IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: **COR 2016 1929**

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	**MR JOHN OLLE, CORONER**
Deceased:	**ANTONIO D'AUGELLO**
Date of birth:	**4 JANUARY 1953**
Date of death:	**30 APRIL 2016**
Cause of death:	**DROWNING**
Place of death:	**262 GODDARD ROAD KYABRAM VICTORIA 3620**

HIS HONOUR:

BACKGROUND

1. Antonio (Tony) D'Augello was born on 4 January 1953. He was 63 years old at the time of his death. Tony lived with his father at Kyabram.

2. Tony had a normal developmental history but following a car accident he sustained an acquired brain injury and was later diagnosed with schizophrenia. He was admitted to hospital as a compulsory patient three times in the 1990s and to the Alexander Bayne Centre (ABC) in Bendigo between 2002 and 2003. Tony was case managed by the Echuca Community Mental Health Team (ECMHT), stabilized and was discharged to his general practitioner's care in 2005. Tony experienced a deterioration in mental state in 2014 from which he stabilised and was case managed by the Bendigo Adult Community Mental Health Team (BACMHT). Tony remained stable on the antipsychotic olanzapine[1] 20mg at night until March 2016, when he was noted to be deteriorating after he had ceased his antipsychotic medications, which was the treatment plan.

3. According to the information available Tony was physically unwell with reports of falls and collapses in the four weeks prior to his death.[2]

4. Tony's brother Dominic D'Augello stated that Tony was unable to swim.

5. **THE PURPOSE OF A CORONIAL INVESTIGATION**

6. Tony's death constituted a '*reportable death*' under the *Coroners Act 2008* (Vic), as his death occurred in Victoria, and was both unexpected and unnatural.[3]

7. The jurisdiction of the Coroners Court of Victoria is inquisitorial[4]. The purpose of a coronial investigation is independently to 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.

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[1] Olanzapine is a second-generation antipsychotic indicated in the treatment of schizophrenia and related disorders, and bipolar disorder.
[2] Coronial Brief of Evidence pages 2, 5, 8 and 20.
[3] Section 4, definition of 'Reportable death', *Coroners Act 2008.*
[4] Section 89(4) *Coroners Act 2008.*

8. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[5] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation, or to determine disciplinary matters.

9. The "cause of death" refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

10. For coronial purposes, the circumstances in which death occurred refers to the context or background and surrounding circumstances of the death. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the death, it is confined to those circumstances which are sufficiently proximate and causally relevant to the death.

11. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners. This is generally referred to as the 'prevention' role.

12. Coroners are also empowered:

    (a) to report to the Attorney-General on a death;

    (b) to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and

    (c) 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. These powers are the vehicles by which the prevention role may be advanced.

13. All coronial findings must be made based on proof of relevant facts on the balance of probabilities. In determining these matters, I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[6] The effect of this and similar 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.

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[5] *Keown v Khan* (1999) 1 VR 69.

[6] (1938) 60 CLR 336.

MATTERS IN WHICH THE CORONER MUST, IF POSSIBLE, MAKE A FINDING

Identity of the Deceased pursuant to section 67(1)(a) of the *Coroners Act 2008*

14. Antonio D'Augello was visually identified by his brother Angelo D'Augello on 30 April 2016. Identity was not in issue and required no further investigation.

Medical cause of death pursuant to section 67(1)(b) of the *Coroners Act 2008*

15. On 4 May 2016, Dr Jia Hao Wu, Forensic Pathology Registrar supervised by Dr Victoria Francis Forensic Pathologist at the Victorian Institute of Forensic Medicine, conducted an examination on Tony's body and provided written report dated 6 July 2016, concluding a reasonable cause of death to be "I(a) Drowning". I accept his opinion in relation to the cause of death.

16. Toxicological analysis of post mortem specimens detected olanzapine[7] (~0.03 mg/L).

17. Dr Wu noted there is no specific autopsy finding for drowning. Drowning is a diagnosis which relies heavily on circumstantial evidence. Post mortem examination showed a plume of white froth at the mouth and nose at autopsy. The lungs were congested and oedematous. These findings can be seen in drowning. The hands were pale, sodden and wrinkled suggestive of immersion of the body in water. There was no identifiable significant natural disease at autopsy that would cause or contribute to the cause of death.

18. Dr Wu commented that according to the medical literature, schizophrenia and olanzapine use are associated with higher risk of sudden, unexpected, cardiac death. Although autopsy showed mild coronary artery atherosclerosis with no acute myocardial infarction, the possibility of a cardiac event precipitating the drowning cannot be excluded.

19. There was no post mortem evidence of any traumatic injuries which may have caused or contributed to death.

Circumstances in which the death occurred pursuant to section 67(1)(c) of the *Coroners Act 2008*

20. From 31 March 2016, Tony and Dominic told BACMHT that Tony was struggling with his mental health. BACMHT made regular contact including several home visits, the last on 27

[7] Olanzapine is indicated for the treatment of schizophrenia and related psychoses. It can also be used for mood stabilization and as an anti-manic drug.

April 2016 by case manager, at which time Tony's mental state was confirmed as having deteriorated. Tony was suspicious, guarded, had some thought blocking and was vague. He was told to restart the medication he had stopped to improve his sleeping, thoughts and to avoid going to hospital.[8]

21. BACMHT received four telephone calls from Tony's brother on 12, 26, 28 and 29 April 2016. These further outlined the family's concerns about Tony's behaviours, disturbed sleep patterns, and his continued refusal to take any antipsychotic medications.

22. Tony was taken from home by Ambulance Victoria to Goulburn Valley (**GV**) Health Shepparton Hospital emergency department (**ED**) on 28 April 2016 after he reportedly collapsed at home. Dominic contacted Bendigo Health psychiatric triage and was advised to call an ambulance. Tony subsequently cancelled the ambulance and it was reissued after Dominic contacted Ambulance Victoria a second time. BACMHT was aware of Tony's transfer to GV Health Shepparton Hospital ED at 9.30am.[9]

23. Tony was assessed by GV Health ED medical staff. Tony was conscious and orientated but with auditory hallucinations and persecutory delusions.[10] He was assessed as medically stable. Tony was assigned a diagnosis of "relapse of schizophrenia to R/O seizure disorder."[11]

24. Tony was assessed by GV Health mental health Acute Response Team (**ART**) clinicians and was documented as dishevelled, with limited insight and judgement, with psychotic features in the context of ceasing his medications some four weeks prior.[12] These included (1) four weeks of experiencing voices by a female who asked him questions and to which he responded, (2) that people were listening to the conversation and he did not want to disclose any information because of it, (3) he was cooperative but appeared to be responding to internal stimuli and (4) that his mother had to die, that he was being tested and people were after his father.[13] He was assigned a diagnosis of psychosis not otherwise specified (NOS) by the ART clinicians.[14] ART also included in the letter to Tony's general practitioner (GP)

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8 Bendigo Health medical records Clinical Contact Record (Community) [Casp5a] dated 27 April 2014
9 Bendigo Health medical record entry by Peter Coleman dated 28 April 2016.
10 GV Health medical records ED5 dated 28 April 2016.
11 This is an unclear classification/diagnosis - query means "rule out" in this context.
12 GV Health medical records ED5 dated 28 April 2016.
13 GV Health medical records, Assessment Details 28 April 2016 pages 1 – 3 and ED Mental Health Assessment dated 28 April 2016.
14 International Classification of Diseases – applicable to psychosis NOS – is an unspecified psychosis not due to a substance or known physiological condition.

on 29 April 2016, that Tony had ongoing psychotic symptoms with auditory disturbances. Tony had consistently stated he would not take any medications at GV Health ED.[15]

25. The ART clinicians discussed Tony's presentation with the Psychiatric Registrar who advised Tony to recommence 10mg olanzapine, be provided with psychoeducation, for GV Health ART to contact Bendigo Health regarding further management and to discharge him home after he was medically cleared. GV Health believes the Psychiatric Registrar also gave a telephone order for a stat dose of olanzapine 10mg.[16]

26. Tony was picked up from the ED by his sister Carmel Kellow and her partner John La Porta after Dominic was contacted and asked to provide transport home. According to John, he told staff Tony should not be going home, and was told they could find nothing wrong with him.[17]

27. Tony was discharged home with a script for olanzapine and was, according to John, "made" to take two tablets before he left ED. He was told the tablets would keep Tony calm until he filled the prescription however John stated he was not aware of what the medication was or what the prescription was for. According to ED nurse, Tony had at the time of discharge refused the olanzapine.[18] The complete GV Health treatment plan was for Tony to take the olanzapine as directed, for him to arrange to see GP and BACMHT to follow up with Tony.

28. BACMHT were aware of Tony's discharge from GV Health ED at 5.00pm on the day of discharge after Dominic contacted BACMHT to express his and the family's concerns regards Tony returning home. The recorded treatment plan by BACMHT was for BACMHT and the family to monitor Tony, encourage compliance with olanzapine and for the family to contact psychiatric triage when needed.[19] BACMHT would make daily contact.

29. According to John, after leaving the ED Tony's behaviour was strange and he refused assistance to fill the prescription for olanzapine. Tony's family state he slept on the night of 28 April 2016 after leaving GV Health. Correspondence from the ART clinician and ED was sent to Tony's GP, including the assessment faxed to the Bendigo Health triage service on the morning of 29 April 2016.

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[15] GV Health medical records assessment details dated 28 April 2016.

[16] GV Health medical records and Dr Phutane's correspondence with the Chief Psychiatrist dated 22 and 25 August 2018.
Telephone conversation by Associate Professor Dr R Bhat on 12 December 2018, who clarified the content of the statement dated 6 November 2018 in which he stated the medication chart order for olanzapine was administered. Dr Bhat believes this order was not administered, however a telephone order by Dr Levitan was administered but not documented as either prescribed or administrated.

[17] Coronial brief of evidence page 5.

[18] The progress notes written by nurse Dempster states Tony refused to take the olanzapine wafer in ED and the stat order on the medication chart is unsigned as ever having been administrated. Goulburn Valley Health Medical Records.

[19] Bendigo Health medical record entry by Peter Coleman dated 28 April 2016.

30. On Friday 29 April 2016 BACMHT was unsuccessful in contacting Tony by telephone and Tony refused to speak with the BACMHT occupational therapist, who was made aware by family that Tony was confused and disorientated, had stayed in a chair in front of the television all night and refused all medications on Friday 29 April 2016. Dominic contacted BACMHT at 5.10pm the same day and it appears BACMHT expected to liaise with Dominic the following day and to possibly admit Tony if he was "still presenting with acute psychotic symptoms and non-compliance."[20] The plan also includes an arrangement for a "HV [home visit] ASAP on LC return Tuesday," some four days later and that there was a low threshold for admission if Tony continued his non-compliance.[21]

31. At approximately 10.00 am on 30 April 2016, John and Carmel visited Luigi and had a coffee. Carmel went to Tony's end of the house and he was not there. Luigi told them that he had seen Tony earlier sitting in chair. Everyone began searching for Tony. John found Tony face down in the irrigation channel just near the driveway entrance to the house. Emergency Services were called. Angelo dragged Tony out of the water.

32. Police and Ambulance Paramedics arrived shortly afterwards. Tony was declared deceased at the scene.

Investigation into Mental Health Care

Care provided by Bendigo Health

33. Bendigo Health and treating psychiatrist Dr John Cooper stated the treatment plan for Tony in the weeks since 31 March 2016 was for community monitoring and encouragement to Tony to take the antipsychotic medication.

34. According to Dr Cooper, the threshold for compulsory treatment of Tony had not been reached and the reported collapse on 28 April 2016 was the trigger to have any underlying medical problems assessed and excluded, as opposed to any risks associated with the deterioration in Tony's mental state and associated behaviours.[22] Dominic stated he believed after Tony's death that BACMHT was planning at this stage to organise an inpatient bed for Tony and he was to be transported via ambulance on that day.[23] The BACMHT case manager supports the intent to arrange an admission however the records in the medical

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[20] Coronial Brief of Evidence page 5.
[21] Coronial Brief of Evidence page 5.
[22] Statement of Dr John Cooper dated 10 October 2018.
[23] Coronial Brief of Evidence page 1.

records of this intent are all dated after Tony's death and related to communication to support Dominic.[24]

35. The least restrictive approach to the use of the *Mental Health Act 2014* (Vic) does not exclude it's use where there is ongoing deterioration in circumstances where encouragement alone has been unsuccessful in commencing and sustaining the identified treatment with an antipsychotic medication, especially in a man known to be recently deteriorating and who had a history of compulsory treatment and associated risks to his family. Tony was repeatedly documented as psychotic and poorly if at all engaged in treatment over many weeks and was last assessed or reviewed by a consultant psychiatrist or psychiatric registrar on 8 December 2015.

36. There is no evidence that Tony's deteriorated mental state, psychotic presentation, sustained non-compliance with his only treatment, antipsychotic medications, and repeated family contacts with their increasing concerns, escalated to a consultant psychiatrist by BACMHT between 28 and 30 April 2016.

37. ART escalated the ED assessment to another Psychiatrist who did not see Tony and did not know the details of his recent deterioration in mental state, details of BACMHT monitoring and details of increasing family concerns.

38. The BACMHT decision to treat Tony in the community was reliant on the involvement of his family who were expected by BACMHT to provide supervision, ensure Tony took the medications, assess his risks and contact psychiatric triage if his mental state deteriorated further.[25] Since March 2016, this approach to treating Tony had been unsuccessful.

Inter-service communication by Goulburn Valley Health and Bendigo Health

39. Tony's assessment at GV Health took place during a business day and there is no evidence ART made any attempt to contact Bendigo Health mental health to gather any information about Tony who they documented was a currently case managed client with the BACMHT.

40. Bendigo Health was also aware that Tony was transported to Shepparton, because Dominic informed them and it was noted in the medical records as confirmed by 9.30am.

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[24] Bendigo Health medical record entry by Peter Coleman dated 1 May 2016.

[25] Bendigo Health medical records, Psychiatric Services Continuation Sheet dated 5, 12, 14, 19, 26,28 and 29 April 2016. Clinical contact record community (CASP5a) dated 27 April 2016.

41. BACMHT case managed Tony and the medical records show ongoing contact, home visits and the records of the family contacts with concerns from March 2016. There is no indication Bendigo Health made any attempts to liaise with GV Health to update ART and inform the treatment plan on 28 April 2016. As the involved case management team, a more proactive approach to providing clinical oversight and input into his care in the context of knowing him well, his recent deterioration and having told Dominic to call an ambulance that resulted in his transport to Shepparton Hospital ED, would have been appropriate.

42. The documentation from GV Health was faxed to Bendigo Health Triage Service on 29 April 2016, however there is nothing to suggest BACMHT made any attempts to contact GV Health for additional information. Bendigo Health consultant psychiatrist Dr John Cooper, was surprised there had been no direct contact by ART at GV Health to BACMHT and in the absence of that contact, there was "scope" for BACMHT to have contacted GV Health for further information.[26]

43. The response by BACMHT to Dominic's telephone call after he was asked by GV Health to arrange for Tony's transport home, resulted in a BACMHT planned home visit for some four days later and a planned telephone contact to Dominic the following day and to possibly admit Tony if he continued to be non-compliant and psychotic.[27]

Family involvement by Goulburn Valley Health

44. There is reference in the medical records of the "family stating" information referred to in assessments however GV Health records for both the mental health and the medical assessments in ED and the family statements[28] contain no evidence either treating team contacted Tony's family directly to gather collateral information prior to completing the assessment and formulating the discharge plan.

45. The ART and ED teams appear to have relied on what was recorded in the Ambulance Victoria Client Information Sheet (VACIS) and paramedic handover. Whilst consent is required to discuss client information in detail with a family/carer, the medical records provide no evidence Tony refused to have his family contacted by either team or if he was even asked. It is reasonable to expect the medical team to speak with Tony's family about what they saw that morning when he was reported to have collapsed and was apparently unarousable. The ART clinician verified that ART made no direct contact with Tony's

[26] Statement of Dr John Cooper, dated 10 October 2018.
[27] Coronial Brief of Evidence page 5.
[28] Coronial Brief of Evidence pages 1 – 9.

family and explains this was due to ART providing a specialist assessment secondary to the primary treating team (ED) who hold responsibility for contacting family.[29]

46. This is not a contemporary approach to mental health care in an ED or in working with families and diminishes the comprehensiveness of the mental health assessment, of any assessment of risk and therefore the appropriateness of the treatment/discharge plan.

47. The Department of Health and Human Services 2010, Working with the suicidal person: Clinical practice guidelines for emergency departments and mental health services guiding principles include that it is very important to gain information, not only from presenting individuals but from their friends, family, caregivers or medical records, which can help gauge their level of risk and determine appropriate clinical options.[30]

48. There was no effort made to communicate with the family to assess their willingness or ability to provide care to Tony, who was assessed and documented to be psychotic with impaired judgement and insight for which no documented reasons other than his current mental state would account. In the context of the discharge plan reliant on Tony taking the olanzapine, it is only reasonable the family were made aware of this and what to do if he continued to refuse.

49. It is assumed Tony took olanzapine tablets before leaving the ED as a condition of his going home, despite the documented refusal by a nurse and lack of record of any administration.[31]

50. Tony's prior presentations included identified risk to family members from their inclusion in his delusional system and there is no evidence family safety was explored by either GV Health or BACMHT between 28 and 30 April 2016 other than the routine and self-reported information from Tony about intent to harm himself or others. ART had access to Tony's GV Health history which included enough indicators of prior risk to warrant a more rigorous assessment of risk to Tony's family or at least a discussion with Bendigo Health about any current risks.

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[29] Statement of nurse Sheeraj Moorolia dated 7 December 2017.

[30] Working with the suicidal person: Clinical practice guidelines for emergency departments and mental health services, guiding principles at www2.health.vic.gov.au/mental-health/practice-and-service-quality/safety/suicide-prevention-in-mental-health-services/suicide-risk-assessment

[31] The progress notes written by nurse Dempster state Tony refused to take the olanzapine wafer in ED dated 28 April 2016 at 5.00pm. Goulburn Valley Health Medical Records.
Associate Professor Dr R Bhat stated on 12 December 2018 that the content of the statement dated 6 November 2018 in which he stated the medication chart order for olanzapine as administered, required further clarification. Dr Bhat believes this order was not administered, however a telephone order by Dr Levitan was administered but not documented as either ordered or administrated.

Mental health guidelines for working with families

51. The ART clinician Sheeraj Moorolia stated there was no guideline at GV Health regards working with families at the time of Tony's assessment in ED but that the service was undertaking further investigation and were developing such a guideline.[32] Associate Professor Bhat provided the GV Health Mental Health Service clinical practice guideline Working with Carers. It is unclear what the date of initial release was as it records only last (20 February 2018) and future review dates.

52. The guideline includes the requirements to seek information from family to contribute to care and that carers should be given an opportunity to be involved in discharge planning.

53. The guideline references the 2005 Chief Psychiatrist Guideline, Working with Families and Carers, which was reviewed and reissued in August 2018,[33] which is clearer in its expectation for family engagement and involvement in care planning and includes:

   - Positively identify and engage family members and carers in a consumer's assessment, treatment and care.
   - Do not assume a family member or carer has the capacity or is willing to resume a care role in the same way as before the consumer's service contact.[34]

FINDINGS

54. Having investigated the death of Antonio D'Augello and having considered all of the available evidence, I am satisfied that no further investigation is required.

55. I make the following findings, pursuant to section 67(1) of the *Coroners Act 2008*:

   (a) that the identity of the deceased was Antonio D'Augello, born 4 January 1953;

   (b) that Antonio D'Augello died on 30 April 2016, at 262 Goodard Road, Kyabram, Victoria from drowning; and

   (c) that the death occurred in the circumstances described in the paragraphs above.

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[32] Statement of nurse Sheeraj Moorolia dated 7 December 2017.
[33] Department of Health and Human Services, Chief Psychiatrist Working together with families and carers 2018.
[34] Involving families and carers in discharge planning, page 8 – 9.

COMMENTS

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

57. The care provided to Tony over the weeks preceding his death by Bendigo Health and GV Health was not proactive, consultative, or focused on an early intervention into his care. I have identified the following issues in respect to improved practice:

    a) The lack of timely communication between the involved public mental health services who were both aware of Tony's involvement with the other on 28 April 2016.

    b) The lack of family engagement by GV Health Acute Response Team and Emergency Department (ED) to collect collateral information to inform their assessment, risks and the plan of care, which is not contemporary or best practice.

    c) The absence of a psychiatrist review over four months in a man known to the service who (1) had a documented deterioration in mental state, (2) was known to be receiving no treatment for at least four weeks, (3) repeated his intent to not take medications in spite of continued encouragement by family and his case manager, (4) a history of risk to his family and of requiring compulsory treatment in such circumstances, and (5) whose family was escalating their concerns to Bendigo Adult Community Mental Health Team.

58. While the *Mental Health Act 2014* (Vic) highlights the need for treatment by the least restrictive means, the safety of the individual is also of utmost importance and the option of less restrictive means should not take precedence over safe clinical practice.

59. There was an apparent reluctance to offer the option of an admission as a voluntary patient to Tony and/or to decide regarding compulsory treatment. Continued community treatment may well have been reasonable over a few weeks however the medical records show the escalation of family concerns and development of bizarre behaviours and most importantly Tony's continued stated refusal to take medications. One dose administered as a condition of Tony's discharge from the GV Health ED, was unreliable and did not diminish this stated intent which was

confirmed by his refusal after leaving ED to fill the prescription and take any further medications.

60. Timely direct communication between GV Health and Bendigo Health initiated by either service would have resulted in greater knowledge for the other on which to inform their response. The issue of consent in this case is moot because communication is supported between public mental health services through policy and the state-wide mental health database and allowed for GV Health to fax the records of Tony's assessment and treatment to Bendigo Health without consent.

61. Tony's family had been escalating their concerns about his mental state, and strange behaviours. There was a lack of assessment of Tony's vulnerabilities without continued compliance with treatment, and the impact of weeks without his antipsychotic medication, for example what was his food and fluid intake like, his sleep pattern etc., ability to drive safety which was collateral information that would have informed the discharge plan.

62. Tony's intent was unclear however there is little to suggest he was intent on harming himself and because of his recent physical illness, unpredictable and strange behaviours, it is more likely his death was accidental.

RECOMMENDATIONS

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

64. Goulburn Valley Health update their Working with Carers clinical practice guideline to reflect the 2018 Chief Psychiatrist Guideline, Working Together with Families and Carers and provide education of these changes to the Acute Response Team.

65. Goulburn Valley Health and Bendigo Health Mental Health Service develop an agreement or understanding, accessible to clinical services which specifies that where possible timely and direct communication with the treating team of a case managed client of either's services occurs, with the intent of gathering collateral information to inform assessments and before treatment planning is completed.

66. Bendigo Health Mental Health Service review the requirement for the timely escalation of the care of a community case managed client who is experiencing a

deterioration in mental state to facilitate timely access to a face to face review by a psychiatrist.

67. I convey my sincerest sympathy to Tony's family and friends.

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

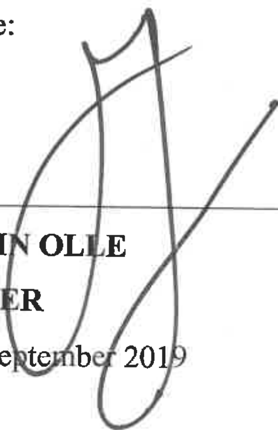
69. I direct that a copy of this finding be provided to the following:

    (a) Tony's family, senior next of kin;

    (b) Investigating Member, Victoria Police; and

    (c) Interested Parties.

Signature:



MR JOHN OLLE
CORONER
Date: 6 September 2019