consumers assessed as high risk of vulnerability to extreme weather events are identified prior to the event;
- Staff are aware of the effects that extreme weather, in particular heatwave conditions, can have on consumers;
- Staff take action to proactively provide information to consumers and their family/carers;
- There are escalation processes in place once days are declared either 'Code Red' or 'Extreme' by the Bureau of Meteorology (BoM) in consultation with the Country Fire Association (CFA) and Department of Health (DoH) has issued a heat health alert;
- Visiting services are delivered in a safe manner and where this is not possible alternative supports are actioned.

What follows are what I consider reasonable measures to achieve the core purpose, to ensure, as best one can, the safety of patients/clients (I don't particularly like the expression consumers). I note that at dot point 3 of the purposes it is stated that there is an expectation that NEAMHS personnel are to take proactive action with escalation processes in place at times of extreme heat. The guidelines propose registered clients be contacted preferably by their case manager, to "establish their wellbeing and discuss necessary support arrangements". In her suggested recommendations Ms Linda Baron proposes daily visits by clinic personnel or alternatively daily phone calls to a family representative. It seems to me that in the case of individuals like Ms Baron and Mr Dokos face to face contact would seem to be preferable and furthermore, family representative phone contact would not be unduly onerous.

34. Ms Linda Baron raises the issue of the Health Department, at public expense, providing people with chronic diseases air conditioners and paying the power costs. It is not an issue I propose to address in detail, save to say that all government departments have budgetary constraints and in any event, it would appear an offer by Mr Dokos' family to provide an air conditioner for the couple was not taken up.

CONCLUSION:

35. An examination of the relevant medical records; including those from Banyule Community Health, demonstrate that there was no contact with the couple, direct face to face or otherwise,

by their case manager or anybody else from the treating teams during the relevant times. As stated earlier, at that time NEAMHS did not have a heatwave plan in place.

36. I have no evidence that Ms Baron and Mr Dokos were alerted to the danger the unprecedented weather conditions posed for them. As to the adequacy of the dissemination of the relevant information in the Heatwave Plan for Victoria, it is noteworthy that Ms Linda Baron, who saw her sister on the evening of the previous Thursday 16 January 2014, was apparently unaware of the dangers the weather posed to individuals in the circumstances of her sister and Mr Dokos. I do accept however that getting the message through is problematic. As Ms Baron and Mr Dokos squarely fitted into several at risk categories:

    - People with mental illness.
    - People on Clozapine.
    - People who are overweight or obese.
    - People who are socially isolated.

    Their management leading to and during the heatwave was sub-optimal. Ms Baron and Mr Dokos should have been clearly advised about the dangers and closely monitored during that period.

COMMENTS

Pursuant to section 67(3) of the **Coroners Act 2008**, I make the following comment(s) connected with the death:

1. At the conclusion of her letter of concerns, Ms Linda Baron suggested a number of recommendations I should make to the Department of Health and Human Services. I have given her suggestions earnest consideration.

2. I have formed the view that the Heatwave Plan for Victoria, while conveying important information to the public, is population based and therefore somewhat generic. It does identify at risk groups, including people with mental illness, together with others likely to be vulnerable to extreme heat such as the young, the infirm and the elderly. I had considered recommending a specific plan for the mentally ill be developed and disseminated by the Chief Psychiatrist. Upon further consideration I believe I can achieve the same outcome for that particular at risk group by recommending the Chief Psychiatrist issue a directive, founded upon the general Health Department plan, to all public mental health services requiring them to develop a suitable plan

of strategy similar to that developed by Austin Health which I view as an appropriately comprehensive template.

RECOMMENDATIONS

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

1. The Chief Psychiatrist issue a directive requiring all public mental health services to develop and introduce an appropriate guideline that identifies, among other things, the clinical responsibilities for case managed and at-risk clients at times of extreme weather conditions.

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

Ms Francis Dokos
Dr Mark Oakley Browne, Chief Psychiatrist
Ms Lynette Russell, Austin Health
Detective Senior Constable Matthew Klova, Homicide Squad.

Signature:

PHILLIP BYRNE
CORONER
Date: **18 March 2015**

Coroners Court of Victoria