IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2016 000180

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	Peter Charles White, Coroner
Deceased:	XY
Date of birth:	20 December 1957
Date of death:	On or about 12 January 2016
Cause of death:	Combined drug toxicity (eucalyptus oil, alcohol, venlafaxine, quetiapine, propranol, diazepam)
Place of death:	Ivanhoe

I, PETER CHARLES WHITE, Coroner,
having investigated the death of XY
without holding an inquest:
find that the identity of the deceased was XY
born on 20 December 1957
and that the death occurred on or about 12 January 2016
at 42 Upper Heidelberg Road, Ivanhoe, Victoria 3079
from:

I (a) COMBINED DRUG TOXICITY (EUCALYPTUS OIL, ALCOHOL, VENLAFAXINE, QUETIAPINE, PROPRANOLOL, DIAZEPAM)

Pursuant to section 67(1) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances**:

1. XY was a 58-year old disability support pensioner who lived at Airlie supported residential service [SRS]. He had a medical history that included chronic headaches, high cholesterol and hypertension, osteoarthritis and chronic gastric ulcers. XY is survived by his sister, CD .

2. According to his sister, XY was always a 'quiet person' but changed, becoming moody and isolative, following the deaths of his mother and father in 1998 and 2000 respectively.[1] He developed psychiatric symptoms and was admitted for treatment as an inpatient on about eight occasions between 2008 and June 2015 with diagnoses of major depression and anxiety and, after 2015, borderline and dependent personality disorders. XY's mental ill-health was characterised by chronic suicidal ideation, multiple suicide attempts (by overdose of prescribed medication and other substances, hanging, causing incised injuries) and incidents of self-harm, including by starvation.

3. XY's physical and mental health was monitored by his general practitioner, Dr Carol Chaivachirasak of the Livingstone Street Clinic. She liaised with the staff at Airlie and mental health professionals including psychologist Wes Johnson, Austin Health and the Crisis Assessment Treatment Team [CATT], North East Area Mental Health and North East Continuing Care Service to co-ordinate XY's mental health treatment.[2] Interventions included mental health case management, monthly review by a psychiatrist, psychological counselling and the trial of a number of antidepressant and mood stabilising medications, including the supervision of medication administration at Airlie to minimise the risk of their misuse (a measure which angered XY).[3]

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[1] Coronial brief of evidence, Statement of CD
[2] Coronial brief of evidence, Statement of Dr Chaivachirasak.
[3] Ibid and Coronial brief of evidence, Statement of Dr Richard Newton.

4. On Friday, 8 January 2016, XY presented to the emergency department [ED] of the Austin Hospital with ongoing suicidal ideation having been found by Airlie staff intoxicated after taking an overdose of alcohol and eucalyptus oil.[4] He was admitted overnight for monitoring but had refused psychiatric admission and referral to CAT. Nonetheless, upon discharge home around 1.30pm the following day, XY had been referred to North East CAT [NECAT] for ongoing assessment and follow-up.

5. On Saturday 9 January 2016, two NECAT clinicians visited XY at home and discussed his progress with an Airlie staff member. XY refused to engage with the clinicians.

6. On 10 January 2016, a NECAT clinician contacted Airlie and obtained an update of XY's progress from a staff member. Later that day, two NECAT clinicians attended Airlie but XY refused to engage with them and so they obtained an update from Airlie staff. XY had reportedly refused food and medication since his discharge from hospital, was 'miserable' and isolated himself in his room.[5]

7. On 11 January 2016, having learned of XY's demeanour and behaviour since discharge from hospital while she was on leave, Airlie Manager Gretta Storer spent most of the day with him in an effort to improve his mood. She also spoke with a NECAT clinician who called to enquire whether it was 'worth coming' to see XY .[6] XY had told Ms Storer that NECAT made him angry and did not want to see clinicians.[7]

8. By the afternoon, though still of flat affect, XY was engaging in conversation with Ms Storer and had agreed to take his medication and have some food. After lunch he dressed and went outside to work in the garden and complete other chores. Upon returning indoors, XY retreated to his room and said he would eat dinner there.[8]

9. Ms Storer took some dinner to XY in his room around 5.30pm. She found him restless and agitated and so called his GP who advised that quetiapine be administered PRN[9] to settle the agitation, which she did with good effect.[10]

10. Ms Storer checked on XY a short time later and found him once again agitated. He went for a short walk in the garden and returned to his room and asked for a coffee. Ms Storer brought him a coffee. XY telling her that he never wanted to see CAT again. He also

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[4] Coronial brief of evidence, Statements of Gretta Storer and Dr Bethany Whitehouse.
[5] Coronial brief of evidence, Statement of Gretta Storer.
[6] Ibid.
[7] Ibid.
[8] Ibid.
[9] As needed.
[10] Coronial brief of evidence, Statement of Gretta Storer.

surrendered to her a kitchen knife with which he had planned to hurt himself. Ms Storer left XY in his room around 7pm.[11]

11. At about 10pm, Airlie staff member Carolena Fonseca went to XY's room to give him a cup of coffee but he was not there. She looked for him in the facility and on its grounds but was unable to find him and so reported his absence to Ms Storer. Ms Storer contacted NECAT at 10.30pm, informed CD at 11pm and reported XY to police as a missing person a little before midnight on 12 January 2016.[12]

12. At about 7.30am on 12 January 2016, Chris Quinlan parked his car behind 42 Upper Heidelberg Road, Ivanhoe, to attend an appointment. Upon alighting from his vehicle, he noticed a male lying face down and unresponsive near the stairwell. The emergency services were called and attending paramedics finding the man, later identified as XY ,[13] with no obvious injuries and no signs of life and declared him deceased.

Coronial Investigation

13. A coronial investigation was initiated and one of the attending police, First Constable Danny Vakulcyzk of Heidelberg Police, later compiled the brief of evidence on which this finding is largely based. A search of the scene located an empty bottle of alcohol and another bottle that had contained eucalyptus oil. A search of XY's room at Airlie, about 120 metres from where his body had been found, revealed two hand-written notes signed 'Tony', one apparently written on 8 January and the other on 11 January 2016.[14]

14. Forensic pathologist, Dr Heinrich Bouwer of the Victorian Institute of Forensic Medicine, reviewed the circumstances of the death as reported by police to the coroner, post-mortem computer assisted tomography [PMCT] scans of the whole body and performed an autopsy. Among Dr Bouwer's anatomical findings were a strong smell of eucalyptus, stomach contents in the trachea and bronchi and moderate single vessel coronary artery atherosclerosis.

15. Routine post-mortem toxicology detected alcohol (0.07g/100mL), cineole (eucalyptol), the beta-blocker propranolol, paracetamol, quetiapine, and venlafaxine and diazepam and their metabolites. It was noted that ingestion of eucalyptus oil affects the central nervous system which may cause loss of consciousness, hypoventilation, depression of reflexes and convulsions. Eucalyptus oil mat further potentiate the central nervous system depression effects of alcohol, venlafaxine, quetiapine and diazepam.

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[11] Coronial brief of evidence, Statement of Gretta Storer.
[12] Ibid.
[13] XY had no identification documents in his possession when located deceased. He was presumptively identified on the basis of a physical description provided by police to staff at Airlie and later formally identified by Gretta Storer.
[14] Coronial brief of evidence, Statements of Sergeant Morris, Constable Hills and Exhibits 43 and 44.

16. Dr Bouwer attributed XY's death to combined drug toxicity (eucalyptus oil, alcohol, venlafaxine, quetiapine, propranolol, diazepam).

17. At my request, the Mental Health Investigator of the Coroners Prevention Unit [CPU][15] reviewed the available materials, including the coronial brief and XY's mental health records, and provided advice about the adequacy of his clinical management by NECAT proximate to his death. The CPU advised as follows:

    a. XY's initial assessment by the Emergency Psychiatric Services [EPS] at the ED on 8-9 January 2016 as low to moderate risk did not take into account his previous presentation, proximate suicide attempts or the Relapse Prevention and Action Plan [RPAP] available in his scanned medical records. The RPAP listed early indicators of deterioration of XY's mental health which were consistent with his presentation. Instead, his symptoms, including increased irritation, were considered to be a function of a reported recent disagreement with his sister.

    b. The decision to discharge XY to Airlie from the ED with follow-up by NECAT in spite of his stated refusal to see CAT clinicians failed to anticipate his continued refusal. That XY would refuse to engage does not appear to have been considered as an added risk nor does it seem that alternative management strategies, such as an involuntary admission or development of a discharge plan to which XY had contributed and agreed, were canvassed.

    c. Neither EPS nor NECAT contacted the Continuing Care Service or XY's Case Manager with which he was engaged between 8 and 11 January 2016.

    d. NECAT did not change the plan of care in response to issues that indicated XY was at increased risk, such as his refusal to eat, refusal of medications, self-isolation and refusal to be assessed by clinicians.

    e. NECAT failed to escalate to psychiatrist review at any point during the three day period it was to monitor XY's mental health.

    f. NECAT clinical review did not occur until 11 January 2016 and it remains unclear if this was a multidisciplinary meeting and whether the decision to liaise with the

[15] The Mental Health Investigator is one of the two clinical divisions of the Coroners Prevention Unit [CPU] established in 2008 to strengthen the prevention role of the Coroner. CPU assists the Coroner to formulate prevention recommendations and comments, and monitors and evaluates their effectiveness once published. The clinical branches of CPU are staffed by practising physicians and nurses who are independent of the health professionals or institutions involved. They assist the Coroner's investigation of deaths occurring in a healthcare setting by evaluating the clinical management and care provided and identifying areas of improvement so that similar deaths may be avoided in the future.

Community Correction Service (which was supervising XY) was actioned or the timeframe in which this was anticipated to occur.

g. The above-mentioned issues were identified during Austin Health's internal review following XY's death. The review recommended a number of improvements be made to clinical handover,[16] staff training in risk assessments and management planning,[17] care pathways[18] and access to an individual's clinical information.[19] As of the date of the statement provided by Dr Richard Newton, Medical Director of the Mental Health Clinical Service, all of the recommendations had been implemented or implementation commenced by March 2016.[20]

h. An additional statement obtained from Dr Lanny Bochsler, Clinical Director of the Adult Mental Health Service in January 2017, asserted that following XY's discharge from the ED he was actively followed-up by NECAT despite his reluctance to engage. Follow-up consisted of daily contact between NECAT and Airlie staff about XY's progress and following the last contact on 11 January 2016, there was a plan to make a further phone call the following day and that Ms Storer was to contact NECAT if there was 'any change'.[21]

i. It was conceded by Dr Bochsler that XY's medical records did not indicate that there had been a discussion between NECAT and Airlie about specific signs, behaviours or situations that should result in escalation to NECAT.

j. The Department of Health and Human Services [DHHS] maintains a register of all SRS facilities and monitors compliance with the regulatory regime established by the Supported Residential Services (Private Proprietors) Act 2010 and Regulations. Among the various regulatory requirements, the DHHS expects appropriate levels of ancillary staff[22] and that a Personal Support Co-ordinator [PCS] with a certificate III or higher qualification works not less than 3.2 hours each day. PSCs must engage in 40 hours of training every three years (13 hours per annum) with specific training options such as 'Residents and Mental Health' funded directly by the DHHS. Training requirements do not provide SRS staff with specialist assessment skills with which to assess risk of suicide and SRSs are not clinical settings.

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[16] Recommendation 1 articulated in Dr Newton's statement.
[17] Recommendation 2 and 4.
[18] Recommendations 3 and 7.
[19] Recommendations 5 and 6.
[20] Coronial brief of evidence, Statement of Dr Newton.
[21] Statement of Dr Lanny Bochsler dated 10 January 2017.
[22] Such as minimum staff to resident ratios of 1:30 or fraction of 30 residents.

k. The DHHS has developed several guides for mental health services and SRSs.[23] All of these documents focus on decision-making and support planning for a prospective and/or new resident in a SRS who has a mental illness and current engagement with a public mental health service or community-based mental health support service. Information provided for mental health services includes information about the narrow skill set, training and other duties undertaken by SRS staff.

18. The CPU concluded that although changes to training and procedures implemented by Austin Health following its internal review should improve the quality of care provided in future, it did not address the expectations of SRS staff who are looking after a resident with overt and acknowledged deteriorated mental state. In short, NECAT effectively and inappropriately left its responsibility to assess XY's ongoing risks to Airlie staff without any appreciation of the role and level of expertise among SRS staff.

19. I find that XY late of Upper Heidelberg Road, Ivanhoe, died on or about 12 January 2016 outside 42 Upper Heidelberg Road, Ivanhoe and that the cause of his death was combined drug toxicity involving eucalyptus oil, alcohol, venlafaxine, quetiapine, propranolol and diazepam. I am satisfied that XY intended to take his own life.

20. The weight of the available evidence enables me to conclude that Austin Health, and particularly the Austin Hospital's EPS and NECAT's management of XY between 8 and 11 January 2016, was suboptimal and may have contributed to his death.

21. I acknowledge and endorse the changes top practices implemented by Austin Health after XY's death and consider that they are likely to address some, though not all, of the issues identified in the coronial investigation.

RECOMMENDATION

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

1. That the Department of Health and Human Services, in conjunction with Supported Residential Services, Mental Health Services, Mental Health Community Support Services and Consumer Representation, develop a guide that improves the safety of SRS residents with an acute deterioration in mental state with associated acute risks who are engaged with

[23] For instance, the Guide for Clinical Mental Health Services and Mental Health Community Support Services, Guide for Proprietors and Managers of Supported Residential Services and Guidelines and a flow chart relevant to the referral of consumers to SRSs.

acute or continuing care teams, rehabilitation-recovery focused or other community mental health services. The guide should address the following, namely:

a. SRS staff are provided with a current safety plan for the resident during a period of deterioration;

b. SRS residents are, wherever possible, engaged in the development of the safety plan developed for a particular episode of deterioration;

c. Refusal by a SRS resident to engage in the development of a safety plan does not preclude the engaged metal health service from completing a safety plan for a specific episode of deterioration with a view to engaging with the resident when s/he is willing;

d. The elements to be included in a safety plan, including clear details and advice for SRS staff about when and whom to contact in particular circumstances;

e. The response the SRS may reasonably expect from the engaged mental health service(s);

f. Reflect the staffing levels and limits of SRS staff skills; and

g. Include a requirement that at the resolution of an acute deterioration of mental state and cessation of any associated acute risks (as assessed by the engaged mental health service), that the SRS resident and the SRS staff are informed that the safety plan is no longer current.

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

CD

Austin Health

Airlie SRS

Department of Human Services

Office of the Chief Psychiatrist

Coroners Court of Victoria

Signature:

PETER CHARLES WHITE
CORONER
Date: 28/3/2018