IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: 2012/21

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
Section 67 of the ***Coroners Act 2008***

Inquest into the Death of: Justin Peter Foster

Delivered On:	17 November 2014
Delivered At:	Coroners Court of Victoria
	65 Kavanagh Street, Southbank, Victoria, 3006
Hearing Dates:	15 August 2014, 17 November 2014
Findings of:	Caitlin English
Representation:	
Police Coronial Support Unit	Leading Senior Constable Stuart Hastings

I, CAITLIN ENGLISH, Coroner having investigated the death of Justin Peter Foster

AND having held an inquest in relation to this death on 17 November 2014
At MELBOURNE
find that the identity of the deceased was Justin Peter Foster
born on 7 February 1971
and the death occurred on 3 January 2012
at Upton House, Box Hill
from:

1 (a) UNASCERTAINED

in the following circumstances:

1. Justin Foster was 40 years of age when he died. He resided at 18 Lightfoot Street, Mont Albert with his parents and his partner Blanche Persich. Mr Foster volunteered as a teacher's aide at the Heatherwood School in Donvale.
2. At the time of Mr Foster's death he was an involuntary patient at Upton House, Box Hill subject to an involuntary treatment order.
3. Due to Mr Foster's 'in care status', his death is a reportable death to the Coroner (s 11 Coroners Act 2008). Further, his 'in care' status mandates a Coroner to hold an inquest into his death (s 52(2)(b)).
4. Mr Foster had a history of bipolar affective disorder, chronic back pain and substance abuse.

Events prior to death

5. A police investigation was conducted into the circumstances of Mr Foster's death.
6. Mr Foster had a history of psychiatric inpatient admissions in 2007, 2008 and 2011.
7. In the latter part of 2011, Mr Foster developed a sore lower back. He was initially prescribed pain medication and physiotherapy and later his general practitioner suggested an MRI. Following an altercation with medical staff at Box Hill Hospital in December 2011, Mr Foster was given an MRI which revealed a prolapsed disc and associated sciatica.
8. On 20 December 2011, Mr Foster was referred to Central East Crisis and Assessment Team (CATT) by Eastern Health Psychiatric Triage. Mr Foster had self presented over concerns he was displaying the early signs of a manic re-lapse of his pre-existing bipolar affective

disorder. Mr Foster was reviewed by Dr Justin Kingsman Foster (no relation) on 20, 23 and 29 December 2011.

9. According to Dr Foster, Mr Foster:

> *"described a two week deterioration in his mental state characterised by poor sleep, driven and disorganised behaviour, irritability in his interactions with his family, grandiose thinking and an increase in spending, all symptoms characterising the early stages of a manic episode. This relapse of his pre-existing bipolar affective disorder appeared to have occurred in the context of an 18 month period of non-compliance with his mood stabilising medications, smoking both cannabis and synthetic cannabis in the recent period and a recurrence of a pre-existing back injury requiring the use of prescribed medications including prednisolone (10mg daily), diazepam (around 15 mg daily) and oxycodone (approximately 20 mg daily)."*[1]

10. Mr Foster was willing to engage in treatment with Central East CATT. According to Dr Foster his:

> *"management included ceasing his prednisolone recently prescribed for his back injury, which I felt may contribute to a deterioration in his mental sate; and the commencement of the antipsychotic quetiapine, to prevent further deterioration, promote restitution of a euthymic mental state and to ultimately act as a mood stabiliser...I commenced tamazepan in order to attempt to regulate his sleeping patterns."*[2]

11. Between 20 December and 30 December 2011, Mr Foster "was reviewed, or there was contact with the family at least once a day by a member of the Central East CATT."[3]

12. On 28 December 2011, Mr Foster was evicted from Eastern Health Linwood Prevention and Recovery Centre where he had been for a short period of respite. Dr Foster stated that this was due to *"escalating behavioural disturbance, in which Justin... refused to respond to limit setting around medication management of his back pain."*[4]

---

[1] Coronial Brief, Page 7.

[2] Ibid.

[3] Ibid.

[4] Ibid, Page 8.

13. At this consultation, Dr Foster also spoke privately with Mr Foster's mother and partner both of whom disclosed Mr Foster had been smoking synthetic cannabis and had had one episode of non-compliance with medication.

14. On 30 December 2011, Mr Foster's care was transferred from Central East CATT to Upton House psychiatric inpatient unit following deterioration in his mental state.

15. Dr Foster stated that Mr Foster's mother contacted *"Central East CATT with concerns about Justin's ... mental state, in that he was becoming increasingly demanding and verbally aggressive. The family felt they were now 'burnt out' and could not continue to manage him at home. Central East CATT clinicians attended his home and whilst he agreed to be transferred to the Box Hill Hospital Emergency Department for an inpatient admission, the recommendation was that he be admitted under the involuntary provisions of the Mental Health Act due to his fluctuating mental state and associated risks."*[5]

16. On 2 January 2012, at Upton House, an adult mental health inpatient service, Mr Foster was reviewed by psychiatric registrar Dr Laura Gavson. Dr Gavson noted that Mr Foster had no overt psychotic symptoms however continued to be elevated and his thought was disordered and grandiose.[6]

17. Dr Gavson noted, *"he had a working diagnosis of Bipolar Affective Disorder (BPAD), presenting with a manic relapse in the context of THC use and non-compliance with prescribed psychiatric medication for over a year. I also noted that his medical history included lower back pain that had been investigated and assessed as being due to a prolapsed disc with associated sciatica. Over the course of his admission (on 30/12/11), I noted that two separate psychiatrists had reviewed him, on two consecutive days (31/12/11 and 01/01/12). His involuntary status under the Mental Health Act had been upheld post admission."*[7]

18. Mr Foster provided background to Dr Gavson regarding events leading up to his admission including *"non compliance with prescribed medication for several months, and heavy regular illicit drug use in the form of 'synthetic dope' – reportedly smoking 1g/day over the*

[5] Coronial Brief, Page 8.

[6] Ibid, Page 9.

[7] Statement of Dr Laura Gavson, Page 1.

preceding six weeks. In addition he reported having used oral amphetamines – most recent of which being 'a few weeks ago'."[8]

19. Dr Gavson noted a plan for Mr Foster to remain in the High Dependency Unit (HDU) where the minimum frequency of patient observations is 15 minutes.

20. According to Dr Gavson, Mr Foster was *"unhappy about being an involuntary patient under the Mental Health Act, and requested to be transferred out of the HDU to the main area of the ward"*[9] however nursing staff felt that Mr Foster was too unsettled to have a trial in the Low Dependency Unit.

21. In the afternoon on 2 January 2012, Mr Foster's family visited him in the HDU.

22. Dr Gavson noted that afternoon, Mr Foster was *"more irritable in his affect and preoccupied with pain in his lower back...[h]e reported to me that he felt 'depressed and suicidal' and wanted an anti-depressant to be prescribed."*[10]

23. These suicidal thoughts were confirmed in a letter dated 2 January 2012 to Dr Gavson requesting to be moved to the Low Dependency Unit and an earlier appeal to the Mental Health Review Board dated 1 January 2012 in which Mr Foster stated, *"[w]hen I was in seclusion I started planning how I could suicide".*[11]

24. Dr Gavson states that she *"explained to him that he was showing signs of mania and that accordingly, any anti-depressant would be contra-indicated... [and] reassured him that he was in the best place, i.e. in HDU, if he was feeling suicidal, and that nursing staff would be able to keep a close eye on him."*[12]

25. Mark Fitzpatrick was involved in the care of Mr Foster on 2 January 2012 as he was the allocated High Dependency Unit nurse for that evening. He notes that Mr Foster, due to his agitation the previous night, had had to be secluded.

26. Box Hill Hospital records indicate Mr Foster was secluded on 30 December 2011 at 10.45pm to 31 December 2011 at 2.45am. Records indicate Mr Foster was again secluded

---

[8] Statement of Dr Laura Gavson, Page 2.

[9] Ibid.

[10] Ibid, Page 3.

[11] Appeal to the Mental Health Review Board, Justin Peter Foster, 1 January 2012.

[12] Statement of Dr Laura Gavson, Page 3.

on 1 January 2012 from 6.10am to 7.45am due to being hostile, verbally abusive and threatening"[13]

27. Mr Fitzpatrick noted Mr Foster entered his bedroom at 11.40pm and was asleep by midnight.

28. Mr Fitzpatrick stated he observed Mr Foster regularly until 3.00am when he went on his break. He resumed at 4.15 am when he returned.

29. At 5.35am on 3 January 2012, he checked on Mr Foster and could not clearly hear him breathing. Mr Fitzpatrick stated that *"he was laying on his right side with his head at the edge of the pillow. He was not responsive, and not breathing, his skin felt tepid and clammy."*[14] Mr Fitzgerald felt for a pulse and checked there was no obvious airway obstruction. He commenced chest compressions and called a 'code blue.' The 'code blue' team from Box Hill Hospital attended.

30. Resuscitation attempts failed and Mr Foster was declared deceased at 6.19am.

31. There was no evidence to suggest Mr Foster had intended to end his own life.

Post Mortem Examination

32. A post mortem autopsy was performed by Dr Sarah Parsons at the Victorian Institute of Forensic Medicine on 5 January 2012. Dr Parsons formulated the cause of death. I accept her opinion. Dr Parsons noted that;

"Toxicological analysis on post mortem specimens has detected Diazepam, Temazepam, Oxazepam, Quetiapine, Codeine, Ibuporfen, Paracetamol at levels consistent with recent usage.

On discussion with family members it was revealed that the deceased's bother died in 2003 (Coroner's Case 1590/03.).

Given the fact that there are two siblings have died in bed at a young age a family referral in this case is important as there may be a genetic cardiac arrhythmic disorder.

Following a full autopsy and ancillary testing a cause of death has not been determined in this 40 year old male. Things that can cause sudden death and cannot be determined at

---

[13] Seclusion Clinical Observations, Justin Peter Foster, 1 January 2012.

[14] Coronial Brief, Page 12

autopsy include metabolic disturbances, seizure disorders and cardiac conduction system disorders."

33. Mr Foster's brother Nicholas Foster died aged 27 on 21 May 2003 from sudden unexpected death in epilepsy. Justin Foster had no medical history of epilepsy and it does not appear that the two deaths are linked in any way.

34. It is noted that Mr Foster disclosed heavy synthetic cannabis use in the months prior to his death. It is unknown when he had last consumed synthetic cannabis prior to his admission to Upton House but his family disclosed to Dr Foster on 29 December 2011 that he had used recently.

35. There is little research available as to the effects of synthetic cannabis. On 29 November 2013, the Chief Health Officer issued a synthetic cannabis safety warning:

> *"Any individual using illicit or synthetic drug products, including synthetic cannabis, is at serious risk of harm. These drugs are untested and unregulated and may therefore include a range of undisclosed chemicals that cause serious health and safety issues."*

36. The original toxicology report did not test for synthetic cannabis. Recent advances in toxicology testing can now detect the chemical make up of 50 different types of synthetic cannabis and there are over 400 types of synthetic cannabis.

Hearing - 15 August 2014

37. This matter was listed for a mandatory inquest on 15 August 2014. As the Victorian Institute of Forensic Medicine was able to re-test for synthetic cannabis, the hearing was adjourned for further toxicology tests to be conducted.

38. An amended toxicology report was prepared and the results of the additional testing has revealed the presence of 8 different synthetic cannabinoids. This finding was presented to Forensic Pathologist Dr Sarah Parsons. She maintains the view that the cause of death for Mr Foster should remain as 'unascertained.' Whilst she noted that there are a number of case reports in the literature that suggest synthetic cannabinoids can lead to cardiac arrhythmias, she was not of the view it could be said to be the cause with sufficient certainty in Mr Foster's case.

39. In her supplementary report dated 25 September 2014, Dr Sarah Parsons stated;

"The drugs detected are all Synthetic Cannabinoids. There are a number of case reports in the literature that suggest this class of drugs can lead to cardiac arrhythmia and sudden death.

However given the family history of sudden death in 2 siblings and the fact the deceased was schizophrenic and on a number of other medications I believe the cause of death in this case remains unascertained even taking into consideration the new toxicology findings.

Clinicians at the Royal Melbourne hospital have reviewed [Justin's] death and believe that his death was probably as a result of a number of drugs he was on for his mental state. They also noted that there is a higher than average incidence of sudden death in patients with schizophrenia.

As we learn more about synthetic cannabinoids we may attribute death to cases where these drugs are detected in the future. However taking in account the circumstances in this case and with the literature available at the present time I would not be comfortable attributing cause of death to these alone."

Issues raised at the hearing on 15 August 2014

40. Mr and Mrs Foster, together with Mr Justin Foster's partner, Ms Blanche Persich attended the court.

41. A number of issues were raised by them, which I have considered as follows. I have sought advice from the Coroners Prevention Unit of the Coroners Court, which employs independent specialist medical practitioners and nurses, including specialists in mental health.

42. One concern was that the nursing staff employed at Upton House during the Christmas/ New Year period were 'agency staff', which coincided with Mr Foster's admission. Whilst there was no specific incident of concern raised, I do note that regardless of whether nursing staff are from an agency or not, they all must be inducted and have appropriate mental health training to deliver care in an acute psychiatric setting.

43. Mrs Foster was concerned that after her son died, she went to collect his belongings, which she said were still in the interview room where he was first assessed on admission. From my inquiries, I understand that for safety reasons patients cannot have their own clothes in mental health inpatient facilities. However, the clothes should have been properly stored by Upton House. In addition, Mrs Foster noted that one of Mr Foster's favourite T-shirts was missing.

44. This is an issue that can be raised with management at Upton House. If concerns remain, a further option available is to contact the Health Services Commissioner.

45. Ms Persich raised an issue regarding the observations conducted on Mr Foster, particularly the statement of Mr Mark Fitzpatrick. He was taking 15-minute observations of Mr Foster and it is unclear if there was a gap in observations between 0500hours and 0535 when he discovered Mr Foster was not breathing.

46. I have had regard to the medical file and the record of observations conducted on Mr Foster by nursing staff. This shows that observations were taken of Mr Foster (in Room A) at 0500, and 0515 and a tick indicates he was asleep.

47. Mrs Foster raised her concerns about the extreme heat during the period Mr Foster was at Upton House. She was concerned whether he was eating and drinking sufficient fluids, particularly given the amount of medication he was taking. There are no records in the medical file of his eating and drinking habits. My inquiries reveal that if he was *not* eating or drinking, that would be recorded in his medical records.

48. Mrs Foster also noted that her son had been placed in seclusion whilst at Upton House and how much he hated that. She had asked staff not to place him in seclusion again. I note the two occasions when he was secluded have been appropriately noted in the medical records, and on both occasions, the medical practitioner and authorised psychiatrist were notified at the time.

49. Mr Foster was not secluded at the time of his death. I am not of the view the seclusion periods had a bearing on his death.

50. Mrs Foster was also concerned that Mr Foster's chronic back pain was overlooked and medical staff at Upton House were only treating his mental health. I have reviewed his medication regime at Upton House. He was prescribed and treated with pain medication of panadeine forte and ibuprofen, as well as diazapane, which is a muscle relaxant and acts as a calming medication. He was also treated with quetiapine, which a mood stabiliser and anti psychotic drug to treat his bi-polar disorder.

51. I am not of view that Mrs Foster's concerns regarding back pain are borne out, as there are repeated references in the medical records to Mr Foster's back pain and the medication regime he was on. The challenge in prescribing for someone in Mr Foster's situation who was in chronic pain, is to ensure pain relief treatment does not have the effect of aggravating or triggering his mania.

52. Finally, Mrs Foster noted the lack of privacy for visitors at Upton House. She described being unable to see Mr Foster on his own and had to see him in a communal area. She contrasted the difference with facilities at the Alfred Hospital. I am unable to comment on the built environment at Upton House but note the difference in the quality of facilities is a feature of the public health system.

Findings

I find that the cause of death in relation to Justin Foster is unable to be ascertained.

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

Mr & Mrs Foster

Ms Blanche Persich

Leading Senior Constable Travis Mulder

Clinical Director, Eastern Health Mental Health Services

Office of the Chief Psychiatrist

Signature:

CAITLIN ENGLISH
CORONER
Date: 17 November 2014