IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: 2008 / 5353

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)

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

Inquest into the Death of: Orce Petrusevski

Delivered On:	11th August 2015
Delivered At:	65 Kavanagh Street Southbank 3006
Hearing Dates:	12th 13th 19th and 20th of February 2014
Findings of:	PETER WHITE, CORONER
Representation:	Ms A McMahon on behalf of the family Ms N Hodgson with Ms S Van Dyk on behalf of Monash Health
Police Coronial Support Unit	Sergeant David Dimsey

I, PETER WHITE, Coroner having investigated the death of ORCE PETRUSEVSKI

AND having held an inquest in relation to this death on 12th 13th 19th and 20th of February 2014

at 222 Exhibition Street, Melbourne find that the identity of the deceased was Orce Petrusevski aged 35 years

and the death occurred between the 23 and 30 November 2008

at Dandenong Creek Kidd's Road Doveton

from: 1 (a) Unascertained, following autopsy.

In the following circumstances:

1. Orce Petrusevski (Jordon) was a 35-year-old man who resided with his wife Zaklina Petrusevski, (Zaklina), and infant son together with his parents at their home in Endeavour Hills, Melbourne. He had trained as a cabinetmaker but was not working at the time of his death.
2. From the evidence of family members, it is clear that Jordan had a long history of alcohol abuse and that he drank substantial quantities of alcohol on a daily basis. It is not clear what treatment he had received in the past for this problem. However, it appears that by 21 November 2008 he was trying to reduce or stop his alcohol intake altogether. There was no known history of psychiatric illness or criminality.
3. On this day a Friday, at approximately 2 am Jordan complained to Zaklina that he could hear voices telling him to play Macedonian music. Later in the day, he told her that the voices were now telling him to turn on the television and the computer. Over this time, Zaklina further observed that he was becoming frustrated, as he was unable to locate the faces of the people who he believed were speaking to him via the television and computer. Thereafter he contacted police telling them that unknown persons were speaking to him via satellite. He then threw the telephone into the back yard before going for a walk around the block, during which time he was talking to himself.
4. Jordan remained in an agitated state for the remainder of Friday and at approximately 10.30 pm his father contacted the Dandenong Hospital on-call service for assistance. During this call Jordan spoke to the nurse privately and later agreed with his father that they would attend Dandenong Hospital.

5. Jordan and his father arrived at the hospital at 11 pm. At around 1 am on Saturday 22 November, they returned home having decided that they did not want to wait the estimated four further hours, to see a doctor. On their arrival home both men went to bed.

6. Later at approximately 3.00 am on Saturday 22 November, Jordan woke his father and told him that there was something on his (Jordon's) neck. He further stated that he was hearing voices and was being watched. Thereafter Jordan and his father agreed that they should return to the Dandenong Hospital.

7. At 3.40 pm on 22 November 2008, Jordon arrived back at the hospital with his father. He was admitted to a short stay bed within the emergency department (ED), after which his father left the hospital.

8. Thereafter at 8.30 am, Jordan's parents returned to the ED and stayed with him until 10 pm that evening. Jordan's sister Tanya, also attended the hospital on 22 November.

9. At approximately 9 am on 23 November 2008. Jordan's parents returned to the hospital and were informed that Jordan had been discharged. (Attending medical staff incorrectly advised that Jordan had discharged himself at 4 am that morning. Jordan had in fact been discharged following a psychiatric review by an ECAT doctor, who mistakenly believed that Jordan had already been cleared for discharge by an ED doctor).

10. Jordan's family were also advised that Jordan had asked that they not be contacted and had advised staff that he would use a taxi to return home.

11. On 30 November 2008, at approximately 12 pm, Jordan's body was located in the Dandenong Creek on Kidd's Road, Doveton, at a distance of approximately 2 km from the entrance to Dandenong Hospital.[1]

Concessions by Monash Health [2]

12. On the first day of the hearing, Counsel for Monash Health made the following concessions in relation to the treatment of Jordan Petrusevski:

'*1. Emergency Department (ED) documentation was inadequate in that:*

a. the ED intern (Dr Amanda Thompson) did not document which senior clinician (Registrar) she consulted regarding Mr Petrusevski; and

[1] See Google map of area exhibit 14(e), attached to this finding as attachment 1.
[2] Monash Health was the corporate entity representing Dandenong Hospital and its employees, during the course of the inquest.

b. No registrar or consultant physician (if any) from the ED who saw Mr Petrusevski documented their attendance on him.

c. The discharging medical officer did not document her discussion with Mr Petrusevski regarding contacting his family, or his plans to catch a taxi home.

2. A senior clinician, preferably a consultant emergency physician from the ED should have seen Mr Petrusevski prior to discharge.

3. The psychiatry medical officer who saw Mr Petrusevski (Dr Jahan) should have discussed him with the senior psychiatrist, preferably a consultant psychiatrist, at some stage that day.

4. The psychiatry medical officer (Dr Kempoosit) who saw Mr Petrusevski prior to discharge should have discussed him with the on-call consultant psychiatrist before discharge occurred.

5. These concessions are made in respect of conduct, which was less than best practice. Evidence will be given by Professor Braitberg, that the identified deficiencies have been remedied by the systems now in place at Monash Health'.[3]

Issues identified for review during inquest.

a) Whether the care provide to Jordan was appropriate and reasonable.

b) Whether the case should have been escalated for the consideration of more senior clinicians.

c) Whether appropriate arrangements were made with family members concerning Jordan's discharge.

d) Whether the death of Jordan at an uncertain time following that discharge, occurred because of any failure of care.

Jordan's presentation at Dandenong Hospital in the early hours of Saturday 22 November, 2008.

Dr Amanda Thompson[4]

[3] The concession statement became exhibit 1. It also made reference to the submission that the actions described should not be viewed as satisfying a 'but for' cause in the death of Jordan.

[4] Dr Thompson MBBS, was a recent graduate and was employed as an intern in the Dandenong Hospital emergency department, at the time under consideration. She made her statement on 23 March 2011, not having become aware of Jordan's death until notified of same in early 2011, more than two years after that event.

13. Dr Thompson first saw Jordan at 4.30 am on the Saturday morning, 22 November 2008.[5] According to the admission form exhibit 2(a), his admission also took place at this time. She confirmed that a consultant or senior registrar supervised all of her work. Dr Thompson stated that the hospital had strict rules concerning interns and their management of patients.

> *'Even though I have not clearly documented this, Mr Petrusevski's presentation and my management plan would have been discussed with my senior colleague, in keeping with the Departments policy. I was and continue to be very strict in my practice of running every patient past a senior colleague'.*[6]

14. In her statement, Dr Thompson went on to explain that she relied upon her unnamed senior colleague in regard to her decision not to prescribe Thiamide, to Jordan.[7] She also explained that she did not clearly document the overall management plan, or whether admission was under a medical team, a psychiatric team or as outpatient care,

> *'as it was not yet clear to me what that plan would be'*[8].

15. Dr Thompson further stated that she was waiting on the pathology results when she completed her shift at 7 am and wanted a thorough medical and psychiatric workup before documenting a plan.

16. The handover process in the morning involved a ward round in which each patient was discussed and allocated to the doctor(s) beginning their shift. A handover by an intern can only occur to a more senior colleague, and not to another intern.

> *'This would have occurred at 7 am on Saturday 22 November 2008 at the conclusion of my shift. Unfortunately, I can not recall who I handed the care of Mr Petrusevski over to, and no other emergency clinician has written any further notes during the day of 23 November 2008'.*

Dr Thompson had been working in the Emergency Department Dandenong Hospital for three to four weeks at the relevant time and had spent two to three nights only on night shift, working 10 pm to 7 am on these occasions with the rest of her time spent on day shift.

[5] See transcript page 32.

[6] See exhibit 3 statement of Dr Thompson.

[7] Dr Thompson was unable to recall the name of the senior colleague concerned. It is also the case that no senior colleague recorded in the clinical notes of having advised Dr Thompson in respect of this matter, or having independently reviewed Jordan. I also note that while reference is made in Dr Thompsons notes to referring Jordan for Psychiatric review, no reference is made in her notes to her seeking a further medical opinion or review of the patient by a senior medical colleague. It is also the case that no explanation has been offered for the failure to place Jordan on a Thiamine programme in respect of his alcohol withdrawal, which Professor Nickolas Kek's later described as a serious therapeutic error. See exhibit 9 at page 6.

[8] Ibid.

17. Dr Thompson also offered that,

> *'for the remainder of (his) stay in the ED, he would have been under the care of at least two other more senior Emergency Department doctors'.*[9]

18. In cross-examination by counsel for Jordan's family, Dr Thompson agreed that a Dr M Buchanan's name appeared on the admission details document, exhibit 2(a) as the admitting doctor. She also agreed that a Dr S Ryan appeared as the treating doctor. She further explained that Dr Buchanan's name appeared on all such admissions, because she was the Head of the Emergency Department. Dr Thompson did not know who the abovementioned Dr S Ryan was, or of any connection, Dr Ryan may have had with Jordan.

19. Dr Thompson stated that she saw Jordan for the first time after triage, and that he had been triaged for assistance with alcohol withdrawal.

20. Dr Thompson confirmed that she had no experience in this area and that Jordan was in fact in acute alcohol withdrawal. When dealing with Jordan she again stated that she was relying on the advice of the admitting officer and the protocol on alcohol withdrawal although I note that her earlier evidence was that she was not sure if he had seen an admitting officer, at the time she saw him.[10]

21. Dr Thompson further confirmed that his symptoms on presentation were those of someone in an acute withdrawal phase and that he was shaking, *'and anxious ++'*.

22. She also confirmed that he claimed to be hearing voices over the past three days, and that he was being told to harm himself. Dr Thompson did not undertake a mental state assessment. She recorded that a psychiatric assessment was to be undertaken. She completed her shift at 7 am and a psychiatric assessment was not conducted before that time.

23. Dr Thompson agreed (from the clinical notes), that in fact a psychiatric assessment was not undertaken until Jordan was seen by Dr Rifat Jahan at 10 am, on Sunday the 23rd of November, some six and a half hours after his admission. She further agreed that nursing staff carried out a withdrawal scale assessment at 5 am and that he had an assessment of 13.[11] She prescribed Diazepam only after that nursing review and when challenged on the matter of her evidence that she saw him earlier at 4.30 am she stated that she would only have ordered Diazepam in accord with and after a withdrawal scale had been established.

---

[9] Ibid.
[10] See transcript page 39.
[11] See nursing notes exhibit 3(b).

24. Dr Thompson was aware of his raised blood pressure 179 over 104 and of a raised pulse.[12] Blood tests were ordered and registered at 4.53 am, with the results found at exhibit 4(d), An ECG was performed at 5.25 am, with evidence of arrhythmia (and tachycardia), which I note is consistent with alcohol withdrawal.[13] She was not aware of and did not receive the blood test results, or follow up on the results before the conclusion of her shift,

'because I handed over the care of the patient to the next doctor'.[14]

25. She had commenced re-hydration but did not check on his progress, because the dose of one litre normal saline would be delivered over two hours and she went off duty at 7 am.[15]

26. She agreed that there was no indication that he was reviewed by an ED doctor, prior to his discharge at around 4.30 am the following morning. She could not say whether a Dr John Cheek, then an ED night shift admitting medical officer had seen Jordan.[16]

27. Dr Thompson further agreed that the record did not suggest that she endeavoured to obtain from Jordan details of his drinking history, when he had his last drink, whether he had attempted to withdraw from alcohol use previously and whether he had suffered from previous seizures or delirium, on those occasions. Dr Thompson also agreed that it would be important to know when assessing such a patient whether withdrawal in the past had been uncomplicated, as opposed to leading to the emergence of severe symptoms.

28. She believed that she must have been given this information by the admitting officer, but also agreed that she did not record this matter, or the name of this person. She did however assess Jordan as being in a severe state of withdrawal, but did not prescribe thiamine, which according to the thiamine protocol, should have been prescribed within two and a half hours of his arrival in the ED.

29. Dr Thompson further confirmed that she did not see Jordan prior to the completion of her shift because of her workload. The medical record also does not suggest that she ever raised his presentation with a more senior colleague. When she left at 7 am a decision about a treatment had not been made because her workup was incomplete.[17]

---

[12] Exhibit 4(b).
[13] Exhibit 3(b) the nursing notes.
[14] See transcript page 70. She would normally have been responsible for between 4 to 6 patients at any one time. She was unable to say whether she made inquiries about Jordan's results before her departure at 7 am, although she felt her normal practise would have been to do so. Transcript page 70-71.
[15] See transcript page 72.
[16] Dr Cheek provided the Court with a statement in which he stated he had been unable to establish whether he had been on duty at the ED over the nightshift in question, and had no recollection of seeing Jordan.
[17] See transcript page 76-84.

30. In conclusion, Dr Thompson considered that her management of Jordan over the two and a half hours following his admission was appropriate. She also re stated that her handover was an oral handover, to an unknown colleague.

Jordan's condition while at Dandenong Hospital.

Dr Rifat Jahan

31. At 9.30 am, on Saturday 22 November Dr Jahan was informed by the ECAT nurse on duty in the ED, Theresa, that she was *'overwhelmed'* by the number of patients in the ED. She requested that Dr Jahan come to the ED to help out. Dr Jahan arrived at the ECATT office at 10 am and after reading Jordan's ECAT notes, she went on to conduct a review. At the time Jordan was in a psychiatric and planning assessment (PAPU) bed, within the ED.

32. Jordan was observed by Dr Jahan to be uncomfortable in speech and was unable to provide a history. Jordan spoke very quietly and stated that he was too tired to talk. Dr Jahan noted that he was suffering from nausea, fatigue and hand tremor. He also stated that he had been depressed for three or four days. Dr Jahan further observed that Jordan was coherent and although quietly spoken, that he appeared to be orientated in time and place.[18]

33. Dr Jahan's progress note also recorded, '*a female voice telling him to kill himself,*' and a high risk of suicide assessment, due to auditory hallucinations.[19]

34. Dr Jahan was unable to say whether Jordan was suffering from alcohol withdrawal or exhibiting psychotic symptoms[20] and informed Jordan that he would be reviewed when he was feeling better and able to speak. After a second review she felt she would be able to complete her assessment and then discuss his case with her consultant. A provisional diagnosis would then be determined.[21] Later he was asked if he was, '*happy to stay in hospital for 24 hours*', and agreed to this. Dr Jahan also told Jordan, that it might be another Dr who examined him.[22]

35. Dr Jahan returned to the ECAT office and informed the nurse that she was keeping the patient in the PAPU bed for 24 hours, until he could be assessed. The nurse then referred her to the on duty ED registrar. According to Dr Jahan, when she informed this registrar of her plan for Jordan the registrar disagreed, stating that he believed it was very uncommon to

[18] Transcript page 56.
[19] Exhibit 8(g) at page 2.
[20] Ibid page 57.
[21] Transcript page 68.
[22] See Dr Jahan's statements at exhibits 5 and 5(a).

have symptoms of auditory hallucination in alcohol withdrawal, and that in his opinion (Jordan) was suffering from a psychiatric condition and should not remain in the ED.

36. In response Dr Jahan confirmed to the registrar whose name she could not recall, that she was keeping Jordan in a PAPU bed in the ED for 24 hours so that he might be properly assessed, and then documented this management plan in the admission notes.[23]

37. Dr Jahan also stated that she was not prepared to admit Jordan under the mental health team, as he was not medically cleared and that he required medical observation and treatment for his physical condition before she could complete his psychiatric assessment. This included a review of his alcoholism, which was a general ward or ED ward issue rather than a mental health issue.

38. According to Dr Jahan, Jordon then remained under the care of the ED.

39. Dr Jahan further understood that Jordon had received Diazepam to assist him with alcohol withdrawal on presentation at the ED, and stated that she did not start him on any additional treatment including Thiamine because she was still in the process of assessing him, and believed that he needed further assessment to clarify his mental state.

40. As above, she also informed the ED registrar and nurse about the need for further medical review and observation, and asked that she be told once Jordan was, '*medically cleared*'.

41. She was on call over the following 24 hours and expected that she would be called back to review him after he was medically cleared.

42. Dr Jahan believed that she need not inform her Consultant of the progress of the matter, because she reasoned that Jordan's psychiatric assessment had not been completed. She finished her shift at 10 pm and verbally handed over to Consultant Psychiatrist, Dr David Huppert. She described the shift as having been a very busy one. She was the only Doctor looking after the mental health wards and the medical and psychological wards so she was constantly receiving calls to make assessments with each such assessment taking about one hour to complete.[24]

---

[23] See exhibit 5 at page 2 and the clinical notes at exhibit 5(b). See discussion of Dr Huppert's contrary view as to the presentation, which is set out below.

[24] Transcript page 64-65.

Nurse Beard and Nurse Sivaganthan

43. Nurse Beard and Nurse Sivaganthan both testified that Jordan's symptoms got better and his alcohol scores steadily improved over his stay in hospital. I also note that both nurses stated that they had no personal recollection of Jordan at all, and also that improvement in his alcohol scores might not reflect an improvement in his mental state.

Tanya Petrusevski

44. Jordan's sister Tanya gave evidence that at 12.30 pm on 22 November Jordan was fidgeting and shaking and was entirely different to how he was normally. She also gave evidence that Jordan was dozing off and then waking and talking to himself and then mumbling and that this behaviour remained the same between 12.30 pm and 6.30 pm that day.[25]

Nurse Irene Wilson

45. Nurse Wilson testified that at uncertain time on the morning of 23 November 2008 Jordan asked to go home and said he would get a taxi. She *'would have'*, advised him to stay until morning but could not remember in the absence of a clinical note, what had occurred. In her statement she stated that she went to the ECAT office to arrange for a psychiatric review. She could not remember who reviewed him but recalled that she was told that he was psychiatrically fit for discharge.[26] She later testified that she *'would have'*, referred him to the taxi phone in the waiting room.[27] She did not see him leave the ED.[28]

Dr Clarita Kempoosit[29]

46. Dr Kampoosit gave evidence that Jordan was given Olanzapine at 11.05 pm on 22 November because he was suffering from hallucinations.

47. Dr Kampoosit further testified that she was recalled to review Jordan at 4am[30] via a pager from the ED. There was no handover by a medical officer[31] and there was no note or information to the effect that Jordan was fit to be discharged.[32] Dr Kampoosit further testified that she was not aware of Jordan's medical treatment within the ED when she

---

[25] Transcript page 16.
[26] See transcript page 337. She did not wait for the ECAT Dr to arrive and was not present during that review.
[27] See transcript page 338.
[28] See transcript page 339.
[29] Dr Kampoosit was a psychiatric medical officer who had worked at Dandenong Hospital for ..... at the time under consideration.
[30] See Exhibit 10a.
[31] Transcript page 206.
[32] Transcript page 216.

decided to discharge him. She believed that it was the medical team's responsibility to review him.

> *'..well assessing a patient at 4 o'clock in the morning, we could not do all the reviewing everything that is in the file, including the time when the medication was last given and when it was given. Because that is not our work, as I said, that is just the staff of the emergency, who usually have to know all of that'.*[33]

Dr D Huppert [34]

48. Dr D Huppert, who took over from Dr Kampoosit, was not called upon to review Jordan, and did not see him prior to his discharge at around 4.30 am on Sunday 23 November.

49. In regard to the ED management generally, Dr Huppert testified that Jordan was admitted to the PAPU short stay unit (SSU) within the ED at Dandenong Hospital, at 4.30 am on Saturday 22 November 2008. The decision to admit to the SSU was typically made by the ED staff and while in the unit patients are primarily managed by the ED staff, mental health staff work in partnership with ED staff to provide mental health evaluation and treatment advice.

> *'The decision to admit to the short stay unit and is made by ED staff and is based on the availability of an SSU bed and the likelihood of the medical condition resolving substantially within 24 hours. If a condition is likely to take more than 24 hours then admission to a relevant medical, surgical or specialist unit (including psychiatry) is arranged'.*[35]

50. Again from the clinical notes, Dr Huppert commented that he was unable to establish why it was felt appropriate to place Jordan in a PAPU bed,

> *'apart from the implied view that Mr Petrosevski's condition was likely to improve within 24 hours'.*[36]

51. Dr Huppert further observed that Jordan,

> *'was nursed in the short stay area of the ED. His bed status was designated as psychiatric assessment and planning unit-BAPU. He was under regular general*

---

[33] Transcript page 234-35.
[34] Dr David Huppert is a Consultant Psychiatrist, who was the Acting Medical Programme Director Mental Health for Southern Health, at the time under examination.
[35] Exhibit 8(a) page 1.
[36] Ibid.

nursing and received a single dose of diazepam 10 mg at 4.55 am on 22/11/08 intravenously and olanzapine 10 mg orally at 11.05 pm. He slept for several hours before requesting to be discharged. He was seen by Dr Kampoosit. (He) was discharged from the ED at approximately 4 am on 23/11/08 on his own undertaking following requests to him to stay by psychiatric staff. He did not want to take up the suggestion that he wait until morning and refused to allow his family to be contacted...'[37]

'...relevant legislation also enables that patient confidentiality may be breached when a patients health or other individuals, or the community is at acute risk... his confidentiality is breached at times of acute risk and then only in a limited way and to specific groups that include carers and emergency services, in order to reduce the risk of self harm or harm to others...(This did not occur as the risks present did not seem to justify). However, the details of that conversation were not extensively documented'.[38]

52. His further view, reference the non-administration of Thiamine to Jordan, was to the effect that Thiamine is usually administered to patients with alcohol related and psychiatric symptoms. This occurs regardless of whether the patient is in the ED or SSU/PAPU unit.

'There is no information as to why ED medical staff did not chart Thiamine or if mental health staff advised for Thiamine to be chartered, why mental health staff did not chart it themselves'[39].

53. Dr Huppert gave evidence that if family members were not to be involved in a patient's discharge, this would only occur after detailed discussions with the patient as to why this should be the case. He further testified that he would have expected a record of such a discussion to be made.[40]

54. In conclusion, Dr Huppert's opinion was that a psychiatric consultant should have been called into review Jordan. This was especially so in a complex case like Jordan's where there a history of drug, alcohol and psychiatric problems. He also stated that,

'It is a general principal that any patient who is admitted to the ED with self harm and appears to have improved is not discharged unless there has been a review or

---

[37] See exhibit 8 page 2.
[38] Ibid pages 1-2.
[39] Ibid.
[40] See transcript page 152.

discussion by more than one mental health clinician. The mental health junior medical staff member (Dr Kampoosit), described Mr Petrusevski as having an improved mental health state with resolution of psychotic suicidal and depressive symptoms.' [41]

Professor Nicholas Keks[42]

55. Professor Keks provided an expert opinion on the review undertaken by Dr Thompson and the provisional diagnosis of Dr Jahan to the effect that Jordan was having alcohol withdrawal and hallucinations during the initial stages of withdrawal, which was that this was a reasonable provisional diagnosis.[43] He further reviewed Dr Jahan's possible secondary diagnosis of a first episode psychosis and stated that such a diagnosis would require a comprehensive history and investigation to confirm. He observed that this was a possible diagnosis only, and that Dr Jahan appropriately intended reassessment, as part of her management plan.

56. Professor Keks also testified that as Jordan may have been suffering from a psychotic episode that should have been further explored. He further testified that a dose of 10 mg Olanzapine is likely to have left a degree of sedation in a person not used to it, and noted that it would be most unusual to send someone home on an antipsychotic following an episode of alcohol withdrawal. [44]

Investigation and Cause of Death

Dr Michael Bourke[45]

57. Investigation into death by drowning is a difficult matter and frequently involves a finding reached by exclusion of all other possible contributing factors. In this case, Dr Bourke was unable to identify a cause of death due to the advanced state of decomposition of Jordan's body.

58. In his report Dr Bourke, reviewed several possibly contributing factors. These included cardiac arrhythmia, which he largely discounted. I note here that counsel for Jason's family

---

[41] See exhibit 8.
[42] Professor Keks is an adjunct Professor of Psychiatry at Monash University and a psychiatrist in private practise, who was engaged to provide an expert opinion in relation to the care provided in this case.
[43] Alcohol hallucinosis is an uncommon complication of chronic alcoholism. It has an acute on set with vivid, acoustic, verbal hallucinations following the reduction or cessation of drinking within 48 hours, mostly combined with fear. See Diagnostic and Statistical Manual of Mental Disorders 4th edition on, '*Alcohol withdrawal and hallucinations.*'
[44] See transcript page 260-61.
[45] Dr Bourke is a senior forensic pathologist at the Victorian Institute for Forensic Medicine.

submits that I should exclude arrhythmia as a possibility because Jordan had no history of arrhythmia, or of cardiac problems of any sort.

59. Dr Bourke also found that there was no evidence of liver damage or disease, and no evidence, which would allow a finding of subdural or subarachnoid haemorrhage. It was submitted by Counsel for Jordan's family that this finding should cause me to rule out the possibility that the cause of death was in any way related to a head injury.

60. Further, Dr Bourke found no evidence of trauma, or bone fracture or indeed of any evidence, which suggested that Jordan had been the victim of an assault.

Finding

61. It is clear that the ED including the short stay unit was extremely busy on the night in question. Accepting that Dr Thompson's recollection as to the surrounding events, and to the fact that a handover by her actually took place, it follows that Dr Thompson was at best loosely supervised by an unknown ED medical officer over her night shift of 21-22 November 2008. It further follows that at the end of her shift at 7 am on 22 November, she orally handed over to a second ED medical officer, also unnamed.[46]

62. It is also the case that the doctor to whom she handed over, did not bother to review Jordan, or refer him to another ED medical officer and that this failure in management continued until he was discharged at approximately 4.30 am on Sunday 23 November.[47]

63. Nor does it seem that an ED medical officer reviewed Jordan's incoming pathology results.

64. I find then that Jordan's condition was not diagnosed by a qualified ED medical officer or above, and that an appropriate course of treatment was not begun in a timely way, this to his considerable detriment.[48] It is also the case that these several significant errors occurred against the backdrop of a dispute between the ECATT medical officer Dr Jahal,[49] and an

---

[46] It seems improbable, but if on the other hand Dr Thompson simply left the ED, (having earlier failed to introduce Thiamine), and took no action to hand over the patient or receive and act upon the results of the blood tests she had ordered-it is evident both that there was a serious failure in care, and again that she was poorly supervised.

[47] Dr Huppert agreed with Counsel that it was unusual for someone to be kept in the ED for such a lengthy period without review, when they had presented with numerous physical symptoms.

[48] Professor George Braitberg gave evidence that he expected an ED Intern would speak to someone more senior within the ED in these circumstances. See transcript page 398. He also testified that he would have expected Liver Function Tests (LFT's) to be undertaken but they were not. See transcript page 422. Professor Nicholas Keks also testified that he would have expected LFT's to be undertaken and that they would have assisted diagnosis of alcohol withdrawal. See transcript pages 268-69.

[49] Dr Jahan was a medical officer attached to the Banksia psychiatric unit at Dandenong Hospital. She had been in this position for three months at the time and this was her first posting in Australia, following the completion of her internship in her country of origin.

unknown ED registrar, who did not agree to Dr Jahal's plan to keep Jordan in an ED, (PAPU) bed, over a further 24 hours.

65. I further note Dr Huppert's testimony that he would have expected the standard medication Thiamine, to be provided to Jordan irrespective of whether he was diagnosed as suffering from an alcohol or psychiatric illness, and that such an approach might have been properly adopted by either ED, or mental health staff. As we know this did not occur.

66. Rather from all of the evidence, I find that Jordan's health remained seriously compromised over the 24 hours he remained in the ED. I further find that the lack of an appropriate clinical response, which should have included the provision of Thiamine, together with review by a senior ED clinician as well as at least contact with a senior Psychiatric clinician, before a decision to discharge was reached, denied Jordan both an appropriate course of treatment, as well as reasonable management in regard to discharge.[50]

67. These were significant failings, which I find were indicative of a chaotic situation within the ED, on the night in question. They appear to have arisen because of inexperience and because of a failure in supervision. Tension between the two disciplines concerned also appears to have been a factor which led to uncertainty over which team was responsible for discharge, with neither the psychiatric or the ED medical team accepting over all responsibility.

68. I further note that Jordan came from a caring family whose members had for some time been deeply concerned about his welfare. It is additionally relevant that Jordan was not shown to be an impulsive person, and indeed I am satisfied that he was instead a person who was willing to take advice from family members most particularly his father, about such matters as his condition and treatment. I find then that collectively the events described concerning his lack of a diagnosis and treatment, coupled with what I find was his unwarranted early discharge from the ER, without review by appropriate senior clinicians, robbed him of any real opportunity to make reasonably supported decisions concerning his own welfare and protection.

69. I find then that Jordan was discharged from the ED at around 4.30 am on the Sunday morning. Before his departure or thereafter, neither Jordan nor ED staff made contact with his family. As a result, and on learning of these events Jordan's family were greatly

[50] The evidence falls short of establishing that Jordan should have been detained as an involuntary patient.

distressed and lived through their personal nightmare, culminating with his body being found in the nearby Dandenong creek, some seven days later.

70. Jordan's movements and the timing of his arrival at Dandenong creek are uncertain, as are the events that led to his entry.

71. In this regard, I note the position in which his body was found and its location approximately 2km southeast of the Hospital, and the fact that there was no evidence suggesting that he had been earlier disabled because of an assault. It is also relevant that at the time, the creek was in flood due to heavy rainfall over the days prior to his admission and that there was no lighting in the area where his body was found.[51]

72. I further note the location of his home in Endeavour Hills, some 6.3 km also to the east of the Hospital, and the fact that these matters combine to suggest that Jordan was, as he had told hospital staff, intending to return to his home at the time of his demise.[52]

73. I surmise therefore that if intending to return home, and if not interrupted by whatever event befell him, Jordan would have continued to walk through a largely built up area and is likely to have reached his destination 6.3 km away, later that morning. From the above I further conclude that in the event that he had become lost or confused or other, it is probable that he would have been found by police or family members, each of which groups engaged in a search for him later that morning, or by local residents.

74. The fact that he was not so found, establishes to my satisfaction that it is likely that the events, which led to his death, occurred on the morning of his discharge, rather than later over the period under consideration.

75. I have considered the possibility that when Jordan left the ER he remained effected by the Benzodiazepine medication earlier provided. I have also considered the possibility that his alcohol withdrawal is likely to have influenced his ability to make his own way home, and the suggestion that he may have slipped and fallen into the flooding Dandenong creek. I have also considered the evidence that Jordan remained at risk of having an epileptic fit.[53]

---

[51] See transcript page 459.
[52] See Google map of area at attachment 1.
[53] See Professor Barton's evidence at transcript page 298.

76. However, having regard to Dr Bourke's autopsy findings, that he could not establish a cause of death (and that the cause was undetermined), I accept this evidence and find that the cause of Jordan's death remains undetermined, following autopsy. [54]

77. Further and after a review of all of the evidence and counsel's submissions, I find that in the absence of a medical cause for Jordan's death, I am unable to draw the inference that the ED failures discussed above either caused or contributed to that death. In these circumstances, I conclude that I must return a finding, which remains open as to this matter.

78. I make this finding, understanding that Monash Health has accepted that significant process failings have been shown to have occurred in the management of Jordan Petrusevski, and from the evidence of Professor George Braitberg, that steps have now been taken to improve the clinical response to patient's who present to the Dandenong Hospital ED, with multi-dimensional toxicology related medical issues.[55]

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

The family of Jordan Petrusevski

The Chief Executive, Monash Health

Dr A Thompson

Dr J Cheek

Dr S Bryan

Dr M Buchanan

Dr R Johan

Dr C Kampoosit

Dr D Huppert

Professor N Keks

---

[54] In other words, that death may have been caused either by either a natural event leading Jordan to fall into the Dandenong creek, or from an accidental immersion from which Jordan himself was unable to self-rescue, or from a combination of both.

[55] In August 2013, the ED at Dandenong Hospital introduced a medical model of management with the appointment of a Toxicology Registrar and a new 4 bed Toxicology unit located within the Short Stay Unit. To the end of December 2013, the unit had 160 admissions and 207 referrals since it opened. See statement of Professor Braitberg, at exhibit 13 together with Appendixes 1, 2 and 3.

Professor G Braitberg

Professor D Barton

Senior Constable Tracey Arnold

Signature:

PETER WHITE

CORONER

Date: August 11, 2015.