IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2009 4996

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of:	**YAMINI BHADRAYU PATEL**
Delivered On:	29 February 2016
Delivered At:	65 Kavanagh Street, Southbank, 3006.
Hearing Dates:	14, 15, 16 and 17 May 2012.
Findings of:	AUDREY JAMIESON.
Representation:	Mr John Snowdon, counsel, on behalf of Southern Health.[1] Mr Sean Cash, counsel, on behalf of Dr Urday Dixit.
Counsel Assisting the Coroner	Senior Sergeant Jenette Brumby, Police Coronial Support Unit.

[1] Southern Health is now known as Monash Health.

I, AUDREY JAMIESON, Coroner having investigated the death of YAMINI BHADRAYU PATEL
AND having held an Inquest in relation to this death on 14, 15, 16 and 17 May 2012
at Melbourne
find that the identity of the deceased was YAMINI BHADRAYU PATEL
born on 19 October 1961
and the death occurred on 20 October 2009
at Monash Medical Centre, 246 Clayton Road, Clayton 3168
from:

1(a) ISCHAEMIC BRAIN INJURY
1(b) TOXICITY TO TRAMADOL AND TEMAZEPAM

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

1. On 9 October 2009, Yamini Bhadrayu Patel (**Yamini**)[2] and her husband, Bhadrayu Patel (**Bhadrayu**) had an argument. That evening, Yamini's family went out without her and returned later in the evening to find her 'sleeping'.
2. On 10 October 2009, when Yamini did not wake up, the family doctor was called to the home for a medical opinion. On the morning of 11 October 2009, an ambulance was called and Yamini was transported, in a comatose state, to the Monash Medical Centre (**MMC**) Emergency Department (**ED**).
3. After receiving intensive care, Yamini did not awake from the coma and on 20 October 2009, she died, aged 48 years old, in McCulloch House Palliative Care Unit, at MMC.

BACKGROUND CIRCUMSTANCES

4. Yamini was born in India and moved to Australia with her family in 1992.[3] She lived with Bhadrayu, her two daughters (Heenal and Dhruti) and her son in Glen Waverley.

[2] The Patel family requested that Yamini Bhadrayu Patel be referred to as Yamini during the course of the Inquest. For consistency, I have, in most part, avoided formality and also referred to her only as Yamini throughout the Finding.
[3] Transcript of Proceedings (T) @ page 63.

5. She worked at Cumberland View Aged Care Services Pty Ltd (**Cumberland**) as a Registered Nurse Division 2.[4]
6. Yamini's medical history included hypertension and sleep apnoea. Dr Urday Dixit (**Dr Dixit**) was the regular doctor of Yamini and her family.[5] Heenal described Dr Dixit's relationship with her family as being a social friend, as well as being the family doctor, with social contact occurring monthly or every two months.[6] Bhadrayu described his family's non-professional relationship with Dr Dixit as being confined to regular social contact, such as seeing him on occasions like birthdays.[7]
7. Heenal did not consider the family's relationship with Dr Dixit as problematic because *"...he was professional...the way he should be"*.[8] Bhadrayu said his family *"had full faith in him* [Dr Dixit]" as a doctor, and that he always had a professional approach.[9]
8. Yamini and Bhadrayu had been arguing for the week prior to 9 October 2009.[10] Their relationship had a history of conflict. Bhadrayu conceded that some of the arguments got too heated, *"lots of times it comes to push and shove sort of thing situation"* but that it *"wasn't much physical"*.[11] Heenal explained that her mother and father did not discuss matters alone, that the children were routinely involved.[12] Dhruti explained their involvement to be *"...as mediators and making sure that...they didn't hurt each other physically..."*[13]
9. As a result of the conflict with her husband, Yamini had moved out of the family home for a couple of weeks in 2009.[14]

---

[4] T @ page 4.
[5] T@ page 22.
[6] T@ page 20.
[7] T@ page 62.
[8] T@ page 20. Heenal elaborated that she considered Dr Dixit professional because the consultations were in a clinical setting, he would make notes, the family would make appointments, he would physically examine when indicated and would provide a diagnosis when appropriate, and a management plan; T@ page 21.
[9] T@ pages 62-63.
[10] Exhibit 3 – Statement of Bhadrayu Patel dated 7 April 2010.
[11] T@ page 51. Bhadrayu also said the argument in the week prior to the incident had not escalated to a physical fight.
[12] T@ page 9.
[13] T@ page 33.
[14] T@ pages 9 and 33.

10. Victoria Police's Law Enforcement Assistance Program (**LEAP**),[15] has no records of any incidents of Family Violence[16] reported to the police by Yamini or any other member of her immediate family.[17]

JURISDICTION

11. At the time of Yamini's death the *Coroners Act 1985* (Vic) applied. From 1 November 2009, the *Coroners Act 2008* (**the Act**) has applied to the finalisation of investigations into deaths that occurred prior to the commencement of the Act.[18]
12. Yamini's death constitutes a '*reportable death*' under the *Coroners Act 1985* (Vic) as her death was unexpected.[19]

PURPOSE OF A CORONIAL INVESTIGATION

13. The Coroners Court of Victoria is an inquisitorial jurisdiction.[20] The purpose of a coronial investigation is to independently investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[21] The cause of death refers to the medical cause of death, incorporating where possible the mode or mechanism of death. For coronial purposes, the circumstances in which death occurred refers to the context or background and surrounding circumstances, but is confined to those circumstances sufficiently proximate and causally relevant to the death and not merely all circumstances which might form part of a narrative culminating in death.[22]
14. The broader purpose of coronial investigations is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of recommendations by coroners, generally referred to as the 'prevention' role.[23] Coroners are also empowered to report to the Attorney-General on a death; to comment on any matter connected with the death they have

---

[15] On 1 March 1993, Victoria Police implemented the Law Enforcement Assistance Program (LEAP) state-wide. The LEAP database is relational and stores particulars of all crimes bought to the notice of police as well as family incidents and missing persons. The database is accessible by Police online and updated constantly, 24 hours a day.

[16] The *Family Violence Protection Act 2008* defines '*family violence*' to be:

(a) behaviour by a person towards a family member of that person if that behaviour (i) is physically or sexually abusive; or (ii) is emotionally or psychologically abusive; or (iii) is economically abusive; or (iv) is threatening; or (v) is coercive; or (vi) in any other way controls or dominates the family member and causes that family member to feel fear for the safety or wellbeing of that family member or another person; OR

(b) behaviour by a person that causes a child to hear or witness, or otherwise be exposed to the effects of, behaviour referred to in paragraph (a).

[17] T@ page 147.

[18] *Coroners Act 2008*, section 119 and Schedule 1.

[19] Section 4(2)(a) *Coroners Act 2008*.

[20] Section 89(4) *Coroners Act 2008*.

[21] Section 67(1) of the *Coroners Act 2008*. All references which follow are to the provisions of this Act, unless otherwise stipulated.

[22] This is the effect of the authorities- see for example *Harmsworth v The State Coroner* [1989] VR 989; *Clancy v West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J).

[23] The 'prevention' role is now explicitly articulated in the Preamble and purposes of the Ac, in contrast to the *Coroners Act 1985* where this role was generally accepted as 'implicit'.

investigated, including matters of public health or safety and the administration of justice; and to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.[24] These are effectively the vehicles by which the prevention role may be advanced.[25]

15. It is not the Coroner's role to determine criminal or civil liability arising from the death under investigation. Nor is it the Coroner's role to determine disciplinary matters.
16. Section 52(2) of the Act provides that it is mandatory for a coroner to hold an inquest into a death if the death or cause of death occurred in Victoria and a coroner suspects the death was as a result of homicide, or the deceased was, immediately before death, a person placed in custody or care, or the identity of the deceased is unknown.
17. Yamini's identity was not in dispute, she was not a person placed in "*custody or care*" as defined by section 3 of the Act and her death was not considered to be a homicide. Therefore, it was not mandatory to conduct an inquest into the circumstances of her death. However, I exercised my discretion, pursuant to section 52(1) of the Act, to hold an inquest because I had identified matters of public health and safety that required further investigation, including issues around when families might consider it appropriate to contact emergency services or hospitals.
18. Leading Senior Constable Shane O'Sullivan (**LSC O'Sullivan**) was nominated to be the coroner's investigator[26] and he prepared the Inquest brief.
19. This finding draws on the totality of the material; the product of the coronial investigation of Yamini's death. That is, the court records maintained during the coronial investigation, the Inquest brief and the evidence obtained at the Inquest, including submissions of legal counsel.
20. In writing this finding, I do not purport to summarise all of the evidence, but refer to it only in such detail as appears warranted by its forensic significance and the interests of narrative clarity. The absence of reference to any particular aspect of the evidence, either obtained through a witness or tendered in evidence does not infer that it has not been considered.

---

[24] See sections 72(1), 67(3) and 72(2) of the Act regarding reports, comments and recommendations respectively.
[25] See also sections 73(1) and 72(5) of the Act which requires publication of coronial findings, comments and recommendations and responses respectively; section 72(3) and (4) which oblige the recipient of a coronial recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation.
[26] A coroner's investigator is a member of the police force nominated by the Chief Commissioner of Police or any other person nominated by the coroner to assist the coroner with his/her investigation into a reportable death. The coroner's investigator takes instructions directly from a coroner and carries out the role subject to the direction of a coroner. LSC O'Sullivan commenced as the coroner's investigator on 21 December 2010, after it was determined that another police member had a personal conflict and could not act as coroner's investigator.

STANDARD OF PROOF

21. All coronial findings must be made based on proof of relevant facts on the balance of probabilities. In determining whether a matter is proven to that standard, I should give effect to the principles enunciated in *Briginshaw v Briginshaw*.[27] These principles state that in deciding whether a matter is proven on the balance of probabilities, in considering the weight of the evidence, I should bear in mind:
    - the nature and consequence of the facts to be proved;
    - the seriousness of an allegation made;
    - the inherent unlikelihood of the occurrence alleged;
    - the gravity of the consequences flowing from an adverse finding; and
    - if the allegation involves conduct of a criminal nature, weight must be given to the presumption of innocence, and the court should not be satisfied by inexact proofs, indefinite testimony or indirect inferences.
22. The effect of the authorities is that coroners should not make adverse findings against or comments about individuals, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

MEDICAL PRACTITIONERS BOARD OF VICTORIA AND AHPRA

23. The Medical Practitioners Board of Victoria, by facsimile dated 15 December 2009, advised me that they had received a notification regarding the professional conduct of a medical practitioner associated with the case.
24. By email dated 8 December 2010, the Senior Investigating Officer at the Australian Health Practitioner Regulation Agency (**AHPRA**) informed me that their investigation had been placed on hold pending the completion of the coronial investigation.[28]

REFERRAL TO THE DIRECTOR OF PUBLIC PROSECUTIONS

25. Initially, the Victoria Police investigated the circumstances of Yamini's death, and determined that there was no evidence of criminal offences connected with Yamini's death.

---

[27] (1938) 60 CLR 336.
[28] I made some comments in relation to AHPRA's investigation at the conclusion of the evidence and final submissions – T @ page 188.

26. After considering the evidence, I formed the belief that an indictable offence may have been committed and directed the Principal Registrar to notify the Director of Public Prosecutions (**DPP**) pursuant to section 49(1) of the Act.
27. By letter dated 6 June 2012, the Principal Registrar wrote to the DPP advising of my direction. By letter dated 13 March 2013, the Office of Public Prosecutions informed me that at that stage, the DPP had considered the matter and was of the opinion that there was no basis for any criminal charge, including the charge of manslaughter by criminal negligence in respect of Dr Dixit.

FORENSIC INVESTIGATIONS

Identity of the deceased

28. Yamini's identity was not in dispute and required no further investigation.[29]

Medical Cause of Death

Autopsy

29. On 22 October 2009, Dr Michael Burke (**Dr Burke**), Forensic Pathologist at the Victorian Institute of Forensic Medicine (**VIFM**), performed an autopsy on the body of Yamini. Anatomical findings included bronchopneumonia, acute pulmonary oedema and acute tubular necrosis (kidney). The autopsy showed no evidence of any injury that would have contributed to or led to death and natural disease process that would have caused death.

Neuropathological examination

30. A neuropathological examination of Yamini's brain was performed by Dr Linda Iles, Forensic Pathologist at the VIFM. No evidence was identified of central nervous system disease that would explain the change in Yamini's conscious state. Microbiological tests conducted on brain tissue showed no evidence of viral infection, including no evidence of encephalitis or meningitis. The neuropathological examination showed cerebral ischaemic injury.

Toxicological analysis

31. Toxicological analysis of the ante mortem blood sample taken from Yamini on 11 October 2009 identified the presence of tramadol and temazepam. Tramadol, temazepam and codeine were also identified within hair segments.

[29] See 'Coroners Release Authority and Confirmation of Name' signed by Bhadrayu Maganbhai Patel (undated).

32. Given that the ante mortem blood samples were not obtained until sometime after Yamini's altered conscious state was first noted, Dr Burke opined that at the initial time of Yamini's change in conscious state, the concentrations of these drugs would have been much higher.
33. Dr Burke noted that the morphine, ketamine and midazolam identified within urine, hair and plasma had most probably been administered in hospital by medical personnel.
34. Dr Burke stated it would be reasonable to conclude Yamini died secondary to an ischaemic brain injury with the underlying cause being an overdose of tramadol and temazepam.
35. Dr Dimitri Gerostamoulos (**Dr Gerostamoulos**), Chief Toxicologist and Manager of Toxicology at the VIFM provided an expert opinion dated 7 May 2012. Dr Gerostamoulos agreed with Dr Burke that tramadol and temazepam concentrations would have been much higher at the initial time of her change in conscious state. He said that although the toxicology does not reveal excessive concentrations of tramadol or temazepam, this is most likely due to the period of almost two days from when Yamini was first found until an ambulance was called. He said the relatively short half-lives of tramadol and temazepam may have resulted in diminished concentration of both drugs which were determined in a specimen taken at the hospital at 4:00pm on 11 October 2009.[30]
36. Dr Gerostamoulos stated that tramadol[31] should be used with caution and in reduced dosages when administered to patients receiving central nervous system depressant such as alcohol, opioids or sedative hypnotics. He noted that temazepam[32] is a sedative drug, often known as a minor tranquiliser.[33]
37. Dr Gerostamoulos commented that higher doses of tramadol (>800mg) may cause coma, respiratory depression and death. He said that the possible ingestion of eight to 12 tablets of tramadol (150mg) is equivalent to 1,200-1,800mg of tramadol, with overdose symptoms including miosis,[34] vomiting, cardiovascular collapse and consciousness disorders including coma, convulsions, respiratory depression, respiratory arrest and death. He said that a significant consumption of opioids and benzodiazepines can lead to unconsciousness, and if not treated appropriately with assisted

---

[30] Exhibit 9 – Statement of Dr Gerastamoulos dated 7 May 2012. In a group of 28 patients received daily oral amounts of normal release tramadol of 200-400mmg for four weeks, measured 12 hours after the last dose resulted in blood concentrations of 0.1-0.8mg/L. The concentration determined in Yamini was 0.05mg/L. The terminal elimination half-life of tramadol is approximately five-seven hours and four to 15 hours for temazepam, with an average of eight to 10 hours. Dr Gerostamoulos said in evidence that working back to the Friday night, based on the known half-lives of the medication, the concentration on 9 October 2009 "*would've been substantially higher...and they're quite significant concentrations...leading to...toxic outcomes*"; T @ page 133.

[31] Tramadol is an opioid and a centrally active atypical analgesic typically given in doses of 50 to 100mg two or three times daily; Exhibit 9 - Statement of Dr Gerostamoulos dated 7 May 2012. Tramadol is a prescription only drug; T@ page 138.

[32] Temazepam is used for the treatment of sleep disorders.

[33] Exhibit 9 - Statement of Dr Gerostamoulos dated 7 May 2012.

[34] Excessive constriction of the pupil of the eye.

ventilation and naloxone,[35] can lead to death. He noted that if over-dosage is due to ingestion of a sustained release oral form of tramadol, emptying the stomach by gastric lavage should be considered due to the possibility of ongoing drug release in the stomach.[36]

THE INQUEST

Directions hearing

38. Prior to the commencement of the Inquest, I held a Directions Hearing on 2 November 2011.
39. I granted leave for the following interested parties to be represented at the Inquest:
    a. Dr Dixit; and
    b. Monash Health.
40. I directed that the main issues for examination at the Inquest concerned the circumstances surrounding Yamini's death. The areas of inquiry included:
    a. whether Yamini deliberately ingested medication with an intention to either harm herself or render herself unconscious;
    b. the source of the medication taken by Yamini;
    c. the state of Yamini's relationship with her husband and whether this potentially influenced her in taking the medication;
    d. the appropriateness of the advice and treatment provided by Dr Dixit; and
    e. the appropriateness in the circumstances for Yamini not to being conveyed to hospital once it was established that she was unconscious.

Viva voce evidence at the Inquest

41. A four-day Inquest was held on 14, 15, 16 and 17 May 2012. Senior Sergeant Jenette Brumby (**S/S Brumby**) of the Police Coronial Support Unit was counsel assisting me. Mr Sean Cash of Counsel appeared on behalf of Dr Dixit and Mr John Snowdon on behalf of Southern Health (as it then was).[37]
42. *Viva voce* evidence was obtained from the following witnesses at the Inquest:
    a. Heenal Patel, daughter;
    b. Dhruti Patel, daughter;

---

[35] Dr Gerostamoulos explained in evidence that naloxone is used for the treatment of people who are dependent on opioids. It reverses the effects of these drugs, and is given to people who have taken an overdose, displacing the drug and therefore lessening or reversing the effects of these drugs; T@ page 134.
[36] Exhibit 9 - Statement of Dr Gerostamoulos dated 7 May 2012. Dr Gerostamoulos said it is important to ascertain whether the tramadol is a slow release formulation, as this can sustain the depressive respiratory effects for much longer; He also said that gastric lavage would stop further absorption of the temazepam; T@ page 132.
[37] Mr Snowdon appeared on the first day of hearing and requested to excuse himself until such time as Dr Churchyard gave evidence, T@ page 1.

c. Bhadrayu Patel, husband;
d. Ms Kerry Carter, Director of Nursing, Cumberland View Aged Care Services;
e. Detective Leading Senior Constable John Fooks, Yarra Ranges Criminal Investigation Unit;
f. Detective Leading Senior Constable Bridgette De Chirico, Yarran Ranges Criminal Investigation Unit;
g. Dr Michael Burke, Forensic Pathologist, VIFM;
h. Dr Dimitri Gerostamoulos, Chief Toxicologist and Manager of Toxicology, VIFM;
i. Leading Senior Constable Shane O'Sullivan, coroner's investigator;
j. Dr Andrew Churchyard, Consultant Neurologist, Southern Health;
k. Associate Professor Morton Rawlin, independent medical expert.

43. At the conclusion of the evidence, on 17 May 2012, Mr Cash and S/S Brumby made oral submissions. I thank counsel assisting and the interested parties in this matter for their valuable contribution and submissions.

Application pursuant to section 57 of the Act

44. Mr Cash made an application, pursuant to section 57 of the Act, for Dr Dixit to be excused from giving evidence, rather than me granting him with a certificate pursuant to section 57(3) of the Act. I received written submissions and heard oral submissions from Mr Cash on 15 May 2012 in relation to this application.
45. Dr Dixit objected to giving evidence on the grounds that for him to do so may tend to prove that he had committed an offence (such as negligent manslaughter at common law[38]), was liable to a civil penalty and/or that his conduct amounted to either professional misconduct or unsatisfactory performance.[39]
46. Mr Cash submitted it was clear that Dr Dixit may be liable to a civil penalty considering the Medical Practitioners Board of Victoria had received notification about Dr Dixit in relation to Yamini's death, and a decision had been made to investigate the issues raised in the notification. AHPRA had also advised me that its investigation into Dr Dixit's conduct was on hold pending the outcome of the coronial proceedings.

---

[38] T@ pages 83-85.
[39] *Police Services Board v Morris* (1985) 156 CLR 397; *The Secretary to the Department of Planning and Community Development v Muto* (2011) VCAT 328 cited as standing for the notion that exposure to disciplinary proceedings amounts to a civil penalty.

47. On 15 May 2012, I delivered a ruling in relation to the application and determined there to be reasonable grounds for Dr Dixit's objection and that this was not a matter where the protection of a certificate, pursuant to section 57(3) of the Act, was appropriate. Accordingly, Dr Dixit was excused from giving evidence at the Inquest.

Evidence at the Inquest

The circumstances in which Yamini's death occurred

48. On Friday, 9 October 2009, at approximately 6:00pm, Yamini, in the company of her daughter, Dhruti, attended an appointment with Dr Dixit. Dhruti recalled that her mother was examined with respect to her blood pressure and a pain in her side.[40]
49. Upon returning home, Yamini's husband and son were at home. Yamini had a verbal argument with her husband over domestic issues. Yamini insisted they discuss the issues, and her husband wanted to wait until the whole family was there.[41] Yamini called her other daughter, Heenal, and asked her to come home after work to discuss some issues she and Bhadrayu were having.[42]
50. Dhruti explained that although Yamini seemed upset on 9 October 2009, it was not dissimilar from how she had previously been while in a fight with her father.[43] Dhruti confirmed her mother wanted to go out with her father and brother, however "*we suggested potentially it was better for her to stay home just so...the arguments didn't continue in a public arena*".[44]
51. Bhadrayu, Yamini's son and Dhruti left the house at approximately 8:30pm. When they returned at approximately 11:30pm,[45] they observed Yamini seated upright in a high backed sofa chair in the lounge room, with her feet on the ground,[46] snoring.[47] The family noticed there was food on the floor in the kitchen. Dhruti cleaned it up.[48] Yamini's family considered this was unusual, because generally if Yamini had spilt something, she would clean it up.[49]
52. Heenal returned home shortly thereafter and attempted to wake her mother by shaking her shoulder and saying "*wake up*". Yamini did not respond. Heenal was not concerned at this stage, and

---

[40] T@ pages 44-45.
[41] Exhibit 2 – Statement of Dhruti Patel dated 10 November 2011.
[42] Exhibit 1 – Statement of Heenal Patel dated 7 April 2010. Heenal told her mother she was going out with friends and would be home late.
[43] T@ page 34.
[44] T@ page 35. Dhruti said her mother seemed to accept this.
[45] T@ page 35.
[46] T@ page 12.
[47] T@ page 54. Bhadrayu said it was common for his wife to snore, and common for her to stop snoring when her children made noise; Exhibit 3.
[48] T@ pages 35-36.
[49] T @ pages 11, 35 and 54.

considered her mother was either sleeping or ignoring her. Heenal placed another one-seater sofa chair in front of Yamini, placed her legs on it and covered her with a blanket.[50]

53. Heenal's evidence was that her mother's sleeping patterns were unusual.[51] She generally worked 3:00pm until 11:00pm, return home at approximately midnight, and would wake up at around 10:00am or 11:00am.[52] Heenal recalled that although her mother had difficulties falling asleep she often fell asleep when there was no one else in the house and once asleep, she would go "*into a deep sleep.*"[53] Heenal said it was therefore understandable that her father did not raise alarm bells upon returning home and finding Yamini in a deep sleep.[54] Dhruti also confirmed that her mother would be awake at all hours, was perpetually tired from a lack of sleep and would on occasions fall into a deep sleep.[55]

54. At approximately 8:00am on 10 October 2009, when Heenal left for work, she noted that her mother was in the same position and appeared to still be in a very deep sleep.[56] Bhadrayu also observed his wife still apparently asleep when he woke up at approximately 8:45am. However, he considered this quite normal for his wife,[57] who had some unusual sleeping patterns due to her working hours.[58] Bhadrayu explained that Yamini would normally sleep from 2:00am until approximately midday, due to her shift-work. He said the family always let her sleep in, especially on the weekends.[59]

55. Dhruti woke up at approximately 9:30am and heard her mother snoring throughout the morning. Dhruti's evidence was that her mother's snoring appeared reactive to the noises she was making.[60]

56. At approximately midday, Heenal returned home from work and was concerned that her mother was still sleeping considering the level of noise around her. Heenal tried to wake her by shaking her and squeezing her hands, but could not elicit a response other than changes in her breathing and snoring.[61] Heenal relayed this to her father, who also tried, unsuccessfully, to wake her.[62] At approximately 1:30pm, the two moved Yamini to the three-seater lounge, lying her in a supine

---

[50] T @ pages 11-12; Exhibit 1.
[51] T@ page 15.
[52] T@ page 22.
[53] T@ pages 22-23.
[54] T@ page 23.
[55] T@ page 45.
[56] T @ page 12; Exhibit 1.
[57] T@ page 55. Bhadrayu also explained that during an argument, it was common for his wife to sleep separately. He stated that she had been sleeping "*anywhere*" for the week prior to the incident; Exhibit 3.
[58] T@ pages 36-37.
[59] Exhibit 3.
[60] T @ page 36; Exhibit 2. Dhruti explained that when she made a noise, her mother's snoring appeared to die down. She would then return to snoring.
[61] Exhibit 1.
[62] T @ page 55, Exhibit 3.

position.[63] Bhadrayu flashed a torch into Yamini's eyes, and observed her pupils to react. He asked Heenal to get the blood pressure machine.[64] Heenal measured Yamini's heart rate and blood pressure, which appeared to Heenal to be within normal parameters. Heenal's evidence was that she told her father "*to call someone*" at this stage.[65]

57. Heenal explained that although on 10 October 2009 her mother was heard snoring, the *"[o]nly difference was that that snoring was a bit louder...[i]t was a strange rumble..."*.[66] Heenal's evidence was that although her father appeared concerned, he did not seem unduly concerned because of Yamini's history of sleep apnoea and deep sleep.

58. Bhadrayu telephoned Dr Dixit at approximately 1:45pm.[67] He relayed the vital sign measurements and answered some of Dr Dixit's questions. Dr Dixit suggested they check the house for any medication wrappers/bottles. Dr Dixit also advised Bhadrayu to call for an ambulance if Yamini's breathing changed.[68] Heenal located some foil leaflets of tablets in Yamini's bedroom drawers, including tramadol and two varieties of paracetamol, which was considered unusual.[69]

59. At 4:30pm, Bhadrayu again telephoned Dr Dixit and advised that the situation remained unchanged. He requested Dr Dixit attend. Dr Dixit attended the Patel's home at approximately 5:30pm.[70] Heenal's evidence was that her father was not conveying a great sense of urgency to Dr Dixit upon his arrival for the home visit.[71] Bhadrayu showed Dr Dixit the medication foil wrappers.[72] Bhadrayu recalled there were approximately eight tablets missing from the pack.[73] Dr Dixit informed the Patel family members that he had not prescribed Yamini with tramadol[74]. Dr Dixit checked Yamini's heart rate and blood pressure, which appeared to be within normal limits and her pupils were reactive to light.

---

[63] T @ pages 12-13. Heenal described her mother as feeling "*limp*" when moved. Heenal said that she later thought of placing her mother in a different position, on her side, in the morning, when she was making noises; T@ page 29.
[64] T@ pages 55 and 69. Heenal explained the family had a blood pressure monitoring machine at home due to her mother's medical history, and that she had learned how to monitor a heart rate, and the normal parameters of both at university (Bachelor of Science; T@ page 28), and had completed a senior first aid course; T@ pages 23-25. Bhadrayu explained they check Yamini's vital signs prior to calling Dr Dixit to avoid wasting his time, and to enable Dr Dixit to make an informed decision by providing Dr Dixit with the readings. He said Dr Dixit explained the normal parameters to him; T, page 69.
[65] T@ pages 13 - 14.
[66] T@ page 25.
[67] T@ pages 14, 55-56.
[68] T@ pages 14 and 56; Exhibit 1 and Exhibit 3.
[69] T@ pages 14 and 59; Exhibit 1. This was considered unusual as all medicine is usually kept in a designated medicine cupboard. Bhadrayu said that after finding the packets, they assumed she had taken some sleeping pills or painkillers based on the foil packet having some missing tablets; T@ page 57.
[70] Heenal recalled Dr Dixit attended at approximately 4:30-5:00pm; T@ page 14, Bhadrayu recalled he attended at approximately 3:45pm; T@ page 58, Exhibit 3, but conceded he might have been mistaken; T@ page 59.
[71] T@ pages 25-26.
[72] T@ pages 59 and 72.
[73] T@ pages 60 and 68.
[74] T@ page 72.

60. Heenal stated that when she spoke with Dr Dixit during his home visit, he considered that Yamini had taken tablets, was in a deep sleep and should sleep it off. Dr Dixit did not discuss the idea of Yamini going to hospital with her and she was not aware of any such conversation with her father as she went upstairs afterwards.[75] It was Dhruti's understanding following Dr Dixit's attendance that her mother had potentially taken something that was causing her sedation (the specifics of which were not known), and that the plan was to monitor her and hopefully she would wake up when the effects of the medication wore off.[76] Bhadrayu confirmed this was his understanding too.[77] Bhadrayu also noted that Yamini's snoring was not as pronounced when Dr Dixit was examining her, explaining that "*whenever there was the slightest noise or movement around her or you touched (sic) her the snoring would stop*", suggesting that she was just deep in sleep.[78]

61. Bhadrayu was asked whether Dr Dixit suggested that he should call an ambulance at the time of his visit. Bhadrayu responded:

> *He did mention that in such cases if you do call the ambulance that it's better. But these kind of medications are known to have people sleep quite a bit...he said, OK, if we can monitor her and if things change we call the ambulance, we'll go that path rather than distressing everyone and making everyone run around.*[79]

62. Bhadrayu said the decision not to call an ambulance at that stage "*was a joint decision*" made between himself and Dr Dixit.[80] Bhadrayu agreed that he conveyed to Dr Dixit that it did not seem to be an emergency situation.[81]

63. When Bhadrayu was asked whether he discussed with Dr Dixit the possible effects on Yamini in the event that she had taken eight tablets at once, he responded:

> *Yes, her doctor did mention this is a sort of sedative thing and if her vital signs are stable then she can sleep it off.*[82]

64. Heenal's evidence was that after Dr Dixit left, she told her father that she did not think it was normal for her mother to be sleeping for that long, even considering the possibility that she had taken medication. Heenal's evidence was that she suggested that her father call for an ambulance.

---

[75] T@ pages 15-16.
[76] T@ page 43.
[77] T@ page 72.
[78] T@ page 72.
[79] T@ page 60.
[80] T@ pages 60-61.
[81] T@ page 73.
[82] T@ page 68.

Heenal's evidence was that her father responded that Dr Dixit had made a decision, and that he would call an ambulance if anything changed.[83]

65. A discussion took place outside the home between Dr Dixit and Bhadrayu. Dr Dixit stressed the importance of monitoring Yamini carefully and constantly, and advised that if anything were to change, to call for an ambulance.[84]

66. Later that evening Bhadrayu again telephoned Dr Dixit and reported that nothing had changed, that Yamini's vital signs were "*as is*". Dr Dixit confirmed his advice to Bhadrayu to monitor Yamini and to telephone for an ambulance if anything were to change.[85] Bhadrayu watched Yamini overnight.

67. At approximately 6.00am, on Sunday, 11 October 2009, Bhadrayu observed Yamini to stretch her arms and he thought she was waking up.[86] Bhadrayu asked Heenal to take over observations and went to shower. Heenal noticed her mother's face had lost colour and her lips had a purple tinge, and thought it sounded as though she was trying to regurgitate something.[87] Yamini was still positioned supine on the couch. It was at this stage that Heenal thought that her mother was not just sleeping.[88] Heenal told her father that an ambulance should be called.[89] Bhadrayu observed Yamini to be grunting, moaning and her breathing became erratic.[90] An ambulance was called and arrived at approximately 7.30am. Heenal handed paramedics the tramadol and two types of paracetamol packets that had been located.[91]

68. Yamini was taken to the ED at MMC. She was reviewed by Intensive Care Medicine Advanced Trainee Dr David Brewster in the ED at 1:00pm. Dr Brewster found Yamini to be intubated, mechanically ventilated and showing signs of severe brain injury. She was deeply comatose. A Computersied Tomography (CT) scan of her brain was performed as well as a drug screen. The CT scan did not show an obvious cause for her decreased conscious state.[92] A plan was developed, in conjunction with the Intensive Care Unit (**ICU**) Consultant Dr Craig Walker, to perform urgent Magnetic Resonance Imaging (**MRI**) and admit Yamini to the ICU. [93]

---

[83] T@ pages 17 and 63.
[84] T@ page 60, Exhibit 3.
[85] T@ page 64, Exhibit 3.
[86] T@ page 64; Exhibit 3.
[87] T@ pages 17-18.
[88] T@ page 29.
[89] T@ page 18. Bhadrayu describes this as a "*joint decision*" between himself and Heenal; T@ page 65.
[90] T@ page 65.
[91] T@ pages 18 and 65.
[92] Statement of Dr David Brewster, Advanced Trainee for the College of Intensive Care Medicine, MMC, dated 3 August 2010.
[93] Statement of Dr Leeroy Williams, Palliative Medicine Specialist, MMC, dated 5 August 2010.

69. The differential diagnoses at the time were drug overdose, central nervous system infection, brainstem stroke or previous hypoxic or hypoglycaemic event.[94]

70. Yamini was managed to diagnose the underlying cause of her deterioration via blood tests, radiology, toxicology and neurological review. During this time, ICU management continued, in an attempt to optimise her chances of recovery, including intubation and intravenous antibiotics to treat any source of infection.[95]

71. Yamini was reviewed by Dr Andrew Churchyard (**Dr Churchyard**), Consultant Neurologist at 8:40pm on 11 October 2009 following a request from the ICU team.[96] An MRI scan of the brain and circulation to the brain showed diffuse changes consistent with either hypoxia or hypotension. There was no evidence of a cerebral disorder such as stroke, encephalitis, cerebral haemorrhage or trauma which might have accounted for Yamini's deep loss of consciousness. The lumbar puncture result was normal.[97]

72. Dr Churchyard observed Yamini to demonstrate periodic breathing (Cheyne-Stokes),[98] usually indicative of a severe cerebral insult. He also observed extensor posturing both spontaneously and in response to painful stimuli. There was no true voluntary movement, tone was generally increased, the doll eyes reflex (indicative of brain stem insult) was grossly abnormal and her pupils did not react to light. Dr Churchyard formed an impression that Yamini had suffered a severe diffuse cerebral insult.[99]

73. On 12 October 2009, Dr Churchyard reviewed Yamini again[100] and an electroencephalogram (**EEG**) conducted was verbally reported as not suggesting a poor prognosis, however a repeat MRI showed diffuse hypotensive injury.[101] The possible aetiologies included hypotension, asphyxia or hypoglycaemia.[102] A somatosensory evoked potentials and more extensive drug screens were performed.[103]

---

[94] Statement of Dr Craig Walker, Intensive Care Consultant, MMC dated 31 August 2010.
[95] Statement of Dr Leeroy Williams, Palliative Medicine Specialist, MMC, dated 5 August 2010.
[96] Exhibit 11 – Statement of Dr Andrew Churchyard dated 19 June 2012.
[97] Exhibit 11.
[98] Cheyne-Stokes respiration/breathing refers to a period of hyperventilation which has a rhythmicity about it that is irrelevant to the patient's oxygen levels, followed by a period of depressed or no respiration. It is an abnormal breathing pattern indicative of a serious cerebral insult; T@ page 161.
[99] Exhibit 11.
[100] Exhibit 11.
[101] Statement of Dr Leeroy Williams, Palliative Medicine Specialist, MMC, dated 5 August 2010.
[102] Statement of Dr Craig Walker, Intensive Care Consultant, MMC dated 31 August 2010.
[103] Statement of Dr Craig Walker, Intensive Care Consultant, MMC dated 31 August 2010. A urinary drug screen was positive for opioids and benzodiazepines, however Yamini had received these drugs with intubation; Exhibit 11.

74. On 13 October 2009, Yamini developed rapid atrial fibrillation which was controlled with amiodarone.[104] An echocardiograph performed, showed significant underlying cardiac disease.[105]

75. On 15 October 2009, Yamini's family were updated regarding her overall poor prognosis as it was considered to be no likely neurological improvement. A referral was made to the Palliative Care Unit following extubation on 16 October 2009.[106]

76. On 18 October 2009, Yamini was transferred to McCulloch House where she was made comfortable and died at 6:25pm on 20 October 2009.[107]

Medical evidence

77. Dr Burke, in detailing the mechanism of Yamini's death, explained that tramadol and temazepam causes a decrease in the central nervous system, conscious state, breathing and oxygenation. These drugs may also decrease blood pressure, so the brain perfusion decreases,[108] leading to brain cell injury.[109]

78. Dr Burke's evidence was that when a person is placed and left in a supine position, particularly when they are unconscious, it is more likely for their mucous secretions to travel down their airways and into their lungs, which is why the recovery position is used for unconscious people.[110] Although Dr Burke was reluctant to comment on aspects of Yamini's clinical patient care, he commented:

> *...I think it would appear pretty straightforward that she should've had an ambulance take her to hospital.*[111]

79. In his evidence, Dr Gerostamoulos explained that the analysis of someone's hair can reveal a number of things about the person's drug use. If the drug is detected along the length of the hair (the hair is segmentally analysed), it is likely to indicate that someone had used that drug over a period of time.[112] Dr Gerostamoulos noted tramadol was found in all analysed segments of Yamini's hair, indicating that she:

> *was actually using this drug over a period of time, not just – not just the days preceding her death.*[113]

---

[104] Statement of Dr Leeroy Williams, Palliative Medicine Specialist, MMC, dated 5 August 2010.
[105] Exhibit 11.
[106] Statement of Dr Leeroy Williams, Palliative Medicine Specialist, MMC, dated 5 August 2010.
[107] Statement of Dr Leeroy Williams, Palliative Medicine Specialist, MMC, dated 5 August 2010.
[108] The brain received less oxygen, less blood with nutrients.
[109] T@ pages 119-120.
[110] T@ page 117.
[111] T@ page 117.
[112] T@ page 124.
[113] T@ page 124.

80. Dr Gerostamoulos explained that the 14cms of Yamini's hair roughly represented 14 months of hair growth, and that the analysis results suggest that she had been either using or exposed to tramadol over that period.[114] Dr Gerostamoulos stated that temazepam was identified in the first three segments (5cms) closest to the root, indicating more recent use, probably the last five months.[115]

81. Dr Gerostamoulos cautioned that it should be recognised that there are limitations in the interpretation of hair analysis results in terms of post mortem contamination, but highlighted that Yamini's blood results also indicated tramadol and temazepam use.[116] Dr Gerostamoulos explained it is very difficult to determine from hair analysis whether someone has taken a significant, small or therapeutic amount of a drug, and whether they have taken the drug consistently.[117]

82. Dr Gerostamoulos opined that had Yamini taken eight tramadol tablets on the evening of 9 October 2009, it would have been sufficient to render her unconscious. He said that if someone who is naïve to taking tramadol ingests this amount, they would be rendered unconscious and should be treated accordingly.[118] He said that this is still considered an excessive amount for someone who is tolerant to the drug and had been using it over an extended time,[119] unless the person took that amount every day.[120] Dr Gerostamoulos said it was possible that Yamini's sedation could have been due to her ingesting less, perhaps two or three 100mg tablets of tramadol, combined with temazepam.[121]

83. Dr Gerostamoulos explained the effects of tramadol would typically be apparent 15 to 30 minutes following ingestion.[122] He commented that snoring is not atypical for people who consume opioids and has often been associated with an indication that someone is under some form of respiratory distress.[123]

84. Dr Gerostamoulos explained that slow release forms of tramadol have effects sustained over 12 to 24 hours. He considered it possible that Yamini seemingly reacting to noise around her (noted by a

---

[114] T@ pages 124-125.
[115] T@ page 125. Dr Gerostamoulos explained that the presence of codeine and morphine detected is likely indicative of panadeine use. He explained that the presence of ketamine may indicate contamination as a result of post mortem artefact.
[116] T@ page 126.
[117] T@ page 141.
[118] T @ page 128.
[119] T @ pages 128-129. Dr Gerostamoulos noted there was no indication that Yamini was able to tolerate large amounts of tramadol.
[120] T@ pages 135 and 142. Dr Gerostamoulos explained that someone taking a therapeutic dose of tramadol regularly would not easily tolerate eight tablets, and if someone is naïve to the induction of eight tablets, the effect would be more profound. He also said that the hair analysis results suggest that there has been a consistent amount of tramadol taken over that period, and does *not* indicate whether she has taken a large or small amount in that time. He said it is not possible to deduce dose or frequency from hair analysis. It is possible for Yamini to have taken one tablet over a month or two that has shown up in the results. He explained that the hair segment represents some hair that has stopped growing, and some that is growing, and therefore there might be "*a disparity when you actually line up the segments; that some hair hasn't got any Tramadol in it, and the previous segment you do have some Tramadol. So it might be that those represent a tablet or two tablets over a period of two months or three months, and it's shown up positive in the hair*" T@ pages 140-141.
[121] T@ page 145.
[122] T@ page 129.
[123] T@ page 131.

perceptible difference in snoring) could have been due to a slow-release form of the drug not having peaked at that point.[124]

85. Dr Gerostamoulos explained that the peak of the drug occurs a number of hours after ingestion, where the drug continues to be absorbed, and the drug continues to have pharmacological effect. That is, the drug does not just sustain a pharmacological effect for the first hour or so, it sustains it over a longer period of time, and the more drug there is, the longer the period of effect.[125]
86. Dr Gerostamoulos was of the opinion, which he qualified as limited to his toxicology expertise, that it is not a reasonable option to leave someone to sleep off the effects of the drug. Dr Gerostamoulos stated that although there are theoretically viable treatment options available in cases of overdose, he was unable to say in the circumstances whether this would have altered Yamini's outcome.[126]
87. In his evidence, Dr Churchyard commented that assuming Yamini's family heard snoring, he would consider that she was breathing and had not at that stage sustained such severe cerebral damage. However, he qualified this evidence by stating that hyperventilation with Cheyne-Stokes respiration can be quite loud and vigorous.[127] However, he stated that Cheyne-Stokes respiration would not normally be affected by external stimulus such as a noise.[128]
88. Dr Churchyard explained the "*cardinal differences*"[129] between a coma/stupor and a deep sleep is that, in the case of the former, a person will not be rousable.[130] Dr Churchyard was asked what he would expect would happen if a person was subject to a range of stimuli, such as pinching or putting ice on the face and he responded that he would expect a more purposeful response if the person was asleep (depending on depth of sleep and individual rousing). However, he stated that a person in a coma would be expected to remain unconscious, and maybe withdraw without alteration in their conscious state.[131]
89. Dr Churchyard stated that from Yamini's clinical signs, that he had elicited, they were all consistent with "*very, very severe diffuse insult.*"[132] Dr Churchyard's considered opinion was that Yamini had

---

[124] T@ page 139. I note there was no evidence that Yamini ingested a slow-release form of tramadol, and that this amounts to no more than speculation.
[125] T@ page 136.
[126] T@ page 134.
[127] T@ page 155.
[128] T@ pages 161-162. Dr Churchyard explained that whether or not a person responds to a stimulus depends on the depth of their coma or stupor. His presumption was that once the event had occurred sufficient to render Yamini stuporose or comatose, then she would not respond to external stimulus, so he presumes that the insult might have occurred after that, however noted it is very difficult to be confident about this in retrospect; T@ page 162.
[129] T@ page 162.
[130] T@ page 162. Dr Churchyard explained that someone with a severe cerebral insult can develop extensor spasming, which is considered a manifestation of severe brain damage, and could be misinterpreted as purposive movement, which it is not, and indicates severe cerebral damage, that the lower brainstem reflexes being left disinhibited; T, page 163.
[131] T@ page 164.
[132] T@ page 157.

already sustained the cerebral insult when he reviewed her in hospital on 11 October 2009.[133] However, he could not say when she sustained the insult, but believed she could have sustained it at any time she was obtunded.[134]

90. Dr Churchyard's presumption was, without being confident, that Yamini must have sustained the hypoxic insult at least 24 hours or more prior to his review of her.[135] He explained that there is a delay between the cerebral insult and some signs becoming apparent. With reference to MRI scans, Dr Churchyard said that it is his clinical practice to order an MRI between 24 and 36 hours after the event when the cerebral insult is likely to be more apparent radiologically.[136]

91. Dr Churchyard explained that in his experience, the pupillary reflexes deteriorate very rapidly and are a sensitive indicator of cerebral insult, and that it would need to be a significant cerebral insult to interfere with pupillary reflexes. He stated that the cerebral insult must have occurred prior to Yamini's pupillary reflexes becoming affected.[137]

92. Dr Churchyard opined that there is no minor causes of an individual's unconsciousness, and his general practice would be recommending that the patient is fully investigated, and potentially admitted to hospital.[138]

93. Although Dr Churchyard was not prepared to comment on the treatment of overdose, he stated that conventional practice in situations of overdose would be that the patient's cardiac and respiratory status would be monitored to prevent the patient from becoming hypoxic, and appropriately treated "*...and hopefully the medication would eventually be cleared, and they would recover*".[139]

94. Associate Professor Morton Rawlin (**A/Prof Rawlin**),[140] gave expert evidence that a patient with unconsciousness of undetermined cause is a medical emergency, and that family members who are not medically trained are not equipped to either assess or look after an unconscious patient. He said

---

[133] T@ page 158.
[134] T@ page 159. Note: Obtunded means having diminished arousal and awareness.
[135] T @ page 159.
[136] T@pages 164 - 165. Dr Churchyard later said "*...my favourite time is about 36 hours or to 48 hours.*" He explained that he is in these circumstances almost always confident (but occasionally not) that a cerebral insult would be seen on MRI at this time, but would always also rely on a clinical examination and an EEG.
[137] T@ page 160. Dr Churchyard was then asked if Yamini's eye had been examined with a torch and reacted accordingly, does that mean that the insult has not yet occurred. Dr Churchyard responded "*I think the insult could – might have occurred potentially, depending on the gap between the insult, its severity and – when the patient was examined. So there has – there would be some delay between the two.*" He agreed that this meant that even though the eyes might present as reactive, that does not necessarily mean that the insult has not already occurred; T @ pages 160-161.
[138] T@ page 159.
[139] T@ pages 165-166.
[140] General Practitioner and (then) Chair of the Victorian Faculty of the Royal Australian College of General Practitioners (**RACGP**), Chair of the RACGP Faculty of Specific Interests and member of the national RACGP Council.

that the transfer of Yamini to an appropriate facility to assess and manage her was paramount, and the longer the delay, the likely poorer outcome.[141]

95. A/Prof Rawlin noted a further concern regarding the discrepancy in the tablet numbers and the possibility of an overdose of prescription medication(s) obtained from another general practitioner (**GP**). A/Prof Rawlin commented this may have indicated intent to harm, and to keep this from Yamini's regular GP who was known both professionally and socially to her family.[142]
96. A/Prof Rawlin commented that overall, he considered that Dr Dixit should have attended earlier and intervened much earlier. He noted that the first call to Dr Dixit was at least 14 hours after Yamini became unconscious, which he said is "*serious and concerning for prognosis.*" A/Prof Rawlin considered that if Dr Dixit was unable to attend, an assessment by trained medical personnel, such as ambulance officers, would have been warranted.[143]
97. A/Prof Rawlin stated that it was unclear whether Yamini's death would have been prevented if intervention had occurred at 1:45pm on 10 October 2009, as it was possible that the brain damage sustained had already occurred. However, he noted that it was at that point that the best outcome may have been achieved, had Yamini been appropriately treated in an ICU setting.[144]
98. A/Prof Rawlin stated telephone advice is appropriate when followed up with clinical assessment in serious situations such as this. He said that in the absence of a comfortable and clear diagnosis, clinical assessment is appropriate and necessary.[145]
99. A/Prof Rawlin said that if Dr Dixit planned to assess Yamini personally, as a matter of urgency, it would be appropriate not to be preceded by an ambulance, but as the hours passed before the assessment, he considered Dr Dixit's actions were not appropriate. [146] He further said that in the context of Yamini's prolonged episode of unconsciousness, with no definitive cause, it was inappropriate not to transfer her to hospital.[147]
100. A/Prof Rawlin considered that at the time of Dr Dixit's home visit, when Yamini had [presumably] been unconscious for 18 hours, and was still unrousable, the appropriate approach would have been to send her to hospital for expert care. A/Prof Rawlin noted that snoring is a sign of probable, if not

[141] Exhibit 12 – Statement of A/Prof Rawlin dated 20 April 2011.
[142] Exhibit 12 - Statement of A/ Prof Rawlin dated 20 April 2011.
[143] Exhibit 12.
[144] Exhibit 12.
[145] Exhibit 12.
[146] Exhibit 12.
[147] Exhibit 12.

definite, airway obstruction and therefore the possibility of obstruction and oxygen deprivation were likely. He opined that non-trained family members cannot manage airway issues at home.[148]

101. A/Prof Rawlin commented that when Dr Dixit was telephoned at 10:00pm on 10 October 2009, Yamini was still unconscious. Approximately 24 hours had elapsed since Yamini had been found and there was no improvement in her condition. A/Prof Rawlin said Yamini should have been in hospital, and that Dr Dixit should have either organised immediate ambulance transfer or have attended in person to assess her and then sent her to hospital. A/Prof Rawlin stated that it was his belief that Yamini received substandard care.[149]

102. A/Prof Rawlin expressed concern regarding comments about longstanding family violence, including physical and emotional abuse, allegedly, suffered by Yamini and the reaction of Dr Dixit.

103. A/Prof Rawlin commented that this may have been a root cause in this matter. He noted services available to assist in these situations. He further noted clear signs of mental distress in Yamini's case that appear to have been missed by her family, and possibly by Dr Dixit, but could not comment further without review of Dr Dixit's medical notes.[150]

104. A/Prof Rawlin referred to the guidelines relating to medical practitioners treating family and friends. He agreed that if you can avoid treating friends you should do so but acknowledged that this was not always possible or practical. He stated:

> *..you should make sure that you are very conscious that they do get the best standard of care and you don't make assumptions because you know them as a friend.*[151]

105. A/Prof Rawlin commented that the outcome for Yamini may not have been different as irreversible damage may have occurred in those first few hours before Yamini's family recognised abnormalities. However, A/Prof Rawlin maintained that the care Yamini received from Dr Dixit "*did not meet the acceptable standard that would be normally expected in a case such as this*".[152]

Whether Yamini deliberately ingested the medication with an intention to either harm herself or render herself unconscious

106. Heenal's evidence was that Yamini had spoken about wanting to harm herself or take her own life, however only "*in the heat of an argument with my dad...*"[153] Heenal did not, however, expect for

---

[148] Exhibit 12.
[149] Exhibit 12 - Statement of Associate Professor Morton Rawlin dated 20 April 2011.
[150] Exhibit 12.
[151] T @ page 168, 169-.
[152] Exhibit 12.
[153] T@ pages 26-27, 29.

her mother to actually take her own life, and rather thought that if she had taken painkillers "*then it would just be to scare everyone. I mean, she thought that no one cared about her.*"[154] Heenal confirmed that, to her knowledge, Yamini had not attempted to take her own life before.[155] Heenal stated that she was not aware of any other occasion when her mother took any medication that put her in a sedated state.[156]

107. Dhruti's evidence was that she did not know her mother to have any mental health issues, and when her parents were not fighting, her mother was "*quite a jolly person*".[157] Dhruti stated that her mother had threatened to harm herself or take her own life in the heat of an argument[158] but she had not said anything like this to her in the week leading up to the incident.[159]

108. Bhadrayu's evidence was that he had no knowledge of Yamini ever having suffered mental health issues,[160] and that his wife had "*not precisely*"[161] made comments about hurting herself or taking her own life in the heat of the moment, "*...not to the extent that you would get – start getting worried*".[162] Bhadrayu confirmed that he did not take any such comments seriously. He said that there was nothing that he detected in his wife's mood or demeanour that suggested to him that she may have deliberately taken an overdose of medication. He said that when Dr Dixit attended his home and suggested that Yamini had probably overdosed, causing her sedation, he did not question this, however noted "*nothing suggested to us that they [the eight missing tablets] were all taken at the same time...at least I assumed...that she may have taken a few of those*".[163]

109. Bhadrayu said Yamini did not have a history of taking an excessive amount of tablets.[164] He said normally if she was agitated, she would call her daughters or some friends, however he checked her phone and there were no recorded calls.[165]

---

[154] T@ page 27. Heenal confirmed her mother had expressed to her that she thought nobody cared in the week prior to the event, however it was not the first time she had conveyed this.
[155] T@ page 29.
[156] T, page 27.
[157] T@ page 40.
[158] T@ page 40.
[159] T@ page 41.
[160] T@ page 66.
[161] T@ page 68.
[162] T@ page 68
[163] T@ page 68. Bhadrayu stated that Yamini had not said directly to him that she was going to take her own life.
[164] T@ page 76.
[165] T@ page 77.

The source of the medication taken by Yamini

110. Heenal and Bhadrayu's evidence was that the location of the medication packets was unusual, as the family normally stored medicines in a central medicine cabinet.[166] Heenal said that, to her knowledge, her mother did not keep separate medication.[167] Heenal considered it possible that Yamini had used sleeping tablets/sedatives in the past, but had no specific knowledge of it.[168] Heenal recalled her mother was not particularly careful about taking her prescription medication, and tended to take medication "*as she saw fit*".[169] Dhruti confirmed that her mother was not routinely compliant with taking her blood pressure medication, and because her mother had her medication endorsement professionally, "*...we'd just sort of assume that she knew what she was kind of doing*".[170] Bhadrayu stated his wife was not very careful and "*very erratic in taking drugs*"[171], however he had never seen her take someone else's medication, and did not observe her to ever bring home medication from her work.[172] Bhadrayu recalled his wife taking painkillers, but had never observed her taking sleeping tablets.[173]

111. Heenal and Dhruti were not aware of where Yamini might have sourced the medications. They were also not aware of their father having brought back medication from India.[174] Bhadrayu agreed that on occasion, he brought back medications prescribed to him to treat high cholesterol from India, and that sometimes during their visits Yamini "*would buy some painkillers or something from India*".[175] He conceded it was possible that she purchased tramadol in India, but he had no specific knowledge of it.[176] He recalled the last time he travelled to India was approximately one year before Yamini died.[177]

112. Ms Carter's evidence was that tramadol at Cumberland is dispensed from the pharmacy in the Webster sealed plastic pockets, not in the original foil blister packs.[178]

---

[166] T@ pages 19 and 57.
[167] T@ page 19, although Heenal said "*...if she had something stronger she might have...or maybe her blood pressure ones somewhere where they're accessible for her, but we kept all of our painkillers in the medicine cupboard.*"
[168] T@ pages 14-15. Heenal explained that Yamini had sleeping issues over the past few years, including sleep apnoea.
[169] T@ page 15.
[170] T@ page 41.
[171] T@ page 57.
[172] T@ pages 57-58.
[173] T@ page 66. Bhadrayu explained further that she was always in some sort of muscular pain due the nature of her work; T@ page 66, for which she would take (to his knowledge) panadol or panadeine. He was not aware of her taking anything stronger. He had never heard of tramadol and was surprised to have found it; T@ pages 75-76.
[174] T@ pages 19 and 41-42.
[175] T@ page 67.
[176] T@ pages 67 and 75.
[177] T@ pages 74-75.
[178] T@ page 102.

113. Evidence obtained through S/S Brumby was that Dhruti had not been prescribed with tramadol due to a surgical procedure that had occurred the week prior to her mother's death. Dhruti conveyed to S/S Brumby that she had been prescribed a different analgesic medication.[179]

114. A Medicare and Pharmaceutical Benefits Scheme (**PBS**) search for Yamini determined that she consulted with Dr Dixit predominantly in the year prior to her death. There were two other doctor visits, which S/S Brumby explained were related to another doctor at the same clinic that Dr Dixit practised medicine and also an eye specialist. The PBS check did not reveal any pharmaceutical benefits for Yamini for the period of 20 October 2008 to 20 October 2009.[180]

Whether Yamini's relationship with her husband potentially influenced her in taking the medication

115. Heenal's evidence was that her mother and father had been arguing for the week prior to 9 October 2009 about *"...difficulties between both of them and not being happy with the relationship."*[181] Heenal recalled that it was *"...pretty much how a normal fight would go down, last about a week"*.[182] According to Heenal, these fights would occur approximately monthly.[183] Dhruti said their parents' relationship had been like that for as long as she could remember,[184] and believed her mother thought her father paid attention to everyone in the house except to her.[185] Bhadrayu confirmed this was the subject of the argument.[186]

116. Heenal stated that the fights between her parents would "*sometimes*" become physically abusive between her mother and father, with both parents becoming physical. She stated that these fights would not get very serious, because she and her siblings, would physically intervene.[187] Dhruti also confirmed witnessing these physical encounters, but said she did not see anything of this nature in the week prior to the event.[188] Heenal and Dhruti recalled their mother received a soft tissue injury as a result of one of these fights.[189] Heenal and Dhruti confirmed that the children had suggested that their parents should separate.[190]

---

[179] T@ page 151.
[180] T@ pages 151-152. S/S Brumby noted this unusual result, in the context of Yamini having been prescribed medication to treat hypertension.
[181] T@ page 9, confirmed by Dhruti, T, page 32.
[182] T@ page 10.
[183] T@ page 10.
[184] T@ page 33.
[185] Exhibit 2 – Statement of Dhruti Patel dated 10 November 2011.
[186] T@ page 50.
[187] T@ page 10.
[188] T@ page 32.
[189] T@ pages 11 and 32.
[190] T@ pages 9-10 and 34.

117. Ms Carter's evidence was that Yamini had previously told her about verbal and physical abuse she alleged she had suffered at the hands of her husband. Ms Carter stated Yamini had told her on two or three occasions and that she recalled seeing a mark on Yamini's neck that she said was a result of the physical violence.[191] Ms Carter's evidence was that she advised Yamini to report these issues to police. Yamini responded that it would bring shame to the family and was not something she was prepared to do.[192]

118. Ms Carter said she met with Yamini on 8 October 2009. Yamini told Ms Carter that she was going to inform her husband that she wanted a divorce and was flagging the issue with Ms Carter in case there was any upheaval that affected her job. Ms Carter offered her support and ensured Yamini had adequate supports in place.[193] Ms Carter's evidence was that Yamini appeared as though it had taken her some time to come to this decision. Yamini told her that it was a difficult decision for her to make as she was concerned there might be issues with her children not being able to live with her and it would be financially difficult.[194] Ms Carter said that Yamini had never indicated to her that she might harm herself.[195]

119. Bhadrayu said in evidence that his wife had mentioned separation/divorce "*in the heat of the moment*"[196], but had not mentioned it in the week prior to the incident. He was not aware that his wife had any intention to ask him for a divorce and was surprised to learn of Ms Carter's evidence they had discussed the matter, as it was his understanding that family arguments stayed within the family unit.[197]

---

[191] T@ page 98.
[192] T@ page 102.
[193] T@ page 98.
[194] T@ pages 99-100.
[195] T@ page 100.
[196] T@ page 67.
[197] T@ pages 52-53. Bhadrayu later noted that "*...Yamini was the first to run to Dr Dixit whenever she had an argument...to get her blood pressure tested...So she would confide in him*"; T@ pages 61-62.

COMMENTS

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

120. In the course of any coronial investigation it is appropriate to acknowledge the reflection of behaviours/actions that individuals and entities have done in response to their involvement in the circumstances surrounding a reportable death.

121. In some instances these amount to restorative and preventative measures. Accordingly, I acknowledge the reflections of Dr Dixit made through his Counsel, Mr Cash that:

> *Dr Dixit understands and accepts the criticism of his medical management of Mrs Patel contained in the report of Associate Professor Rawlins (sic). And (sic) in retrospect he recognises in particular that it would seem that his judgement and conduct was affected by virtue of the close proximity of his relationship with the Patels. And he regrets that that's interfered with his judgement and would like to convey to the court that he has in fact taken steps to ensure that none of his patients are in a similar situation.*[198]

122. I also note that on 9 June 2015 the Victorian Civil and Administrate Tribunal (VCAT), having been provided with a copy of Dr Rawlin's expert medical opinion, provided Orders and Reasons in the decision of *Medical Board of Australia v Dixit [2015] VCAT 809*. Dr Dixit was reprimanded and conditions attached to his registration following findings that he had engaged in professional misconduct and unprofessional conduct within the meaning of the *Health Professions Registrations Act 2005*(Vic) in respect of matters associated with his care of Yamini prior to her death.

123. I accept the medical evidence given by A/Prof Rawlin, Dr Burke, Dr Gerostamoulos and Dr Churchyard. Recognising that it is not the role of the coroner to determine civil proceedings or disciplinary matters, I consider that Dr Dixit's professional care fell well short of what is acceptable and optimal medical care, in the circumstances.

124. The difficult decision I am required to make in this matter is whether Yamini's death represents an accidental or non-accidental prescription medication overdose death. That is, was Yamini's death as a result of suicide?

125. I have considered a number of aspects of the evidence in forming a view. It should be said at the outset there is no definitive evidence bearing on this difficult issue. A finding of suicide can attach

---

[198] T @ page 187.

a stigma and reverberate throughout a family for generations, it can impact upon both the memory of Yamini and her surviving family and friends.

126. Such a finding, in my opinion must only be made upon clear and cogent persuasive proofs, not upon indirect inferences and inexact proofs. To make such a finding a comfortable degree of satisfaction must be reached, the test expounded in *Briginshaw v Briginshaw*[199] must be applied.

127. My coronial investigation has identified there are inferences open to be drawn which support both a finding of intentional and non-intentional/accidental death. The question is "am I comfortably satisfied with a finding of suicide?" I am not.

128. On the evidence, I am unable to say whether Yamini intentionally took her own life, or whether her untimely death represents an accidental overdose of tramadol and temazepam.

129. My investigation did not identify any clear and direct evidence which, to the *Briginshaw* standard, that I could find Yamini intended to take her own life.

130. The weight of the evidence was that Yamini was unhappy when the family went out without her, that she was unhappy in her marriage and that she was intending to seek a divorce. These facts individually and in combination do not meet the required threshold to make a finding of suicide.

131. I note that Yamini's nursing training provided her with a greater knowledge, than members of the general public would have, about the effects of certain medications. However, when attaching weight to the evidence, it is important to balance the fact that no 'suicide note' was located. In addition, there is no known history of suicidal ideation or self-harm albeit that her daughters gave evidence that she had made a reference to ending her life from time to time in the heat of the moment, during arguments with their father.

132. Although exhaustive enquiries failed to determine the source of the tramadol and temazepam taken by Yamini, the results of the ante mortem blood sample indicates that she took both drugs for prolonged period. I am satisfied that Yamini intentionally took these medications at a dose in excess of the therapeutic amount, likely on Friday 9 October 2009. I am also satisfied on the totality of the evidence that Yamini's ingestion of tramadol and temazepam, likely on 9 October 2009, has played a causative role in her death. However, these factors alone do not satisfy me to the requisite standard that she intended to take her own life.

---

[199] (1938) 60 CLR 336

133. I must also turn my mind to whether Yamini's death could have been prevented. I consider that the relationship between Dr Dixit and Bhadrayu played a part in Dr Dixit being influenced not to override the wishes of Bhadrayu to keep his wife at home rather than calling for an ambulance. He said that it is a very hard conversation to have with friends when you, as the doctor think "*no, look, you just can't do what you really want to do here*".[200] Yamini's situation; a patient that could not be roused, warranted this hard conversation and A/Prof Rawlin agreed with Mr Cash of Counsel that Dr Dixit was guilty of not having had it with Bhadrayu.

134. Again, such a finding that Yamini's death could have been prevented must only be made upon clear and cogent persuasive proofs, not upon indirect inferences and inexact proofs. To make such a finding a comfortable degree of satisfaction must be reached, the test expounded in *Briginshaw v Briginshaw* must be applied. A/Prof Rawlin's evidence that it was unclear whether Yamini's death would have been prevented if intervention had occurred at 1:45pm on 10 October 2009 is germane to this issue. I am not satisfied on the medical evidence that it is clear Yamini's death could have been preventable, however, the failure to ensure she received earlier medical attention was a lost opportunity to intervene and possibly change the fatal outcome.

135. I make no adverse comments about the care Yamini received while she was a patient at Monash Health.

FINDINGS

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

136. I find that the identity of the deceased was Yamini Bhadrayu Patel, born on 19 October 1961 and her death occurred on 20 October 2009 at Monash Medical Centre in Clayton.

137. I accept, and adopt, the conclusions of Dr Burke and I find that Yamini Bhadrayu Patel's death was due to ischaemic brain injury arising from toxicity to tramadol and temazepam.

138. I am not, however, able to find on the evidence, that Yamini intended to take her own life or whether her death was the unintentional consequence of her intentional ingestion of medication to excess and which she was not known to have been prescribed.

[200] T @ page 178.

139. I find that Yamini was denied the opportunity to receive potentially life-saving medical attention in a timely manner because her family and Dr Dixit did not adequately differentiate between Yamini's normal sleeping patterns and a medical emergency.

140. I am not able to make any findings on what, if any, role the relationship between Yamini and her husband played in influencing the behaviour of inaction by Bhadrayu and his children. The relationship between Yamini and Bhadrayu was described as not a particularly happy one and there was evidence of physical altercations between them. However, it is not apparent on the available evidence that this history of family violence between the two was in any way causative to Yamini's death.

141. I find that Dr Dixit, by virtue of his profession, his medical training and clinical practice, was equipped with the knowledge and authority to initiate contact with the ambulance service and arrange for Yamini's urgent transfer to hospital from as early as 1:45pm on 10 October 2009 when he first received a telephone call from Bhadrayu. At the time of this telephone call approximately 14 hours had already elapsed since Yamini had been located in a "*deep sleep*" and most probably unconscious. None of the Patel family were medically trained so their failure to differentiate Yamini's normal sleeping patterns from her behaviour from 9 October 2009 is more readily understood in the context of the decision by Bhadrayu to contact their family friend and family GP, Dr Dixit. However, Dr Dixit's failure to separate his professional standing from his personal relationship with the Patel family denied Yamini the most basic standard of care that the ordinary person in Victoria can and should be able to expect of a registered medical practitioner.

142. I concur with the opinion expressed by A/Prof Rawlin[201] and I find that Dr Dixit's care of Yamini was substandard.

RECOMMENDATION

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

1. That the Royal Australian College of General Practitioners use the circumstances of Yamini's death and in particular, how Dr Dixit's relationship with the Patel family influenced his clinical decision making about Yamini, as part of its 'conflict of interest' training to general practitioners.

[201] Expert Opinion Report of A/Prof Rawlin dated 20 April 2011.

Pursuant to section 73(1) of the *Coroners Act 2008*, I order that this Finding be published on the internet.

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

- The Patel family.
- Monash Health.
- TressCox Lawyers on behalf of Dr Dixit.
- Australian Health Practitioner Regulation Agency (Medical Practitioners Board of Victoria).
- Dr Michael Burke.
- Dr Dimitri Gerostamoulos.
- Associate Professor Morton Rawlin
- Royal Australian College of General Practitioners

Signature:

AUDREY JAMIESON, CORONER

29 February 2016