Rule 63(1)

IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2017 0595

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 63(1)

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

Amended pursuant to section 76 of the Coroners Act 2008[1]

Inquest into the passing of: JACOB WILLIAM KENNEDY

Findings of:	JOHN OLLE, CORONER
Delivered On:	24 May 2024
Delivered At:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank 3006.
Hearing Dates:	23 May 2023, 19 to 23 June 2023, 26 to 30 June 2023, 14 September 2023 and 21 November 2023
Appearances:	Mr T Farhall (List A Barristers) and Mr N Boyd-Caine (Green's List Barristers) instructed by Gilbert + Tobin Lawyers on behalf of the family. Ms N Hodgson on behalf of Peninsula Health.
Counsel Assisting the Coroner:	Dr Sharon Keeling of Counsel.

[1] A correction has been made to the names of legal representatives on pages 1, 63 and 71.

Aboriginal and Torres Strait Islander readers are advised that this content contains the name of a deceased Aboriginal person. Readers are warned that there may be words and descriptions that may be culturally distressing.

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I, JOHN OLLE, Coroner having investigated the passing[2] of **JACOB WILLIAM KENNEDY**

AND having held an Inquest in relation to this passing beginning on 23 May 2023,

at Southbank

find that the identity of the deceased was **JACOB WILLIAM KENNEDY**

born on 24 February 1980

died on 4 February 2017

at Frankston Hospital, Nepean Highway, Frankston, 3199

from:

1 (a) UNDETERMINED

In the following summary of circumstances:

On 24 January 2017, Jacob William Kennedy (**Jacob**) was brought to the emergency department (**ED**) at Peninsula Health's (**PH**) primary hospital Frankston Hospital, having been found near the Main Street in Frankston in a confused state, walking with an unsteady gait. After his assessment by ED clinicians, Jacob was admitted as an involuntary inpatient at PH under the provisions of section 351 *Mental Health Act 2014* (Vic) (**MHA**).

At the time of his passing, Jacob had been an inpatient at PH for a period of eleven days, including a stint in the psychiatric unit for a period of seven days. In the eleven-day period at PH, due to repeated bouts of agitation, Jacob was treated with antipsychotic medication.

[2] The term 'passing' is generally more accepted and sensitive terminology to use when discussing the death of Aboriginal and Torres Strait Islander people due to the spiritual belief around the life cycle. (*See* 'Sad News, Sorry Business: Guidelines for caring for Aboriginal and Torres Strait Islander people through death and dying', Queensland Government, December 2015). On the advice of the Coroners Aboriginal Engagement Unit, the term 'passing' will be used instead of 'death' in this finding, save where required by the words of relevant statutes.

On 31 January 2017, the seventh day of his admission to PH, Jacob was recommenced on a course of Methadone. The medical records indicate that Jacobs was paranoid for the duration of his admission.

On 4 February 2017, Jacob was administered 10 mg Olanzapine[3] by intramuscular injection (**IMI**) at 2.28 am, as well as the following oral medication:

i. Clonazepam 1 mg at 8.24 am;[4]

ii. Methadone 30 mg at 8.24 am;[5]

iii. Pregabalin 300 mg at 8.25 am;[6]

iv. Haloperidol 2.5 mg at 9.38 am;[7]

v. IbuProfessoren 400 mg at 9.38 am;[8]

vi. Diazepam 10 mg at 10.06 am;[9] and

vii. Chlorpromazine 50 mg at 1.14 pm.[10]

The medical records indicate further that from 2.30 pm onwards Jacob was asleep in his bedroom. The nursing staff recorded their observations of Jacob through the bedroom window and had interacted with him at 3.30 pm and again at 6 pm, when Jacob refused to have his dinner. The last record of Jacob's position was made at 7 pm, when the nursing staff recorded his position. No record of Jacob's vital signs was taken between 8.30 am and 7.40 pm, however.

[3] An atypical or second-generation antipsychotic drug.
[4] A benzodiazepine drug indicated for the acute treatment of panic disorder and epilepsy, amongst others.
[5] A synthetic opioid agonist used for chronic pain and for opioid use disorder.
[6] Marketed as 'Lyrica', Pregabalin is an anticonvulsant drug indicated for the treatment of epilepsy and nerve pain.
[7] A first-generation typical antipsychotic drug.
[8] A non-steroidal anti-inflammatory drug.
[9] An anxiolytic Benzodiazepine drug indicated for anxiety and seizures, amongst others.
[10] An antipsychotic drug indicated for the treatment of schizophrenia, bipolar disorder, and acute psychosis.

At 7.40 pm, attending staff found Jacob in cardiorespiratory arrest and when the attending staff went to his aid, they were unable to resuscitate him. At 8.35 pm, it was confirmed that Jacob had passed.

BACKGROUND CIRCUMSTANCES

1. Jacob William Kennedy[11] was a proud Plangermaireener Aboriginal man from the Ben Lomond Nation of Tasmania. His parents, Cyril Kennedy and Linda Hartle, adored their son Jacob who was also a much-loved sibling of Sherrie and Adrian.

2. Jacob was a talented artist who partook in art exhibitions, annually exhibiting his artwork at the St Kilda City Hall. Jacob often described how he would feel a sense of tranquillity and enlightenment when he was working on his art and further, how by immersing himself in his artwork, he would feel a sense of spiritual connection to his ancestors.

3. Despite his artistic flair, however, Jacob was known to use dependency producing substances which had a narcotic effect from a young age. The evidence indicates that from the time he was about 13 years old, Jacob used heroin, methamphetamines, benzodiazepines, and alcohol.[12]

Health concerns[13]

4. As a teenager, Jacob suffered from transient psychotic attacks and between the years 1996 and 2015, he had multiple admissions to various hospitals in Metropolitan Melbourne for treatment related to his substance use. The evidence indicates that

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[11] Transcript of Proceedings (T), Directions Hearing (**DH**) dated 22 October 2021, page 3. In consultation with his family Jacob William Kennedy was referred to as **JACOB** during the running of the Inquest. For consistency I have endeavoured to refer to him as Jacob throughout the Finding except where I have deemed it appropriate to refer to his full name.
[12] T, Inquest Proceedings, page 54.
[13] Ibid.

Jacob's symptoms of psychosis which often presented in the form of seizures or pseudo-seizures were related to his substance use.

5. Between 2012 and 2015 alone, Jacob had been admitted to the ED at PH four times when he presented with issues related to sedation and erratic behaviour secondary to recreational drug use.

SURROUNDING CIRCUMSTANCES

Events leading to Jacob's passing[14]

6. On 24 January 2017 at approximately 5.53 pm, Jacob was found wandering near a main road, unsteady on his feet and in a confused state. After emergency services were contacted, AV paramedics conveyed Jacob to the PH where the ED staff noticed an aged haematoma in his left eye. While he was being triaged, however, Jacob suffered two tonic clonic seizures for 20 seconds and 10 seconds respectively. A subsequent CT brain scan did not reveal anything unusual. Jacob was then admitted to the ED short stay unit.

7. On the following day, PH staff noted that Jacob had persecutory delusions and visual and auditory hallucinations. On 26 January 2017, the PH staff took the decision that Jacob was to remain in the ED pending the availability of an inpatient bed.[15]

8. On 27 January 2017, Jacob was placed on an Inpatient Assessment Order (**IAO**) because he reported that he was hearing derogatory voices and that there were people who wanted to kill him. PH (**PH**) records indicate that Jacob was treated with *pro re nata* (**PRN**) antipsychotic drugs to manage his mental health. The PH records indicated

[14] Court File, Statement of Agreed Facts. I have considered all the evidence relating to Jacob's 11-day admission to PH leading to his passing. For the purposes of my finding, I do not propose to set out all the evidence but will refer to salient points contained in the evidence before me for narrative clarity.
[15] Exhibit 26, pages 546-559. Jacobs was assessed by a Mental Health Nurse from the PH Consultation Liaison Inpatient Psychiatry Service (**CLIPS**).

further that Jacob behaved aggressively towards the nursing staff. After further information about Jacob was obtained from his family, the attending staff referred Jacob to their consultant psychiatrist for review.[16]

9. On 28 January 2017, Jacob refused to allow the ED staff to examine him but demanded Lyrica and Clonazepam for his back pain. However, after the hospital security staff were called, he allowed the ED staff to examine him. That afternoon, Jacob was admitted to the Acute Management Area (**AMA**) of Ward 2 West (**W2W**), PH's mental health ward. After his arrival at W2W, Jacob was assessed by the psychiatrist on duty at the time who issued an Involuntary Temporary Treatment Order (**ITTO**) to manage Jacob's "hallucinatory experiences and delusional ideation". The records indicate further that treating psychiatrist opined that Jacob was "[at] the end of drug induced psychosis" with "ongoing underlying psychotic process" and "Clear (. . .) Personality Disorder".[17]

10. On 29 January 2017, when Jacob was assessed by the PH Psychiatric hospital medical officer (**HMO**), Dr Sadat Yousefi, he reported that he had visions of people but he himself attributed his "seeing people" to a "cultural" experience. In the context of Jacob's history of polysubstance use as recorded on his PH file, Dr Yousefi noted Jacob's recent cannabis use and his daily consumption of alcohol and diagnosed Jacob with "psychomotor agitation" and "drug induced psychosis". Dr Yousefi noted further that Jacob was "preoccupied [with] his methadone and asking [for] methadone". It was also noted that Jacob was irritable, agitated and verbally abusive towards the PH staff.[18]

[16] Ibid, page 62. According to Jacob's sister, Sherrie, his regular prescription medications included Pregabalin and Temazepam for the last four weeks prior to his passing. Sherrie informed the staff at PH further that Jacob was "on methadone" and that a history of schizophrenia ran in their family.
[17] Exhibit 26, page 519.
[18] Ibid. The PH record indicate further that Jacob thought that the PH staff were "laughing and talking about him". On 30 January 2017, the PH pharmacist confirmed that Jacob had his last dose of methadone on 10

11. On 30 January 2017, PH Psychiatrist, Dr Thi Nhu Trang reviewed Jacob and noted that he was content with his "hospital stay for now" and was "pleasant and cooperative". Although Jacob was "assessed as having polysubstance use", Dr Trang found that Jacob was "resolving" his "drug induced psychosis". Dr Trang opined further that "differential diagnoses were complicated [by Jacob's] delusions [which were] caused by benzodiazepine and opiate use". The evidence indicates that Jacob's delusions were the effects associated with his concomitant use of opioid and benzodiazepine drugs.

12. On 31 January 2017, Dr Raymond Chan of PH's specialist addiction medicine treating team, the Consultation Liaison Addiction Medicine (**CLAMS**) clinic, assessed Jacob's condition. Dr Chan noted Jacob's long-term illicit drug and alcohol use and, in the context of his pattern of aggression towards others, Dr Chan recommended that Jacob be recommenced on 40 mg of Methadone per day. At 2.48 pm, PH staff administered the prescribed dose of Methadone which appeared to have pacified Jacob.[19]

13. On 1 February 2017 at 5.15 am, however, Jacob became upset and teary, and his behaviour escalated to a point where he was swearing loudly. To de-escalate the situation, attending staff administered PRN drugs and they were then able to pacify Jacob. At 8.39 am, Jacob received his dose of Methadone for the day and was unable to attend his dental appointment at 2.30 pm because of the sedative effects of his medication.

14. Dr Chan noted that Jacob was "drowsy" and suggested that a reduction in Jacob's Olanzapine or his Methadone dosages may counter the sedative effects of his

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January 2017. The methadone dispensing pharmacy refused to administer Jacob's methadone any further because of his aggression towards pharmacy staff.

[19] Ibid. Dr Chan's opinion was informed by Jacob's history of aggressive behaviour in the community and towards hospital staff and fellow inpatients. The PH records indicate that a local IGA Grocer had to apply for an intervention order to prohibit Jacob from threatening the staff when he came to their shop.

medication. The decision to alter the dosages, however, was left to Jacob's treating team.

15. At 2.30 pm, a CLAMS team member noted that Jacob was "drowsy but rousable" and that his speech was "incoherent". Although Jacob was able to tolerate food and fluid that evening, the staff was unable to conduct a full Mental State Examination (**MSE**) due to Jacob's level of sedation.

16. The medical records indicate that Jacob went to bed around 5 pm and slept most of that evening, but awoke at the start of the nightshift, however, in an agitated state. Jacob was treated with PRN drugs which settled his agitated state.

17. On 2 February 2017 at approximately 6 am, Jacob requested medication. The nurse on duty noted that Jacob was irritable. Later that morning, when Dr Chan reviewed Jacob, he was "alert but agitated". Dr Chan noted that Jacob was "happy with his methadone dose of 30 mg daily" but noted further that Jacob wanted "his clonazepam [to be] recommenced".

18. At 12.30 pm, the on-duty HMO, Dr Trang, reviewed Jacob who was refusing to take any oral medication other than his Methadone. According to Dr Trang, Jacob was angry because the W2W clinicians had stopped his Clonazepam and did not want to give him his drugs of choice. The PH records indicate that Jacob was paranoid and angry, and staff planned to administer IMI sedatives if his agitation increased.[20]

19. At 4 pm, Jacob was reviewed by another HMO clinician, Dr Tan who noted that Jacob was becoming more agitated. In discussion with Dr Jane Nguyen, W2W Psychiatrist, the decision was taken to restart Jacob on 1 mg of Clonazepam three times daily.

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[20] Ibid. The evidence indicates that that the clonazepam was stopped due to concerns about over-sedation.

i. Ritalin is a central nervous system stimulant; and
ii. Xanax is a potent sedative indicated for the treatment of anxiety disorders.

20. The PH records indicate further that by 6.45 pm Jacob had not received the dose of Clonazepam decided upon by Dr Tan and Dr Nguyen. The attending staff noted that Jacob was becoming increasingly agitated and paranoid, and he was "preoccupied with his medications" and it appeared that he was expressing his anger and frustration by pulling out his hair. The evidence indicates that attending staff had substituted PRN 2 mg Clonazepam, in the interim, pending delivery of Jacob's prescribed dosages to W2W. Jacob was then "more settled" and turned to doing "his artwork in the AMA".

21. At 9.15 pm, Jacob was reviewed by the HMO Psychiatrist, Dr Yousefi, who noted that Jacob had complained of abdominal pain and was vomiting. Jacob was uncooperative and did not allow Dr Yousefi to examine him physically. For symptomatic relief, Dr Yousefi prescribed Gastrogel antacid, Buscopan to relieve his abdominal pain and Pantoprazole to reduce the amount of stomach acid.

22. At 11 pm, when Jacob was still vomiting, staff administered Metoclopramide by IMI to manage Jacob's nausea. The PH records indicate that at 11.14 pm, Jacob was angry and requested the staff to give him "endone" and refused to accept any other analgesic medication offered to him. Jacob then became "paranoid" and started "yelling" and "threatening to sue the hospital" because he believed that hospital staff were "laughing at him". The notes indicate further, however, that "Jacob's vital signs were normal".[21]

23. On 4 February 2017 at 2.20 am, W2W staff called a "Code Grey" due to Jacob's threatening behaviour which did not abate with their "de-escalation techniques". The PH records indicate that Jacob became paranoid and agitated, running headlong into the wall "trying to bang his head". Jacob eventually settled down when the PH Hospital security attended to the "Code Grey" call.[22]

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[21] Ibid.
[22] In a hospital setting, a "Code Grey" is called for abusive or combative behaviour.

24. At 3.30 am, the Psychiatric Registrar (**PR**), Dr Parekh was called to attend to Jacob's persistent vomiting and the pain he was complaining about. On examination, other than his body temperature, which was recorded as 37ºC, Jacob's vital signs were normal. Dr Parekh advised the nursing staff to continue to administer antiemetic medication with subsequent review by the medical registrar. Fr Parekh ordered further blood tests and an abdominal x-ray.[23]

Events proximate to Jacob's passing

25. During the morning of 4 February 2017, Jacob was agitated and behaved aggressively towards the staff, refusing to undergo the tests and observations ordered by Dr Parekh. At 1.24 pm, a PRN dose of Promazine was administered to treat his episode of psychomotor agitation. The evidence indicates that Jacob became more settled after the Promazine was administered.[24]

26. Throughout the afternoon, staff observed Jacob at 15-minute intervals and at 3.30 pm, Nurse DJ roused Jacob to enquire whether he was now ready to have the x-ray which Dr Parekh had ordered the night before. According to Nurse DJ, Jacob refused in an agitated manner and returned to sleep. During their observations, Jacob was snoring audibly. The PH records indicate that Jacob "could be heard snoring loudly".[25]

27. At approximately 6 pm, when Nurse DJ attempted wake Jacob to have his dinner, Jacob woke up momentarily, but declined to have his dinner and went straight back to sleep.

[23] T of DH held on 22 October 2021, page 6. Promazine is indicated for the treatment of schizophrenia and as a short-term add-on treatment for psychomotor agitation.
[24] Ibid.
[25] Exhibit 26, pages 103-104. Around the same time, PR Dr LFG came to review Jacob per Dr Parekh's orders but was told that he was asleep. The PH records indicate that two attempts were made to review Jacob to follow through with the orders from the previous night to review Jacob. Unable to examine Jacob at the time, Dr LFG resolved to defer Jacob's review to the following day.

At the time, Jacob's breathing appeared to be within normal limits and, as Jacob was asleep "throughout the afternoon", the staff did not record any concerns.[26]

28. During the observation period at approximately 7 pm to 7.15 pm, staff observed that Jacob had changed his position and was positioned on a mattress on the floor of the room he occupied in W2W.[27]

29. At 7.30 pm, Nurse DJ checked on Jacob and found him sleeping in the same position. At 7.35 pm, Nurse DJ, looking through the room window, noticed that Jacob had moved his head off the mattress. Accompanied by Nurse EW, Nurse DJ then entered Jacob's room and on closer inspection, they found that "Jacob was not breathing'". A Code Blue was called but attempts to resuscitate Jacob were unsuccessful.[28]

JURISDICTION

30. Jacob's death was a reportable death under section 4 of the *Coroners Act 2008* (Vic) (**the Act**), because it occurred in Victoria, and was considered unexpected, unnatural or to have resulted, directly or indirectly, from an accident or injury.

PURPOSE OF THE CORONIAL INVESTIGATION

31. The Coroners Court of Victoria is an inquisitorial jurisdiction.[29] 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.[30] The cause of death refers to the medical cause of death, incorporating where possible the mode or mechanism of death. For coronial purposes,

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[26] T of DH, page 7.
[27] Ibid. Nurse DJ described the acute management area at W2W where Jacob was housed. According to Nurse DJ, the layout enabled staff to observe patients fully. From their vantage point outside the room, staff were able to identify changes in "patient position, respiration rate, chest falls and the sounds of breathing".
[28] A "Code Blue" is called when a patient is experiencing cardiac or respiratory arrest.
[29] *Coroners Act 2008* (Vic) s 89(4) ('the Act').
[30] Ibid s 67(1).

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.[31]

32. 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.[32] Coroners are also empowered to report to the Attorney-General on a death; 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 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.[33] These are effectively the vehicles by which the prevention role may be advanced.[34]

33. 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.

34. 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 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.

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[31] See for example *Harmsworth v The State Coroner* [1989] VR 989; *Clancy v West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J).

[32] The "prevention" role is explicitly articulated in the Preamble and Purposes of the Act.

[33] See sections 72(1), 67(3) and 72(2) of the Act regarding reports, comments, and recommendations respectively.

[34] 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.

35. The circumstances in which Jacob's passing occurred, during an involuntary hospital admission pursuant to section 351 of the MHA, renders this a mandatory Inquest under section 52(2) of the Act.

STANDARD OF PROOF

36. 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*.[35] 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 any allegations 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.

37. 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.

[35] (1938) 60 CLR 336.

INVESTIGATIONS PRECEDING THE INQUEST

38. At the inception of my investigation into Jacob's passing, I directed my Coroner's investigator (**CI**), Senior Constable (**SC**) Jeffery Dart of the Police Coronial Support Unit (**PCSU**), to compile a full Coronial Brief of Evidence (**CB**).

Sources of Evidence

39. This Finding draws on the totality of the evidential material produced during the investigation into Jacob's passing. That is, the Court records maintained during the coronial investigation, the CB and all other material sought and obtained by the Court prior to the Inquest, the evidence adduced at the Inquest and submissions of CA Interested Parties.

40. In writing this Finding, I do not propose to summarise all the evidence but will endeavour to refer to the evidence yielded by the coronial investigation, only in such detail as would appear to be warranted by its forensic significance and in the interests of narrative clarity. The absence of a reference to any aspect of the evidence, does not imply that I have not considered that evidence.

41. The circumstances in which Jacob had passed, while "in care" and admitted as a patient on an ITTO under the relevant provisions of the MHA, was apparent at the outset of the coronial investigation. Consequently, I was obligated to refer this matter to Inquest at a public hearing.

Identity

42. On 7 February 2017, the body of Jacob William Kennedy was visually identified by his stepfather, Graham Hartle, who signed a formal Statement of Identification.[36]

[36] Court File, Statement of Identification.

43. Identity is not in dispute and does not require any further investigation.

Medical Cause of Death

44. On 8 February 2017, Senior Forensic Pathologist Dr Matthew Lynch of the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy upon the body of Jacob William Kennedy.

Toxicology

45. Toxicological analysis of the post-mortem blood samples retained at autopsy was conducted by Melissa Peka, VIFM Forensic Toxicologist (**FT**). The in the execution of her duties, Ms Peka identified the presence of the following drugs:[37]

    i. Methadone ~0.4 mg/L;
    ii. 1-Ethylidene-1,5-dimethyl-3,3-diphenylpyrrolidine (**EDDP**) ~0.03 mg/L;[38]
    iii. Diazepam ~0,5 mg/L;
    iv. Nordiazepam ~0.5 mg/L;[39]
    v. 7-Aminoclonazepam ~0,2 mg/L;[40]
    vi. Olanzapine ~0.08 mg/L;[41]
    vii. Chlorpromazine ~0,04 mg/L;[42]
    viii. Haloperidol ~0,01 mg/L;
    ix. Pregabalin ~2 mg/L;

[37] Court File, VIFM toxicology Report dated 7 March 2017.
[38] A Methadone metabolite.
[39] A Benzodiazepine derivative drug, it is indicated for its sedative properties, amongst others. It is also a principal metabolite of Diazepam.
[40] A certified reference material categorised as a Benzodiazepine drug. It is the primary metabolite of Clonazepam.
[41] An atypical antipsychotic drug indicated for the treatment of Schizophrenia and Bipolar Disorder, *inter alia*.
[42] Indicated for the treatment of psychotic disorders.

x. Zopiclone ~0,02 mg/L;[43]

xi. Paracetamol < 5 mg/L;

xii. Lignocaine;[44]

xiii. Metoclopramide;[45]

46. The FT, Ms Peka, noted that "All drugs found (. . .) are normally detectable at therapeutic concentrations unless otherwise indicated". Considering that the "Department of Health and Human Services" records indicated that at the time of Jacob's passing, there was a valid permit to treat him with Methadone and or Buprenorphine for opioid dependence" with effect "from 11 October 2016", Ms Peka commented further that the "presence of (. . .) these drugs as being administered by emergency/hospital staff should be considered".

Forensic pathology opinion

47. Having considered his own autopsy findings and the findings the Forensic Toxicologist, Ms Peka, Dr Lynch recorded the medical cause of death in his Medical Examiner's Report (**MER**) dated 6 April 2017 as *1(a) Undetermined*.

The Family's concerns

48. On 10 April 2017, Jacob's sister, Sherrie, brought their family's concerns to my attention. Subsequently, Jacob's mother, Linda, also submitted her concerns to the Court.

49. In my review of the letters submitted to the Court, Sherrie and Linda's concerns about the care provided to Jacob were not substantively different.[46]

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[43] A non-Benzodiazepine drug, indicated for the short-term treatment of insomnia.
[44] A local anaesthetic drug.
[45] An anti-emetic medication indicated for the prevention of nausea and vomiting.

50. In summary, Sherrie raised the following concerns:[47]

i. PH only treated Jacob's mental health issues but ignored his physiological health issues like the abdominal pain he complained of and, a recent head injury he sustained which was surgically stapled.

ii. Methadone was administered to Jacob against his family's wishes, without their consent. According to the family, Jacob's Methadone treatment should not have been recommenced because Jacob's placement in a detoxification and/or rehabilitation program had been confirmed previously.

51. According to Linda, the care provided to her son was inadequate. She believed that Jacob was left unattended for "at least a couple of hours" while in a "terrible state (. . .) fitting with the door being closed".

52. During the course of the coronial investigation, Jacob's family appointed Gilbert and Tobin Lawyers to represent them, and, on 25 June 2019, the family filed an Application for Inquest. According to Linda, her family believed that "there have been a number of concerns raised by" my "investigation this far" which could "only be appropriately dealt with through the rigour of a formal inquest".[48]

53. On 11 July 2019, given that Jacob was "in care" at the time of his passing which mandated the examination of the circumstances in which he had passed at a public hearing, I informed the family that I had already decided that the matter would proceed to Inquest.[49]

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[46] Court File, Sherrie and Linda's correspondence to the Court. In <u>my summary</u> of the family's concerns of care which I consider to be relevant to my investigation, I have omitted duplicate concerns for the sake of fluency and narrative clarity.
[47] Ibid.
[48] Court File, *Form 26* Application for Inquest dated 25 June 2019.
[49] Court File, *Form 28* Rule 50(1), dated 11 July 2019.

Conduct of my Investigation

54. At my direction, the investigation of this matter was undertaken by SC Dart of the PCSU. On 31 October 2019, SC Dart submitted the first version of the CB for my consideration. During the course if my investigation into Jacob's passing, however, the CB was adapted to accommodate the growing body of evidence including the following:

    i. PH medical records;
    ii. Practice Guidelines and Procedures for Mental Health Service at PH;
    iii. Statements from attending clinicians and nursing staff;
    iv. Root Cause Analysis (**RCA**) Report dated March 2017; and
    v. Statements of Jacob's family members.

55. To advance my investigation into Jacob's passing and to interrogate the medical cause of death, I engaged Associate Professor (**AP**) Narendra Gunja, a New South Wales Clinical and Forensic Toxicologist in private practice.

56. On 15 April 2021, AP Gunja submitted his expert report for my perusal. In summary, AP Gunja opined that it was likely that Jacob suffered an acute asphyxiating event "either from abnormal prone posture and/or aspiration of vomitus" and further, that Jacob's "drug regimen may have been contributory to his death" in that his declined liver function may have contributed to the chronic accumulation of benzodiazepines, opioids and antipsychotics and their metabolites.[50]

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[50] Ibid, page 80.

i. AP Gunja was given electronic access to the current version of the CB around the time he completed his Export Report dated 15 April 2021.
ii. T of DH, page 8.

57. AP Gunja also expressed the view that there were "concerning aspects to the clinical management with respect to adequacy of monitoring, recording of observations and investigations performed in the days prior to [Jacob's passing]".

58. In the ordinary course, AP Gunja's expert report was disseminated to the interested parties for their review and comment.

59. On 18 October 2021, in response to AP Gunja's expert report, PH submitted an expert report of Consultant Psychiatrist and Adjunct Professor of Psychiatry at Monash University, Professor Nicholas Keks. In my review of PH's expert report, I noted that Professor Keks invariably dissented from the opinions of AP Gunja including those aspects of AP Gunja's opinion dealt with above.[51]

60. Together with Professor Keks' report, PH also submitted the statement of Dr David Badov, specialist clinician and Head of Gastroenterology at PH. In summary, Dr Badov did not share AP Gunja's opinion that Jacob's declining liver function may have contributed to the chronic accumulation of "benzodiazepines, opioids and antipsychotic medication and their metabolites".[52]

Preparation for Inquest

61. Recognising the need for additional evidence to compliment the opinions of AP Gunja and Professor Keks, given the conflicting evidence before me, I determined to obtain expert evidence of a consultant psychiatrist, specialising in addiction medicine to advance my investigation into Jacob's passing.

62. To expedite the Inquest proceedings in this matter, I listed the matter for a DH to inform the interested parties of the progress of my investigation to date and further, to

[51] CB, page 93, Report of Professor Keks dated 12 October 2021.

[52] CB, page 132, statement of Dr Badov dated 8 October 2021. Dr Badov holds a concurrent appointment as Adjunct Lecturer at Monash University.

inform the parties of the witnesses whose evidence I intended to adduce at the Inquest. In addition, guided by the yield of evidence before me at this juncture, intended to invite submissions on my proposed Scope of the Inquest and to propose further investigation before the matter is listed for Inquest.

Directions Hearing

63. On 22 October 2021, I convened the Directions Hearing (**DH**). Ms Stephanie Wallace of Green's List Barristers appeared on behalf of Jacob's family and Ms Hodgson appeared for PH. SC Dart of PCSU appeared to assist me.

64. After SC Dart delivered the opening summary, I heard submissions on my proposed Scope of the Inquest and the further investigation and, by agreement *inter partes*, the finalisation of the Scope of the Inquest was deferred until after the further investigation has been completed.

Further investigation

65. On 1 March 2022, I engaged Dr Michael Atherton, a Psychiatrist and Specialist in Addiction Medicine in private practice in New South Wales. As part of the Court's Expert Briefing Summary, Dr Atherton was provided with the PH medical records, the VIFM Toxicology Report, Dr Lynch's MER, Version 5 of the CB and the expert opinions of Dr Gunja and Professor Keks.

66. On 17 April 2022, Dr Atherton submitted his Report to the Court for my consideration. Dr Atherton's Report included his opinion on the following:

    i. Whether the PH's prescribing regime for Jacob was—

        a) reasonable medical practice at the time of Jacob's passing;

        b) whether it is currently reasonable medical practice;

c) whether PH's policies and/or procedure was appropriate at the time of Jacob's passing;

d) Dr Atherton's views on AP Gunja and Professor Keks' opinions respectively;

ii. Whether the visual and/or physical observation conducted by the PH nursing staff was appropriate in the circumstances.

iii. Dr Atherton's views and comments regarding the use of sedating medicines as a means of chemical restraint *vis-à-vis* AP Gunja and Professor Keks' opinions in this regard.

iv. Dr Atherton's views on Professor Keks' comments on the distinction between tranquilisation and sedation and how that distinction applies to Jacob's medication regime.

v. Dr Atherton's views on addiction management in the context of psychiatric care peculiar to Jacob in relation to the opinions of AP Gunja and Professor Keks respectively. Dr Atherton considered the decision of the PH addiction specialist to recommence Jacob's Methadone treatment in light of his Opiate Use Disorder.

vi. Dr Atherton considered the overall medical management of Jacob's health concerns while he was admitted to W2W.

vii. Dr Atherton considered whether PH clinicians obtained adequate information about Jacob's medical history and/or the history of the medicines prescribed for him or any other collateral information to inform their decision on his treatment and prescribing practices while Jacob was an involuntary patient at their facility.

viii. Dr Atherton commented on contemporary prescribing practices for patients in Jacob's position with dual diagnoses of substance abuse disorder and

psychiatric disorder and then went on to consider best practice principles in this regard.

67. I have reviewed Dr Atherton's Report and incorporated his Report into my CB. In summary, on all the points of reference outlined above, on which Dr Atherton was asked to comment at my direction, Dr Atherton's opinion appeared to represent a significant departure from Professor Kek's opinion on the same points. In contrast, Dr Atherton's views appeared to have been aligned with the opinion of AP Gunja in this regard. Dr Atherton's Report was circulated to the interested parties in the ordinary course.

68. Following my further review of the evidence before me and, with the further input of the interested parties, I obtained the further evidence of the following experts to advance my investigation:

    i. Cardiologist, Professor Jitendra Vohra;[53]

    ii. Psychologist and Aboriginal Cultural Expert, Vanessa Edwige.[54]

69. In engaging these experts, I provided them with the same information previously provided to the other experts including the expert reports I previously received into evidence. The expert evidence of Professor Vohra and Ms Edwige was submitted to the Court on 18 July 2022 and 9 March 2023 respectively.

70. In addition to the further expert evidence, I obtained a statement from the Aboriginal Liaison Officer at PH, Auntie Helen Bnads and a statement from Dr Jane Nguyen, Consultant Psychiatrist at PH.[55]

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[53] Cardiologist and Electrophysiologist, Department of Cardiology and Genomic Medicine, Royal Melbourne Hospital (**RMH**).

[54] Registered Psychologist in private practice who was engaged to assist my investigation by examining the adequacy of culturally safe care afforded to Jacob and the adequacy of PH's policies and guidelines from a cultural perspective.

71. Having disseminated the additional expert evidence to the interested parties and having considered the submissions of the interested parties in this regard, the Scope of the Inquest was settled. By further agreement *inter partes*, I determined who would testify at my Inquest into Jacob's passing and which witnesses' evidence would be heard concurrently.

Scope of the Inquest

72. Having considered the submissions of the interested parties, I determined that I would advance my investigation into Jacob's passing by examining the following points more closely at a public hearing:

    i. In relation to the medical cause of death, whether it was reasonable for clinicians to prescribe the medication administered to Jacob during the period between 24 January 2017 and 4 February 2017 for the purpose of managing his ABD, either by itself or in the setting of his regular medication. My focus would be on the following medicines:

        a) Clonazepam and Diazepam;

        b) Olanzapine and Chlorpromazine.

        c) Haloperidol and Zopliclone;

        d) Pregabalin;

        e) Methadone for the period 31 January 2017 to 4 February 2017; and

        f) Any other medicines administered to Jacob at the relevant and material time.

    ii. What were the requirements for undertaking an Electrocardiogram (ECG) on Jacob between 24 January 2017 and 4 February 2017;

[55] CB, statements of Helen Bnads and Dr Jane Nguyen.

iii. What were the requirements in place at the PH inpatient psychiatric unit, W2W, on 4 February 2017 for observing and monitoring patients to whom medication with a sedative effect was administered, including patients who appeared to be asleep. If there were existing observation requirements, were those requirements:

    a) Reasonable at the time; and

    b) Were they undertaken *vis-à-vis* Jacob himself;

iv. The degree to which the care provided to Jacob between 24 January 2017 to 4 February 2017 was culturally appropriate and culturally safe and whether the cultural aspects of his clinical care could be improved for other Aboriginal patients in future;

v. Any further prevention opportunities and/or identified recommendations including whether any recommendations should be made by the Court with regard to the following:

    a) Improved articulation of the definitions of "restrictive intervention" and/or "chemical restraint";

    b) The administration of medication for ABD which has a sedative effect. The purpose of a recommendation of this nature is to be aimed at establishing requirements for monitoring patients whose freedom of movement is restricted by chemical or physical means;

    c) The frequency at which ECGs are undertaken for patients admitted on an involuntary basis where such patients have been administered medication, including medication indicated for the treatment of ABD

which are known to have a sedative effect and known to cause prolonged QT intervals;[56] and

d) The extent to which monitoring or observing patients to whom medication with sedative effects has been administered to treat ABD, including those patients who appear to be asleep, in a health care facility in Victoria.

INQUEST

73. Having settled the Scope of the Inquest and having determined what *viva voce* evidence would advance my investigation into Jacob's passing, the Inquest was listed to commence 23 May 2023 and further dates set down from 19 to 30 June 2023. By agreement, further dates were to be confirmed for any ancillary matters including oral submissions.

<u>*Viva Voce* Evidence at the Inquest</u>

74. *Viva voce* evidence was led from the following witnesses:

- Dr Jane Nguyen, PH Consultant Psychiatrist
- Cyril Kennedy
- Sherrie Kennedy
- Linda Hartle
- Dr Matthew Lynch, VIFM Forensic Pathologist

[56] The QT interval is a measurement which represents the total time from ventricular polarisation to complete repolarisation. The process begins at the start of the "Q" wave and extends to the end of the "T" wave on the ECG. Certain drugs are known to cause QT prolongation which carries a risk of sudden cardiac death (**SCD**).

- TSA, Psychiatric Nurse
- LS, Psychiatric Nurse
- SJ, Psychiatric Nurse
- DJ, Psychiatric Nurse
- EW, Psychiatric Nurse
- Dr LFG, Psychiatric Registrar
- Dr Raymond Chan, Addiction Medicine Physician
- Dr Kerryn Rubin, Psychiatrist and PH's Current Clinical Director of Mental Health (**CDMH**)
- Lisa Coppe, Ph Aboriginal Liaison Officer
- Vanessa Edwige, Psychologist
- Auntie Helen Bnads, Elder/ PH's Cultural Leader
- Dr Richard Newton, Psychiatrist and former CDMH at PH

75. Further *viva voce* evidence was led concurrently in expert panels which were constituted as follows:

- Associate Professor Narendra Gunja, Clinical Toxicologist
- Dr Jitendra Vohra, Cardiologist

  AND
- Professor Nicholas Keks
- Dr Michael Atherton

ISSUES INVESTIGATED AT THE INQUEST

76. At the inception of the Inquest, the Court heard evidence from the various witnesses who, by and large, testified about the circumstances in which Jacob had passed. Given that the circumstances surrounding Jacob's passing and his identity were not in issue at Inquest, my finding is focused on the cause of death and further, whether the available evidence supports a conclusion that his passing was preventable in the circumstances. In making my findings, however, I have considered the all the available evidence.[57] I have also been assisted by and carefully considered the respective submissions of CA (**CA**) and Counsel for the interested parties.

Evidence on the medical cause of death

77. Dr Lynch's evidence indicated that the presence of vomit in Jacob's airway reflected an agonal event in the setting of an unprotected airway which, to him, raised the questions as to why Jacob was unconscious resulting in an unprotected airway.[58]

78. Though Dr Lynch was unable to determine the medical cause of death, based on his findings at autopsy, he was able to postulate three possible causes. Namely, that death was:

    i. Possibly caused by sedation and/or respiratory depression due to the combined effect of sedative drugs administered in the days leading to Jacob's passing which caused asphyxiation because he was unable to protect his airway when he vomited; or

    ii. Possibly caused by a fatal cardiac arrythmia arising from the prolongation of his QT interval caused by the drugs administered to him; or

    iii. Possibly caused by a seizure.

[57] Court File, Statement of Agreed Facts.
[58] Transcript of Proceedings, page 100.

79. Dr Lynch opined there were, “a number of possible mechanisms of death warranting consideration”, and his “comments” include the following notes:

    i. “Mixed drug toxicity, specifically in a degree of respiratory depression which has been complicated by aspiration of gastric contents.”

    ii. “Patients with ‘seizure disorders’ can die suddenly and unexpectedly and the mechanism is not entirely clear but may be related to cardiac arrhythmia induction in the setting of cerebrocardiac reflexes, central apnoeic phenomena or airway compromise in a post ictal state.”

    iii. “There were also two findings of uncertain significance identified within the heart. There was focal fibrofatty scarring in the right ventricular lateral wall and also so-called dysplasia of the artery to the atrioventricular node. These conditions might be implicated in the development of a cardiac arrhythmia.”

80. After Dr Lynch read the expert reports of A/Professor Gunja, Professor Keks and Dr Badov, he said, “I'm not sure how helpful they are in resolving the issue of cause of death”. When he was subsequently provided with the report of Dr Atherton, he said that there was nothing further to add but noted Dr Atherton had been critical of aspects of the management of Jacob. In his oral evidence, Dr Lynch said, “the presence of vomit within Jacob’s airways is reflective of a terminal event and an unprotected airway. So the antecedent question is, why was his airway unprotected, i.e. why was he in an unconscious state? And the possible - well, possibilities that I raised in my initial autopsy report were, given the history of the seizure disorder, that perhaps he had suffered a seizure and ended - ended up with an unprotected airway. Or in any case where the heart is essentially normal, irrespective of the toxicological findings, I'd propose a possibility that, you know, a patient has suffered a cardiac arrhythmia, rendering them unconscious and perhaps dying, but not dead, vomiting - unprotected airway. So the presence of vomit in an airway tells us that ultimately Jacob had an

unprotected airway, but it doesn't actually help us determine why he was rendered vulnerable".

81. Dr Lynch explained, in forensic medicine, where there is more than one possibility of the medical cause of death, it does not follow that if one becomes less likely, the other becomes the most likely, if they did not, or could not be equally proportioned possibilities in the first place. He did not consider that he could apportion the likelihood of each of the possibilities he canvassed in this case.

82. Consequently, my first line of inquiry was to examine the facts upon which I would be enabled to discharge my statutory obligations pursuant to section 67(1)(b) of the Act.

Oversedation with vomiting and aspiration as the medical cause of death

83. The evidence indicates that on 4 February 2017, Jacob was administered the following medicines-- Olanzapine 10 mg IMI at 2.28 am, Clonazepam 1 mg orally at 8.24 am, Methadone orally 30 mg at 8.24 am, Pregabalin 300 mg orally at 8.25 am, Haloperidol 2.5 mg orally at 9.38 am, Diazepam 10 mg orally at 10.06 am, IbuProfessoren 400 mg orally at 9.38 am and for agitation, Chlorpromazine orally 250 mg at 1.24 pm.

84. Over the five-day period leading to his passing (from midnight on 31 January 2017), Jacob had received a total of 60 mg oral Olanzapine, 10 mg Olanzapine by IMI, 325 mg oral Chlorpromazine, 7.5 mg oral Haloperidol, 180 mg oral Methadone, 1500 mg oral pregabalin, 13 mg oral Clonazepam, 70 mg oral Diazepam, 40 mg oral Temazepam and 30 mg oral Zopiclone.

85. According to AP Gunja Jacob was heavily sedated and if he had not been sedated, it is more likely than not that he would have deteriorated in the way that he did. Dr Atherton agreed with this contention.[59] Professor Keks disagreed on the basis that there were

[59] T 1095.8-24.

other mechanisms involved given Jacob's trajectory, and heavy sedation does not happen with the whole of the pharmacological strategy for Jacob.[60]

86. According to Dr Atherton, the effect of the accumulation of drugs led to fluctuations in Jacob's consciousness and, if his medication had been streamlined in keeping with the Guidelines, Jacob is likely to have survived.[61] Dr Atherton stated further that if Jacob was not on Methadone, his chances of surviving would be even greater because that drug that carries the most potential for oversedation.[62]

87. Dr Atherton testified that Jacob had no symptoms of opiate withdrawal during the admission, and it had been two or three weeks since he had any opiate drugs of significance such that prescribing Methadone was not a priority, except that Jacob wanted it.[63] Dr Atherton did not state emphatically, however, that Methadone Therapy should not have been offered to Jacob.[64]

88. In qualifying his stance on Methadone Therapy for Jacob, Dr Atherton expressed the view that it would have been appropriate to offer Jacob Methadone at some point but because he did not exhibit symptoms of opiate withdrawal at the time, it would have been preferable to wait to recommence Methadone Therapy, or alternatively to start at a lower dose.[65] I note, however, that according to Dr Chan, Jacob had a strong risk of returning to heroin use if he were to be discharged without Methadone Therapy treatment.[66]

89. Dr Atherton testified further that:

[60] T 1095.27 – 1096.4.
[61] T 1064.10-27.
[62] T 1131.5-9.
[63] T 1130.12-29.
[64] T 1130.15-17.
[65] T on 14 September 2023.
[66] CB 37.

i. In his view, the cause of death was respiratory depression pursuant to the administration of drugs having a sedative effect such that he was not able to protect his airway when he vomited. Jacob was clearly sedated and was snoring for a long period of time;

ii. He agreed with AP Gunja's view that Jacob's cause of death was sedation with vomiting and aspiration, and stated that a seizure would have been detected;

iii. The fact that Jacob had aspirated vomit indicated that he was not protecting his airway.;[67]

iv. Methadone is long-acting drug and its level stays high and then slowly reduces over time;[68]

v. "Methadone would have reached its peak level around lunchtime but its level would have remained high after this and would, in his opinion, have contributed to a decreased level of consciousness in conjunction with the other medication";[69]

vi. Sleep deprivation would definitely have had an impact on Jacob's overall level of sedation but the drugs in his system had a role in the level of sedation.[70] However, sleep deprivation would not have caused Jacob to be unable to protect his airway when he vomited;[71]

vii. The dangerous part of Methadone induction,[72] as the outcome is unpredictable, is the combination of Methadone with Benzodiazepine drugs. According to Dr Atherton this combination is "a common cause of death";[73] and

[67] T 1056.4-23.
[68] T 1189.23-31.
[69] CB 981.
[70] T 1076.123.
[71] T 1076.24 – 1077.7.
[72] T 1136.19-21.
[73] T 1078.18 – 1079.7.

viii. It is relatively common in patients admitted to a mental health ward to have fluctuating levels of consciousness. Such patients may be more alert at times and at other times be very sedated.[74]

90. With regard to sleep deprivation, AP Gunja agreed with Dr Atherton and testified that sleeping poorly the night before and having a period of agitation leading to a Code Grey does not cause a person to be sedated, to stop breathing or die.[75] AP Gunja testified further that patients in Jacob's position who had been administered sedative drugs "which are accumulating" over an approximate period of "four days", are known to have intermittent episodes of being rousable and go back to being sedated.[76]

91. In contradistinction, Professor Keks testified:

i. Accumulative sedation is quite improbable[77] because he has seen accumulation of drugs only when a patient cannot metabolise a drug, and that Jacob did not have any impairment of drug metabolism of note;[78]

ii. If a patient is very sedated, that patient is not going to have lunch and an altercation with somebody;[79] and

iii. The sedation hypothesis is not viable as he himself does not subscribe to the notion that Jacob could have been having lunch and having an altercation and then be deeply sedated.[80] Professor Keks then expressed the view that the timing was all wrong for Jacob to be sedated from the drugs that he was given, as he would expect Jacob to be sedated from the Methadone after administration and not late in the afternoon because it had been 12 hours since

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[74] T 1192.6-11.
[75] T 949.6 – 950.11.
[76] T 996.16 – 997.8
[77] T 1218.3-4; 1229.8 – 1230.2
[78] T 1072.23-27.
[79] T 1060.29-31.
[80] T 1060.29-31; T 1194.6-12.

Jacob was given Olanzapine.[81] Professor Keks then went on to testify that Jacob was asleep on the afternoon of 4 February 2017 because he experienced disturbed sleep the night before.[82] However, stating that the "big episode" of sedation for Jacob followed the initiation of his Methadone treatment, Professor Keks agreed that it is possible for a patient, or even likely, to have varying degrees of sedation throughout the day, dependent upon what drugs have been given and the patient's general condition.[83] In my view, Professor Keks' concession in this regard is inconsistent with the general tenor of his evidence.[84]

92. In response to Professor Keks' evidence on this point, AP Gunja testified that he disagreed with Professor Keks' view that chronic drug accumulation did not occur in Jacob's case because he believed that assumptions were made about Jacob's physical condition which led to use of medications outside of the usual protocols.[85]

93. AP Gunja noted further in his evidence that Jacob was administered relatively small doses of antipsychotic medication to manage his behaviour but unfortunately there was an underestimation of the accumulation of other medicines in his system. By the time he fell asleep on the afternoon of the 4 February 2017, he had been given significant doses of long-acting Benzodiazepines, relatively high-doses of Methadone and had been sedated with numerous doses of antipsychotics and Pregabalin which is usually indicated for pain and has a sedative effect.[86]

94. AP Gunja said that it was appropriate to prescribe both clonazepam and diazepam at the same time, but that people needed to be aware the effects were additive and summative.

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[81] T 1087.1-19.
[82] T 1075.28 – 1076.12.
[83] T 1068.21-28.
[84] T 1069.6-9.
[85] CB 987.
[86] CB 985.

This is precisely what Dr Nguyen did in attempting to rationalize the number of benzodiazepines Jacob was prescribed and to try to reduce doses in accordance with his clinical presentation and needs.

95. CA submits it was reasonable to prescribe clonazepam for Jacob by reason of his clonazepam addiction, although a management plan for reduction of the dose over time ought to have been made. CA submits, however that clonazepam should not have been prescribed at the same time as diazepam.

Were the appropriate medicines administered to Jacob?

96. Dr Jane Nguyen was Jacob's treating psychiatrist during his admission between 30 January and 4 February 2017.[87]

97. My review of the relevant medical records that and subsequent evidence heard at the Inquest indicated that:

    i. Dr Nguyen did not make any enquiries to find out who Jacob's treating neurologist was and further, no enquiries were made about the treatment he received;[88]

    ii. Dr Nguyen did not enquire from the clinician who admitted Jacob to W2W whether his instructions that he was prescribed Clonazepam for epilepsy was followed up. When asked about this discrepancy, Dr Nguyen conceded that she or her delegate was responsible to following up this information;[89]

[87] T 5.12-15.
[88] T 6.18-30.
[89] T 7.20-24.

iii. No enquiries were made of Jacob's general practitioner and Dr Nguyen could not recall if she made any contact with the general practitioner who was prescribing Jacob's Methadone in the community;[90]

iv. On 30 January 2017, the PH pharmacist undertook a medication reconciliation with Jacob's usual dispensing pharmacist. That reconciliation revealed that Jacob was prescribed 40 mg Methadone per day, 4 mg Clonazepam per day and further that Jacob was taking more Clonazepam than he was prescribed. Jacob was also prescribed 300 mg Pregabalin per day. The community pharmacist was not dispensing Temazepam for Jacob.[91]

98. According to Dr Atherton, he considered it to be reasonable practice for a treating psychiatrist, during Jacob's admission to PH between 24 January and 4 February 2017, to make enquiries with Jacob's treating doctors in the community to determine what his diagnoses were, what course of treatment was indicated and which drugs were prescribed to him and their relevant dosages. Dr Atherton testified that such enquiries should have been the first thing that occurred. [92]

99. Professor Keks disagreed with Dr Atherton's contention in this regard and testified that while it could reasonably be expected from a psychiatrist to conduct enquiries of this nature, they were of low priority for a treating Psychiatrist in W2W.[93] If these enquiries were necessary, they had to be addressed by the ED staff. Professor Keks did not consider information of this nature to be of a "high order". [94]

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[90] T 15.7-16.
[91] CB 1250. PH stated to the Court that the medication reconciliation form dated 30 January 2017 was omitted from the records that were provided to the Court on 7 February 2017. Due to the passage of time, PH is unable to identify the reason why this form was not included in the medical records initially provided to the Court. This form was scanned to the electronic file on 2 March 2017 which is approximately one month after the records were provided to the Court.
[92] T 980.25 – 981.12.
[93] T 979.15-2.
[94] T 979.30 – 980.19.

100. Although not an expert in psychiatry, Professor Vohra noted in his report that he considered that the combination of various drugs Jacob was administered were correct therapeutic doses because of his psychosis and agitation. He also noted they were appropriate.

101. A/Professor Gunja acknowledged that his assessment of the medications administered to Jacob and his views of the purposes of sedating medications was from his own context as a clinical toxicologist and was not informed by psychiatric treatment of Jacob and that they were quite different things.

<u>Treatment with antipsychotic medication</u>

102. Dr Nguyen testified that Jacob's psychosis was drug-induced. The PH medical records indicate that, on 4 February 2017, with an approximate 12-hour period, Jacob was treated with 10 mg Olanzapine,[95] 2.5 mg Haloperidol[96] and 50 mg Chlorpromazine.[97]

103. According to Professor Keks, Clonazepam "probably" contributed to Jacob's psychosis, causing him to convulse which was exacerbated by administering opiate medication, opiate withdrawal, Methamphetamine use and possibly alcohol.[98]

104. Professor Keks testified further that it was reasonable to prescribe Chlorpromazine for Jacob during his admission[99] because Jacob presented with convulsions, agitated psychosis, irritability and anxiety, which are manifestations of Clonazepam withdrawal, and it was not established that Jacob did not have an underlying schizoaffective disorder.[100]

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[95] At 2.28 am.
[96] At 9.38 am.
[97] At 1.24 pm.
[98] T 1017.10-19.
[99] T 1006.17-19.
[100] T 1195.15-22.

105. In Professor Keks' opinion, Jacob was suffering from Clonazepam withdrawal on 4 February 2017 as he had relatively little Clonazepam during his admission. It was recommenced during his admission, but the dosage was later reduced.[101]

106. On this point, Dr Atherton testified that in the context of Methadone Therapy induction, as in Jacob's case, it was not standard practice for a psychiatrist to prescribe three antipsychotic medications simultaneously.[102] In his view, Jacob ought to have been prescribed one antipsychotic medication in a more reasonable dose, or one antipsychotic medication with an option for a PRN antipsychotic medication where the PRN medication would be the same medication as the one given, or potentially something different.[103] Dr Atherton believed further that it was reasonable in the circumstances to prescribe Chlorpromazine for Jacob during his admission.[104]

107. Dr Atherton qualified his concession with a condition that it may have been appropriate to prescribe three antipsychotic drugs simultaneously if there was a decision to change antipsychotics.[105]

108. According to Dr Nguyen, it was not her intention for Olanzapine and Haloperidol to be administered at the same time.[106] In this regard, I note that the Guideline states that for moderate agitation, Olanzapine or Chlorpromazine may be prescribed, but not both.[107] Dr Nguyen, however, testified further that it is common to use both drugs if the patient's ABD episode is not contained, and a guideline is only a guideline from which deviations can be made on the clinical basis.

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[101] T 1196.1-17.
[102] T 1014.15 – 1015.6.
[103] T 996.1-19.
[104] T 1007.10-15.
[105] T 1035.17-28.
[106] T on 17 August 2023 at 94.25-95.3.
[107] CB 420.

109. Dr Nguyen testified further, however, that Jacob had two generalised tonic clonic seizures on 24 January 2017 and in those circumstances, it was reasonable to prescribe Haloperidol, an epileptogenic drug, for Jacob as he was also receiving a "reasonable" dose of Clonazepam, which is an anticonvulsant. According to Dr Nguyen, she did not believe that Jacob was suffering from epilepsy, however.[108] In this regard, I note that the Guideline which is PH's own guideline in force in January and February 2017, provided that the administration of two or more antipsychotic mediations is to be avoided, and if prescribed, the patient is to be monitored.[109]

110. According to AP Gunja, with whom Professor Vohra agreed, there is no absolute contraindication to prescribing the drugs that were prescribed for Jacob, but there are relative contraindications.[110] Professor Vohra testified that "none of the drugs utilised in the treatment of the patient are contraindicated for use in combination".[111]

111. In the final analysis, though Dr Atherton questioned the utility of small doses, he acknowledged it may have been reasonable to prescribe three antipsychotics at once. On the weight of the evidence, I am satisfied that the prescription of antipsychotic medication for Jacob was not unreasonable in the circumstances.

Methadone therapy treatment

112. The relevant contemporaneous medical records indicated that Jacob repeatedly requested Methadone Therapy whilst he was an inpatient at PH in the January to February 2017 admission period.[112] In particular, on 29 January 2017, the following notations appear from the relevant records:

[108] T 9.20-29.
[109] CB 418 and 422.
[110] T 855.3-5.
[111] T 856.23-27.
[112] Exhibit 26 at 64, 20 65, 67, 68, 70, 79 and 87 – 88.

i. Dr Nguyen noted that Jacob was "pre-occupied with his methadone and asking methadone";[113]

ii. On the same date a nurse noted that Jacob "exhibited moments of outbursts – due mainly to pt requesting methadone" and further that "Pt has several times argued re him not having Methadone";[114]

113. The contemporaneous notes of 30 January 2017 to 2 February 2017 reflected that Jacob continuously requested Methadone Therapy and wanted to discuss "his methadone with [his] treating team". Jacob was subsequently referred to CLAMS for assessment. After his CLAMS assessment on 31 January 2017, by exercising his clinical discretion in the execution of his duties, Dr Chan recommenced Jacob's Methadone Therapy.[115]

114. According to Dr Chan, given that Oxycodone had been administered to Jacob in the ED, he was not opiate naïve.[116] In his evidence, Dr Atherton essentially agreed with Dr Chan on this point but qualified his view further.

115. Dr Atherton testified that, in his view, given the relatively low doses of Oxycodone administered to Jacob in the ED, he was *relatively* opiate naïve when he started Methadone induction on 31 January 2017[117] because he did not have any other confirmed opiates for at least two weeks.[118]

116. Given Jacob's recent history of opiate medication, Dr Atherton testified that he would have started Jacob on 30 mg of Methadone per day,[119] which may have reduced the risk

[113] Exhibit 26 at 64; T 8.11-12.
[114] Exhibit 26 at 67.
[115] CB 36 at [6].
[116] T 433.9-14.
[117] T 1079.8-28; T 1221.9-19.
[118] T 1166.26 – T 1167.5.
[119] T 1080.16-20.

of excessive sedation as opposed to the 40 mg of Methadone per day on 31 January 2017.[120]

117. According to Dr Atherton, although specific predictions about the pharmacological action of Methadone Therapy cannot be made, Methadone Therapy was probably the more effective treatment for Jacob in terms of helping him with his psychosis.[121] Dr Atherton also believed that although it was not a priority given his clinical history and that other medicines like Buprenorphine, given its safety Professorile, were not adequately considered as an option for Jacob, recommencing Jacob's Methadone Therapy was appropriate in the circumstances.

118. Dr Atherton testified further although consultation with Jacob's family about his treatment is desirable, there are times when clinical judgement can override the patient's family's views. In Jacob's circumstances, the risk of his going out to use opiates when he is discharged from hospital outweighs the family's preferences for him not to be on opiate maintenance while he was in hospital.[122] In this regard, Dr Atherton held the view that the predominant reason for someone like Jacob to be prescribed Methadone, is to keep him alive because it will increase his tolerance to other opiates, so he will be at less risk of overdose in future.[123]

119. Having considered the expert evidence on this point, the weight of the available evidence supports a conclusion that the decision taken to recommence Jacob's Methadone Therapy on 31 January 2017, was not unreasonable in the circumstances. In the same vein, the evidence does not support a conclusion that an altered dose of Methadone could have altered the outcome for Jacob. On the evidence available to me,

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[120] CB 986.
[121] T 1147.31 – 1148.2.
[122] T 1137.1-9.
[123] T 1136.14-21.

I am therefore satisfied that the clinical decision taken to recommence Jacob's Methadone Therapy did not constitute a deviation from reasonable practice standards.

120. Despite submissions to the contrary on behalf of the Jacob's family, Jacob was known to those treating him at PH to have a history of heroin abuse and a long history of being on opiate substitution programs. This is clear in the note of Dr Michael Lee, who assessed Jacob and placed him on an inpatient temporary treatment order under the Mental Health Act on 28 January 2017, noting Jacob had a very long history of intravenous drug use (of ice and heroin and other drugs) and that he only recently ceased methadone, at a daily 40 mg maintenance dose.

121. CA submits that there is no evidence before the Court to suggest that Jacob would have survived if a dose of 30 mg had been administered to Jacob on previous days instead of 40 mg.

122. Jacob's family were also critical of the information "that they didn't want Jacob recommenced on methadone", not being passed onto Dr Chan. However, various detailed records of conversations between family members and medical and allied health staff from 27 – 29 January included a reference to methodone but no recorded expressed opposition to methodone.

123. In the final analysis, I am unable to determine this issue. Clearly family recollections of conversations in respect to their opposition to methodone, are not reflected in detailed contemporaneous medical records.

<u>Treatment with Benzodiazepine drugs</u>

124. On 30 January 2017, under Dr Nguyen's clinical management, Clonazepam was administered to Jacob, indicated to treat his agitated state, his seizures and

Benzodiazepine dependency issues. The evidence indicates that Dr Nguyen did not want Jacob to be at risk of Clonazepam withdrawal-related symptoms.[124]

125. Dr Nguyen testified that she did not believe that Diazepam had been prescribed or administered to Jacob at the same time as he was receiving Clonazepam.[125] However, when her evidence on this point was taken up with her and examined more closely, Dr Nguyen conceded that Jacob was receiving Diazepam at the same time as Clonazepam on 30 to 31 January 2017 and 2 to 4 February 2017. In making this concession, Dr Nguyen said that she considered that Diazepam to be similar to Lorazepam and she intended the Diazepam to be administered on a PRN basis.

126. Dr Nguyen had attempted to provide alternative benzodiazepine medication to Jacob, but this was unsuccessful with the records revealing he experienced high levels of distress and agitation on the alternative regime.

127. Professor Keks opined that it was totally reasonable to prescribe clonazepam to Jacob and would have been "life threateningly dangerous" not to do so in the circumstances.

128. In contradistinction, Dr Atherton testified that he found it unusual for Clonazepam to be prescribed in the circumstances of Jacob's presentation because it would only be reasonable to prescribe the drug if Jacob was Benzodiazepine dependent and there was a management plan in place. Dr Atherton did not consider it was reasonable practice for a psychiatrist to prescribe Clonazepam with Diazepam, in circumstances in which he could not identify a rationale for doing so.[126]

129. Dr Atherton explained from an addiction psychiatrist's point of view, Benzodiazepines are all sedative medication and affect the brain in similar ways with variations in the

[124] T 19.27 – 20.8; Transcript on 17 August 2023.
[125] T 20.14-19.
[126] T 1013.1-15.

duration of their on individual patients.[127] However, on the strength of the existing records, it is not possible to extrapolate Jacob's situation to the results of trials conducted on average healthy persons in individual Benzodiazepine drug trials.[128]

130. In circumstances in which Jacob had multiple medications and multiple concurrent health concerns, the Guidelines ought to have been followed to ensure that the correct medicines in their correct dosages were administered to him.[129] Further, there was no indication in the medical records that the treating team was managing Jacob for symptoms related to Benzodiazepine withdrawal.[130] Dr Atherton considered Jacob was a standard patient for a busy inner city psychiatric unit and the Guidelines are there to ensure that the patient is not getting into a grey area where it is not known what might happen to that individual.[131]

131. Conversely, Professor Keks testified that it was reasonable to prescribe Clonazepam to Jacob for the purpose of managing his addiction to Clonazepam,[132] because he was using high doses of Clonazepam and Pregabalin.[133] However, Professor Keks was not aware of any protocol for treating Clonazepam withdrawal symptoms with Diazepam which he described as a low-potency Benzodiazepine drug. According to Professor Keks, in his experience, Clonazepam withdrawal symptoms are better managed by gradually reducing the drug's dosage rather than by administering Diazepam instead. The evidence indicates that the combined effect of the drugs administered to Jacob, including the Olanzapine which was the only therapeutic drug and Haloperidol and

[127] T 1072.31 – 1073.8.
[128] T 1073.9-15.
[129] T 1073.16-22.
[130] T 1073.23-31.
[131] T 1073.11-17.
[132] T 1019.9-13.
[133] T 1016.25.

Chlorpromazine which were only marginally therapeutic in Jacob's case was to be considered to be "overlap treatment".[134]

132. Having considered the expert evidence with regard to prescribing and administering Benzodiazepine drugs to Jacob, the weight of the available evidence supports a conclusion though not inappropriate in the circumstances to prescribe Clonazepam for Jacob, there should have been a management plan in place to wean him from the drug.

Monitoring sedated patients

133. The 2017 PH Guideline included Monitoring Recommendations (**MR**) for staff to monitor the patients admitted to their inpatient psychiatric unit. The relevant MRs for post-sedation patients were the following:[135]

    i. Vigilant monitoring particularly for signs of airway obstruction, respiratory depression and hypotension, during the post-medication period is essential.

    ii. Post-medication observations are carried out as below, if feasible, until the patient is ambulatory, able to maintain oxygen saturation >90% on room air, has intact airway reflexes (the airway must be checked if the patient is asleep, especially if snoring) and has a systolic BP >100 mm Hg (or higher for elderly or those with cardiovascular disease).

    iii. Visual observations: conscious state, airway patency, movement, skin integrity and colour.

    iv. Physical observations: respiratory rate, pulse, blood pressure, temperature, oxygen saturation +/- ECG.

    v. Consider monitoring of the patient's ECG when:

        - High doses of antipsychotics have been administered

[134] T 1022.28 – 1023.2
[135] CB, Version 3 in force on 4 February 2017.

- Two or more antipsychotics are being administered concurrently
- Parenteral injections of antipsychotics have been administered
- Identified cardiac risk factors are present

vi. The MR included the following guidelines for monitoring frequency:

- Oral medication—every 30 minutes for one hour; and
- IMI medication—every 15 minutes for the first hour, then every 30 minute from the second hour onwards.

134. Having perused the Guideline in respect of sedated patients, I noted that MR does not include recommendations for the frequency at which vital signs like heart rate, respiratory rate, blood pressure and oxygen saturation levels, *inter alia*, are to be monitored from the time when the sedative drug is administered to a patient and when the patient first becomes ambulatory.

135. On the other hand, the Nursing Visual Observations Chart (**NVOC**) in force at the material time, February 2017, only prompted staff to record whether the patient was observed to be alert, responsive to verbal cues, observed to be in pain or verbalising that they are experiencing pain and whether the patient was unresponsive.[136]

136. According to Professor Atherton, on the afternoon of 4 February 2017, when Jacob appeared to be asleep, attending staff ought to have monitored Jacob's heart rate, respiratory rate blood pressure, oxygen saturation levels and Glasgow Coma Scale (**GCS**) every half hour to one hour by rousing him, if they were required to do so. Dr Atherton testified further that monitoring Jacob's vital signs in this manner was

[136] CB, statement of Homie Thomsom dated 16 September 2020.

required because he was unwell and had been examined by clinicians overnight because he was complaining of abdominal pain and was vomiting.[137]

137. On his review of the medical records, Dr Atherton stated there was an opportunity for the staff to monitor Jacob's vital signs at 6 pm when he was roused and that he would consider it to be reasonable practice at that time to have placed a pulse oximeter on Jacob's finger to check his pulse. Dr Atherton testified further that if the patient is on the floor, then staff must enter the seclusion room when they monitor the patient, which the nursing staff did not do.[138]

138. AP Gunja testified that he was concerned that the NVOC completed by the AMA nursing staff did not appear to record actual respiratory rate or effort. According to AP Gunja, on his perusal of the NVOC, none of the key parameters in monitoring a sedated patient were covered and, in his view, visual monitoring on its own may be insufficient in detecting cardiorespiratory depression in sedated patients.[139]

139. Before me, when their observation and monitoring practices were interrogated, the PH nursing staff testified that they considered vital sign monitoring and recording for sedated patients, as described by AP Gunja, to be optional and only necessary under circumstances where the patient is known to have shortness of breath, complain of chest pain, has pre-existing ailments and is generally restless.[140]

140. AP Gunja testified further that it is unlikely that attending staff would have been able to determine respiratory the rate or effort of a patient, as in Jacob's case, from five

[137] T 1042 – 1043.
[138] T 1090 – 1097.
[139] T 924.19 – 925.11.
[140] T 147 – 265.

metres away and it is not possible to determine whether that patient is experiencing "apnoea by standing 10 feet away".[141]

141. In this regard, Dr Atherton stated that if a patient is lying supine and snoring it may be possible to determine if a that patient is breathing, but agreed with AP Gunja that a proper clinical assessment is impossible especially when the patient, as in Jacob's case, is not lying on their back.[142]

142. According to AP Gunja and Dr Atherton, for a patient in Jacob's position, there is a need to monitor heart rate, respiratory rate, GCS, blood pressure, shallowness or difficulty breathing, oxygen saturation levels and end tidal carbon dioxide levels. In their view, given the known risks associated with cardiorespiratory deterioration in sedated patients and further, given that cardiorespiratory deterioration in sedated patients is "often missed",[143] it was not best practice to monitor a psychiatric patient by merely "looking at" the patient to determine if the patient is breathing or has moved.[144]

143. AP Gunja and Dr Atherton expressed their concerns that there are associated risks of self-harm if a monitoring cord were attached to a patient who is mentally unwell, but agreed that when patients are sedated, psychiatric facilities were bound by duty to ensure that the sedated patient is adequately monitored which could be achieved by attaching an oximeter to their finger.[145]

144. Although Professor Keks believed that Jacob did not require his vital signs to be checked on the afternoon and into the evening of 4 February 2017,[146] he agreed that using an oximeter, where a clip is placed on a patient's finger to monitor heart rate and

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[141] T 897.10-25.
[142] T 1094.19 – 1095.
[143] T 924.24 – 925.10.
[144] T 924.24 – 925.11.
[145] T 899.6-28.
[146] T 1045.30 – 1046.5.

oxygen saturation levels is an achievable practical and reasonable measure to take in monitoring sedated patients in an inpatient psychiatric unit.[147]

145. Having heard the evidence of the expert witness on the monitoring regime of sedated patients admitted to psychiatric units as involuntary patients under the MHA 2014, I am satisfied that the weight of the available evidence supports a conclusion that the monitoring regime adopted by the attending staff in observing Jacob's vital signs on 4 February 2017 was inadequate.

146. Similarly, with regard to the monitoring practices adopted by the AMA nursing staff, as prompted by the NVOC, who considered vital sign monitoring for sedated patients to be an optional practice, the evidence before me indicates that their practice of not monitoring vital signs as described by AP Gunja and supported by Dr Atherton, was inconsistent with the relevant MR in PH's own Guideline in force at the time. To the extent that the NVOC is inconsistent with the MR in the PH Guideline, the weight of the available evidence supports a conclusion that this inconsistency represents a significant systemic error.

147. It is acknowledged that on the day of Jacob's passing he was not monitored in accordance with the policy in place. The nursing staff who gave evidence also confirmed that in 2017, it was not the usual practice to wake a sleeping patient to do vital signs monitoring at that time, unless there was a concern about their respiration. While this was not best practice that had developed seemingly as a custom at the hospital at the time, it is no longer the practice at PH. Dr Rubin gave evidence that currently, the policy is adhered to in the sense that staff consistently attempt to perform vital signs where required and the unit is audited for compliance.

148. Jacob had been suffering abdominal pain and vomiting overnight and was awake until

[147] T 1040.6-13; T 1101.31 – 1102.9.

at least 4.13 am and was up at 6.45 am. Before going to sleep he ate biscuits and had a drink. Prior to this, security had been called twice overnight due to Jacob's aggression towards staff while he was physically unwell. The first doctor who attempted to review him at 9.15 pm on 3 February 2017 was unable to examine him due to Jacob not cooperating. Jacob was successfully reviewed prior to 3.30 am on 4 February 2017 by a second doctor. The morning nurse noted Jacob was very unsettled that shift due to another patient. That nurse noted that Jacob was visited by his father at 12.30 pm in the courtyard, which was good for him and that he was unsettled due to the pain in his abdomen but was refusing to go to x-ray or have bloods taken. At handover (after 1 pm), there were two duress calls by staff as Jacob was highly agitated and hostile. After handover, Jacob is recorded by the afternoon nurse to have refused to attend for an abdominal x-ray when he asked Jacob.

149. Counsel for PH further submitted Professor Newton and Dr Rubin gave evidence about the importance of sleep on a person's psychiatric state and treatment. Both also agreed that it was reasonable not to wake Jacob in the circumstances put to them.

150. It is not submitted that it was appropriate only to visually observe Jacob for much of the time through the window to his room, as was done. However, it is submitted that the context of the situation must also be considered here. Jacob's door was closed because he had been disturbed by a co-patient that day who had been going into Jacob's room, waking him up and pulling his hair tie out. Jacob was described as close to hitting him the co-patient and Jacob told nursing staff that if he continues to be harassed by the other patient, he will hurt him. Accordingly, Jacob's door being shut was as a result of the dynamic situation at play and his clinical need for sleep. Nursing staff gave evidence that the doors were heavy and made a noise that woke patients up when opened. Further, Dr Rubin opined, he could understand why nurses did not have a high index of concern in Jacob's case on this afternoon, saying, "... my comment would be that when I look at the medication that was used I would

understand the nursing staff not having a large degree of concern because the doses would seem so small".

151. Accordingly, while it is submitted that it is not appropriate to perform visual observations of respiratory rates in lieu of vital signs observations through a window, the Court is asked to consider that nursing staff were instead frequently observing Jacob through the window of his bedroom, to allow him to get some sleep, of which he was deprived, in circumstances where they did not have concerns about him being overly sedated by his medication, or indeed any concerns for his respiration or wellbeing.

152. In respect of Dr LFG, it cannot be suggested that there was a requirement to physically assess Jacob on 4 February 2017. At the time and bearing in mind the resourcing available in a public hospital on a weekend, Jacob was to be reviewed daily on the AMA. It is noted that this guideline was amended to reflect this requirement was Monday – Friday.

Did Jacob require an ECG on 4 February 2017

153. PH guidelines stipulate that an ECG is required when two or more antipsychotic drugs have been administered to a patient, as in Jacob's case. Dr Atherton stated that an ECG was a "pressing issue" for Jacob on 4 February 2017. However, in the final analysis, the consensus of expert evidence is that conducting an ECG would unlikely have averted Jacob's passing.

154. Counsel for PH submitted, with the benefit of hindsight, it is accepted that despite having had ECGs performed on 7 January 2017 and 15 January 2017, an ECG should have been attempted to be performed on Jacob at some point during his admission between 24 January and 4 February 2017.

Was the care provided to Jacob culturally competent and culturally safe?

155. As Jacob was a proud Plangermaireener Aboriginal man from the Ben Lomond Nation of Tasmania, his sister Sherrie testified that Jacob would have derived a cultural benefit from a cleansing ceremony[148] if she, accompanied by her children, had been invited to perform a cleansing ceremony.[149] According to Sherrie, Jacob would have derived further cultural benefit if she and their mother, or a community elder, were given the opportunity to talk to Jacob while he was in hospital.

156. According to Linda, Jacob's mother, she would have liked to have been consulted about the decision to recommence Jacob's Methadone[150] and she also would have liked the doctors or nurses to let her know how Jacob was every day[151] and to have informed her directly of Jacob's passing.[152] A bereavement counsellor did, however, contact her in the week after Jacob's passing.[153]

157. Jacob's father, Cyril, testified that he would have liked two telephone calls from the hospital in the eleven days that Jacob was an inpatient there.[154] He did not, however, want to attend any cleansing ceremony for Jacob.[155]

158. Dr Nguyen testified that it was a regular practice at PH for a team member, including doctors and nurses, to consult with a patient's family members. According to Dr Nguyen, family consultations are usually arranged by the social worker at her direction

[148] https://bare.com.au/blog/aboriginal-funeral-and-burial-traditions. Aboriginal communities have specific rituals and mourning practices that vary across different regions and clans. These rituals often involve cleansing or smoking ceremonies, storytelling, singing, and dancing. Mourning periods can last for days or even months, allowing the community to grieve collectively and honour the deceased.
[149] T 45.26-29.
[150] T 71.20-29.
[151] T 74.7-12.
[152] T 74.13-25.
[153] T 75.6-13.
[154] T 25.21 – 26.1.
[155] T 26.2-4.

or at the direction of another member of her team.[156] Dr Nguyen stated further that she always tries to meet with family members before a discharge plan is made and that this was her usual practice.[157]

159. The PH records indicate that hospital staff had the following interactions with Sherrie.[158]

    i. On 27 January by telephone;

    ii. On 28 January 2017, while Jacob was in the emergency department, consultation liaison psychiatry team member spoke with Sherrie;[159] and

    iii. On 30 January 2017, Sherrie and Linda had a discussion with a nurse at the hospital when they attended.[160]

160. Sherrie acknowledged that the prescription of medication for Jacob was a matter for his doctors,[161] but testified that she wanted to have been consulted about recommencing Jacob's Methadone Therapy treatment.[162] Sherrie was unaware of the observations that were being taken of Jacob and unaware that the stitches in his scalp were removed at the hospital on 29 January 2017.[163] Sherrie said that it would have been helpful for her to have had a family meeting and a discussion whenever anything was going to be changing with Jacob's care plan.[164]

161. In response to Dr Nguyen's evidence that she usually meets with a patient's family prior to discharge, Dr Atherton expressed the view that meeting with the family in the

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[156] T 12.14-25.
[157] T 13.6-7.
[158] Exhibit 26 at 62; T 34.25-30.
[159] Exhibit 26 at 62; T 34.25-30.
[160] T 34.25-30; T 36.30 – 37.3.
[161] T 62.11-20.
[162] T 40.3-4; T 62.11-20.
[163] T 41.18-27; T 42.6-31.
[164] T 45.14-25.

week prior to discharge was problematic because most patients are only in hospital for one week and the better option would be to meet with a patient's family as soon as possible, especially when it is envisaged that the patient may be in hospital for a longer time than the usual period of one week. Professor Keks agreed with Dr Atherton's contention that earlier contact with the family is expected under these circumstances and stated that such contact did occur with Jacob's family.[165]

162. The PH Aboriginal Health Liaison Officer (**AHLO**), Lisa Coppe, gave evidence that, at the time, she did not ask Jacob if she could call his family[166] because she did not consider that offering to speak to his family was a useful way of ensuring that Jacob's cultural needs were met.[167]

163. Ms Coppe stated further that in 2017, it was the role of the treating doctors to facilitate meetings between the patient, Jacob in this case, the family and the AHLO[168] and further that when there was a meeting held with a patient's family, the AHLO would only participate on invitation from the family and the patient.[169] At the time, it was routine for the AHLO to sit in with a First Nations patient and the doctors when they meet and it was her role to suggest that to the patient. Ms Coppe could not, however, recall if she offered Jacob the opportunity to have her sit in on his consultations with the doctors.[170]

164. According to Ms Coppe, AHLO contact with an Aboriginal person's family after their passing is not something that routinely occurs[171] and she believed that the staff on duty at the time would call Jacob's family. Ms Coppe testified further that, after Jacob's

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[165] T 1227.11-12.
[166] T 596.3-6.
[167] T 596.7-9.
[168] T 618.22-27.
[169] T 599.2-15.
[170] T 600.8-14; T 619.17-2.
[171] T 603.19-29.

passing, she assumed that a cleansing ceremony was conducted because she recalled a telephone conversation which Auntie Helen Bnads, the PH Aboriginal Elder and Cultural Lead, had in this regard with someone. Auntie Helen could not recall with whom she had the conversation but acknowledged some of the content referred to by Ms Coppe. I noted that that Auntie Helen disagreed with much of Ms Coppe evidence on this point.[172]

165. Although Ms Coppe did not attend a cleansing ceremony for Jacob and did not believe that a cleansing ceremony could be performed remotely, she was satisfied that the care provided to Jacob during his admission to the hospital between 24 January 2017 and 4 February 2017 was in accordance with the hospital's Aboriginal Health Policy (**AHP**) and AHLO procedures in place at the time.[173]

166. Ms Edwige, the Court's cultural expert witness, reviewed the AHP and the AHLO Guidelines and, in her report submitted to the Court, she expressed the view that there was a need for recognition in the document of the relationship between historical events, intergenerational trauma, racism and contemporary health inequalities. Based on her review of the AHP and AHLO Guidelines, to Ms Edwige proceeded to make the following recommendations:[174]

    i. Involving the family and the AHLO in discharge planning and referrals to external agencies;

    ii. The Aboriginal Hospital Liaison Officer Guidelines requires more information about the role for the AHLO and how this role is to be implemented within the hospital context, without Ms Edwige stating what should be added beyond

[172] T 739.27 – 744.17.
[173] Statement of Lisa Coppe dated 27 April 2022 at page 5.
[174] CB, Report of Vanessa Edwige.

stating that the AHLO should participate in family meetings and support discharge planning and community follow up;

iii. The acronym 'ATSI' is offensive and should the term 'Aboriginal and Torres Strait Islander people' should not be abbreviated;

iv. The AHLO Brochure version 2 dated February 2020 requires more information about the role of the AHLO in user friendly terminology and should reflect a recognition of the factors that impact social and emotional wellbeing. A photo of the two AHLO's on the brochure would be beneficial, with a brief statement about where their mob is from;

v. The policies/guidelines in place at PH need to acknowledge the imbalances of power between a doctor and a client and the potential impact this has on the therapeutic relationship and care in general. The guidelines could include the importance of obtaining information from family, meetings to include the AHLO, the family and the client and assessment of the client to have the AHLO and the family present;

vi. When speaking with an Aboriginal person, hospital staff should:

    a) Allow time to build rapport - allocate more interview time;

    b) Listen and be patient, allowing time for silence;

    c) Adopt a consistent non-threatening body language and tone of voice;

    d) Adopt a non-judgemental attitude and approach;

    e) Speak in plain English and take the time to explain;

    f) Avoid technical language and medical jargon;

    g) Do not mimic Aboriginal ways of speaking, i.e. words, slang, speech or accent;

    h) Use open-ended probing questions where appropriate;

i) Use active listening skills;

j) Speak quietly if other people are around;

k) Simplify forms and written information as much as possible, sensitively offer assistance with reading and writing if required;

l) Use visual aids to assist with explanations;

m) Always check to ensure that consumer has understood what is being said;

n) Do not make assumptions and clarify throughout the process;

o) Use caution when discussing areas of sensitivity;

p) Do not ask hypothetical questions.

vii. Emphasise confidentiality, but also be upfront about the limits of this confidentiality; and

viii. Consult with Aboriginal staff within the service, other government departments or non-government services where appropriate.[175]

167. Before me, Ms Edwige testified that the AHLO has an advocacy role between the medical staff, the family and the patient[176] and that there ought to have been more contact between Jacob's family, the AHLO, the nursing staff and the doctors.[177] Ms Edwige gave further evidence that an Aboriginal patient's family ought to be provided with the AHLO's contact information.[178]

168. When she was asked about her views on performing cleansing ceremonies after an Aboriginal person had passed, Ms Edwige stated that she had seen cleansing

[175] CB 1218 Statement of Vanessa Edwige dated 9 March 2023.
[176] T 672.4-15; T 686.2-3.
[177] T 680.23 – 681.1.
[178] T 681.2-9.

ceremonies before and they were usually performed by a very respected Elder in the community and that cleansing ceremonies are mob-specific.[179] However, Ms Edwige was unable to comment upon a cleansing ceremony being performed remotely and stated that she has never seen a cleansing ceremony being performed remotely and could not imagine how a remote cleansing ceremony would work.[180]

169. Ms Edwige expressed the view that Dr Chan should have contacted Jacob's family to obtain his medical history and his pharmaceutical regime,[181] and there ought to have been ongoing contact between the medical staff and the AHLO with Jacob's family.

170. With regard to the AHP and the AHLO Guidelines, Ms Edwige testified that, in her opinion, both documents did not provide sufficient information on culturally competent and culturally safe mental health care for Aboriginal people and further that the documents did not adequately provide specific concrete actions or steps to be taken to provide culturally competent and culturally safe mental health care for Aboriginal people.[182]

171. According to Auntie Helen, although she was not sure what qualification Ms Coppe held at the time, to her knowledge, an AHLO was required to hold the Aboriginal and Torres Strait Islander Practitioner Certificate IV qualification in Aboriginal primary health care, conferred by an accredited education service provider.[183] Because of this requirement, it was difficult to appoint someone to the AHLO position. However, at the time of the Inquest, another AHLO had been appointed and PH were currently recruiting for another AHLO to cover the weekend shift in their ED.[184]

[179] T 662.24 – 663.17.
[180] T 663.18-26.
[181] T 678.30 – 679.14.
[182] CB 1218 at [10] Statement of Vanessa Edwige dated 9 March 2023.
[183] T 7143.4-17.
[184] T 713.28 – 714.18.

172. Auntie Helen testified that Jacob was suffering from serious mental health issues and severe paranoia, particularly for the first part of his admission to the ED. He remained very unwell, and his mental state was still extremely unsettled for the duration of his stay in the AMA in W2W. His distress, refusal of care and initial denial of who he was are all part of the acute symptoms of his mental illness. In this context, Auntie Helen expressed her view that because Jacob was so unwell, it would have been unsafe for an AHLO to conduct an interview with Jacob and to intervene in his medical care or to have introduced cultural practices during this time because it could have caused serious spiritual, emotional and mental harm to Jacob.[185] Consequently, although Auntie Helen agreed with Ms Edwige that it was the role of the AHLO to facilitate communication between Jacob, his family and the doctors,[186] she did not support the view that the AHLO should make contact with the patient even if they are mentally unwell.[187]

173. According to Auntie Helen, she made telephonic enquiries around the greater Melbourne area to find another Aboriginal Elder to conduct a cleansing ceremony, but was unable to find someone suitable at such short notice.[188] With regard to her views on performing a remote cleansing ceremony for Jacob, Auntie Helen testified that she had learnt the processes of long-distance cleansing and helping Aboriginal people pass over[189] by developing her own spirituality to perform cleansing ceremonies remotely.[190] With the benefit of hindsight, Auntie Helen went on to acknowledge that she herself should have contacted Jacob's family before undertaking the cleansing ceremony, but instead told Ms Coppe to explain to the family how the cleansing ceremony was conducted.[191]

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185 CB 1118 at [8] Statement of Helen Bnads dated 3 October 2022.
186 T 719.16-22.
187 T 717.20 – 718.10.
188 T 737.4-10.
189 T 733.8 – 734.8.
190 T 735.3 – 736.4.
191 T 737.11-29.

174. However, as Aunty Helen noted, "the fact that [Jacob's] family did not feel that they were listened to, is an area where the hospital can improve. Although the medication regime for a patient is ultimately a clinical decision for the treating team, they should hear from the Family and have clear communication about the Family's loved one".

175. Ms Vanessa Edwige offered several criticisms of PH, including criticisms of PH's policies and procedures. Aunty Helen Bnads however, noted the "complexity of providing culturally appropriate care to Aboriginal and Torres Strait Islander patients and the skill and experience necessary. It cannot be a one size fits all approach. It is through the Aboriginal Health Policy and AHLO Policy that calls on that specialised skill and experience to be included in the care of Aboriginal and Torres Strait Islander patients, that culturally appropriate and specific care is delivered. It is the kind of skill and expertise that is broad and considered and cannot be reduced to a how-to policy for each area of clinical practice".

176. The undisputed evidence before the Court is that the AHLO did not make contact with Jacob's family prior to his passing. The evidence is also, that despite previous contact with Jacob's family by staff from ED and when he was first transferred to the AMA, the treating team had not yet spoken with Jacob's family. While it is the usual practice in the hospital that a family meeting would not have been held with the treating team at that stage, and while the social worker, Ms Fiona Burke, had spoken to Jacob's sister and mother, about which she recorded a detailed note on 30 January 2017, it is acknowledged that Jacob's family ultimately did not feel they were listened to. This is therefore an area, as Aunty Helen suggests, in which PH can improve, particularly in relation to Aboriginal patients.

177. Aunty Helen Bnads, Elder, performed a cleansing ceremony of Jacob's room following his passing. It is submitted that it would be inappropriate for this Court to opine on the cultural appropriateness of such a matter, which has been undertaken by an Aboriginal Elder of Aunty Helen's standing. However, as Aunty Helen conceded, Jacob's family

should have been contacted after his passing to discuss the cleansing ceremony and, in hindsight, it would have also been appropriate for her to contact Jacob's family when she returned from leave.

Was cultural awareness training provided to PH staff?

178. In an email to the Court dated 23 June 2023, PH informed me that is mandatory for all their staff to complete an Aboriginal and Torres Strait Islander Cultural Awareness e-learning course comprised of individual compulsory modules. When all the modules have been completed and the staff member has completed a course evaluation, a certificate is issued to the staff member. According to Auntie Helen, the Cultural Awareness Course also contained a link to a video titled "An introduction to Australian Indigenous History". The evidence indicates that PH had training initiatives in place to assist staff to in developing an awareness of Aboriginal culture when working with Aboriginal and Torres Strait Islander people.

179. According to Dr Nguyen, she was aware that Jacob was a First Nations person [192] and she would have been happy to be guided by the cultural consultants if there were any cultural matters that she needed to take into account when consulting with Jacob. Dr Nguyen did not, however, recall any discussion regarding Jacob's Aboriginality while he was in the AMA.[193] Dr Nguyen was also unable to recall whether any changes had been made in the management of AMA in respect of the cultural safety needs of Aboriginal people.[194]

180. The current Clinical Director of Mental Health at PH, Adjunct Professor (**Adj Professor**) Richard Newton, who had been at a Psychiatrist at PH since August 2017 testified that he was not familiar with, and had not read, the PH Aboriginal Health

[192] Transcript on 17 August 2023 per Dr Nguyen.
[193] Transcript on 17 August 2023 per Dr Nguyen.
[194] Transcript on 17 August 2023 per Dr Nguyen.

Policy in or shortly after August 2017.[195] He was also not familiar with any recommendation that staff working with Aboriginal patients are required to ask the patient if they wish to have family present for discussions about their health and treatment.[196] However, Professor Newton stated that it was routine practice at PH to enquire from a patient whether they wanted their family present when talking with doctors.[197]

181. In my view, the staff did their best to provide Jacob was culturally appropriate, culturally safe and culturally competent care to Jacob. In evidence, staff made concessions which I consider reflect a determination to ensure cultural care is paramount and that the families of Aboriginal patients, always feel acknowledged and listened to.

182. I am satisfied that the weight of the available evidence does not support a conclusion that a lack of culturally appropriate care contributed to Jacob's passing.

183. I turn now to consider the extent to which PH has considered or implemented any restorative and preventative measures after Jacob's passing.

Jacob's cause of passing

184. Counsel for PH submits A/Professor Gunja noted possible causes of Jacob's deterioration were seizure, arrythmia and sedation and asphyxia due to his position is a possible cause. Professor Vohra agreed with those propositions. Professor Vohra also said that he could not say whether a fatal arrythmia (which is the ultimate event in all deaths) was a primary or secondary event. In other words, he could not say whether Jacob died of heart failure or whether his heart failed as a result of another cause.

[195] T 788.11-20.
[196] T 788.21-27.
[197] T 789.8-16.

185. And further, A/Professor Gunja and Dr Atherton did not suggest that sedation and vomiting and asphyxiation were a primary cause of death, rather than consequent upon another primary event, namely either a seizure or cardiac arrythmia.

186. In evidence, A/Professor Gunja acknowledged he would defer to the expertise of Dr Badov, in respect to his initial opinion that Jacob had an accumulation of sedation medications due in part to his theory that Jacob had some degree of hepatic impairment.

187. Dr Badov's opined it was unlikely that there was any significant functional impairment of liver function and thus impaired hepatic clearance as suggested by A/Professor Gunja. He said that the autopsy result excludes the possibility of advanced cirrhosis and therefore does not support the proposal of impaired medication clearance via hepatic metabolism.

<u>Seizure</u>

188. CA submits, on the basis of the available evidence that Jacob:

    i. did not have epilepsy;

    ii. did have seizures when withdrawing from clonazepam;

    iii. on 4 February 2017, was not withdrawing from benzodiazepines as:

        a) prior to his passing, he was prescribed and was administered a benzodiazepine, clonazepam;

        b) benzodiazepines were shown on postmortem toxicology testing, according to Dr Matthew Lynch;

    iv. the benzodiazepine, clonazepam, that Jacob was receiving had anticonvulsant activity; and

    v. is unlikely to have had a seizure on 4 February 2017.

189. CA acknowledged it remains a possibility that Jacob had a seizure on 4 February 2017.

190. A/Professor Gunja stated that he would be surprised if Jacob suffered a benzodiazepine withdrawal seizure however noted Jacob could have had a pseudo seizure or actual seizure on 4 February.

191. For his part, Professor Vohra considered it quite likely that Jacob had a seizure or pseudo seizure on 4 February. But conceded this was not his area of expertise.

192. Professor Keks believed it was likely that Jacob had suffered a benzodiazepine withdrawal seizure based on the evidence but was not critical of the management of Jacob in this respect and said that it was an opinion taken with the most extreme hindsight bias.

Cardiac Arrythmia/Ventricular Fibrillation

193. Jacob's treating doctors were not aware of his intermittent prolonged QTc interval in 2015, and no ECG was requested for Jacob during the admission. CA submits I should prefer the opinion of Dr Atherton, being that reasonable psychiatric practice required an ECG to be undertaken for Jacob during the admission, and as a pressing issue on 4 February 2017, to the opinion of Professor Keks that an ECG was low priority. Jacob had intermittent prolonged QTc interval in 2015, and Dr Atherton's opinion is consistent with the Guidelines whilst Professor Keks' opinion is not. It is a systems issue that the requirements of the Guidelines regarding undertaking ECGs for inpatients were not completed.

194. No expert witness supported the proposition, on the balance of probabilities, that:

    i. had Jacob undergone on ECG during the admission, he is likely to have survived (from the point of view of what the ECG showed); or

ii. Jacob died from a primary event of a cardiac arrythmia on the balance of probabilities. The evidence supports a conclusion that this is a possibility only.

195. It remains a possibility that Jacob had a fatal arrythmia on 4 February 2017.

196. As noted above, A/Professor Gunja stated that seizure and arrythmia, sedation and asphyxia due to his position are all possible causes of Jacob's deterioration. Professsor Vohra agreed with those propositions.

197. Professor Vohra stated that ultimately, all deaths are cause by arrythmia, but that it is impossible to say whether a cardiac arrythmia was a primary or secondary event.

198. Again, given the uncertainty of the other possibilities, and imposing a *Briginshaw* standard of proof, it is not open to conclude that a cardiac arrythmia as a primary event, is more likely the cause of Jacob's passing.

<u>Sedation/Vomit/Aspiration (as a primary or secondary event)</u>

199. Counsel for the family and CA submit I should find there was a significant systems error in the inconsistency between the content of the Monitoring Recommendations in the Guidelines combined with the consultant psychiatrists' view of the mandatory nature of the undertaking of vital sign observations for a sedated patient, and the usual practice on the AMA of nursing staff considering vital sign observations to be optional with the resultant usual practice of nurses not undertaking vital sign observations for sedated patients, including Jacob. The Monitoring Requirements were mandatory.

200. Dr Atherton stated that if, on the afternoon of 4 February 2017, Jacob's heart rate, respiratory rate, blood pressure, oxygen saturation and an ECG had been undertaken, he was more likely than not to have survived because this would have involved active interaction with Jacob. Professor Keks said that undertaking observations of Jacob

would not have made any difference to the outcome. CA submitted the reasoning of Dr Atherton should be preferred, as Professor Keks' reasoning is based on Jacob being likely to have had a seizure, which CA submits I ought not accept.

201. Counsel for PH submits, it is not open on the evidence before the Court to find that Jacob's passing was caused by sedation/respiratory depression caused by an accumulation of sedating medications administered over the previous days, causing asphyxiation.

202. In her submission., Professor Keks explained that the clinical effects (sedation) of a massive overdose of benzodiazepines would go quickly into the brain and out again, despite the long-term presence in the blood, it would have not much affect centrally. He said the only time it would accumulate is where there was severe liver failure, which wasn't the case here. Professor Keks said that the duration of action of a normal therapeutic dose of diazepam was about four hours.

203. A/Professor Gunja opined that it was more likely than not that sedation, vomiting and asphyxia were contributory to Jacob's passing, but did not go so far as to say that they were the cause of Jacob's passing. He said that Jacob could have had a seizure or arrythmia, and there was a higher chance he may be alive if he wasn't sedated and/or vomited.

204. Professor Vohra said that he could not say that one is more likely than the other... "whether aspiration was subsequent to his cardiac arrest or whether it was the cause of cardiac arrest, it is impossible to say".

205. Professor Vohra would not be drawn on the question of whether medication had a role in Jacob's sedation but said that sedation certainly played a role, whether it was the only thing or not was difficult to say. He pointed to the possibilities of other unknowns that may have contributed to the "un-regulation of his consciousness" such

as sleep apnoea; ventricular fibrillation, which he said is more common in people with schizophrenia, and also to other potential factors such as electrolyte imbalance.

206. A/Professor Gunja concluded if Jacob was not heavily sedated, he would unlikely deteriorate in the manner he did. Had Jacob been awake, he considered, he could exclude the possibility of a seizure or arrythmia, though probably not.

207. Professor Vohra disagreed with that proposition, explaining that people who are awake, have fatal cardiac arrythmia. A/Professor subsequently acknowledged this point, however maintained it less likely than sedated persons.

208. Though food material was in Jacob's airway upon autopsy, PH submits there is insufficient evidence to suggest whether any aspiration by Jacob was a primary or secondary event of his passing in view of the other possibilities available on the evidence. In accepting this submission I am unable to find this was the cause of Jacob's passing.

Changes at PH since Jacob's passing

209. According to Honie Thompson, Program Manager—Acute Mental Health, the Nursing Physical Observation Chart (**NPOC**) now includes a sedation scoring system which assists staff to identify the level of a patient's sedation.[198]

210. Similarly, after Jacob's passing, the NVOC was amended to standardise abbreviations used by clinicians. The NVOC has also been amended to standardise where on the form clinical notations are to be found which reflect the presence of visible signs of respiration. The evidence indicates that the changes to the NPOC and the NVOC after Jacob's passing were aimed at improving the outcomes for patients admitted to the PH psychiatric unit and at alleviating and improving upon some of the issues identified by

[198] CB, statement of Honie Thomson.

my investigation into his passing. I acknowledge the restorative measures taken by PH in this regard.

211. According to Psychiatrist Dr Kerryn Rubin who was the current Clinical Director of Mental Health at PH when this matter was heard, when reviewing a patient, he expected his staff to talk to the patient,[199] ascertain their level of wakefulness,[200] review the treatment that the patient is receiving and address the reasons for the patient's admissions to hospital and specifically, in the AMA.[201]

212. Dr Rubin testified that, in his experience, it is difficult to observe patients through a window or through a thick door because of the level of noise from the surrounding area in the ward. In his view, monitoring patients in this manner is inadequate.[202] However, it is a common practice to observe a patient through a window in most of the units he has worked at over the last two and half decades,[203] but it is not a good practice.[204] Dr Rubin stated further that has never worked in any hospital where the practice is consistent with guidelines as it should be.[205] According to Dr Rubin, although patient to staff ratios were not ideal, he believed that the ratio was not an issue because the ratio was adequate for safe patient care. Despite these challenges, Dr Rubin stated that a new mental health unit was currently being built at Frankston Hospital, which will have a different model of care to address the issues of observing patients.[206] At the time of the Inquest, in 2023, six-monthly audits of quality of care were being conducted in the inpatient mental health unit by the PH Quality Safety and Governance Committee.[207] I

[199] T 506.5-7.
[200] T 507.1-9.
[201] T 507.14-20.
[202] T 522.4-21.
[203] T 522.13-21.
[204] T 523.23-25.
[205] T 524.28-30.
[206] T 530.14-20.
[207] T 546.22 – 547.3.

commend these measures taken by PH to improve the outcomes for future patients admitted to their PH mental health unit.

Introduction of Version 4 of the Guideline

213. According to Adj Professor Newton, Version 4 of the Guideline ‘Pharmacological Management of Acute Behavioural Disturbance in the Mental Health Inpatient Units’ came into effect in April 2019.[208] This version of the Guideline effectively brought about significant changes to Version 3, in force at the time of Jacob’s passing.

214. Version 4 of the Guideline reflected the following changes:

    i. Amendments to the level of agitation scale to make it easier to follow and assess or classify a patient;

    ii. Separate pharmacological algorithms (i.e. recommendations around doses and frequency of medications) for adults and elderly/medication naïve/medically ill/ frail patients;

    iii. Options for less sedating / non-sedating antipsychotic drugs were included according to the patient's level of agitation;

    iv. The addition of Droperidol IM (for adults only) with precautions and notes on the suitability and effects, as well as recommendations around doses and frequency;

    v. Modifications were made to the recommended medication doses for adults with the maximum daily dose for many medications increasing;

    vi. Further clinical considerations were included when implementing pharmacological intervention. This included:

[208] CB 77 at [25].

a) Considering whether nicotine and replacement therapy may be helpful in reducing agitation and aggression secondary to nicotine withdrawal in patients who smoke cigarettes; and

b) Considering prophylaxis of Venous Thromboembolism (**VTE**) given the increased risk associated with antipsychotic use and acquired risk factors for VTE typical of patients presenting with ABD;

vii. The inclusion of '*Safewards*'. *Safewards* is a state-wide initiative, which originated in the United Kingdom of Great Britain and Norther Ireland (**UK**) and has been implemented internationally. The objective of this model is to reduce conflict and containment (i.e. restrictive interventions) within mental health services and increase a sense of safety and mutual support for staff and patients. PH's approach to pharmacological and non-pharmacological interventions is in line with the *Safewards* model;

viii. Recommendations around elderly/medication-naïve/medically ill/frail patients' dosing was adjusted; and

ix. Modifications were made to the frequency of visual and physical monitoring including more frequent visual monitoring for oral and IM medications, and more frequent physical monitoring for IM medications over a two-hour period.

215. I acknowledge the reviews conducted by PH into Jacob's passing and while I commend the restorative and preventative measures emanating therefrom, having considered the evidence on PH's review of Jacob's passing, I note that there have not been any substantive changes to the MR in the Guideline since Jacob's passing to the time of the Inquest Hearing.

216. On 14 September 2023, the Inquest Hearing was finalised, and the matter was adjourned to for the parties to file their written submissions for my consideration.

217. On 25 September 2023, CA, Dr Keeling, filed written submissions for my consideration. I received further written submissions from Mr Farhall and Mr Boyd-Caine on behalf of Jacob's family.

218. On 26 October 2023, Ms Hodgson filed written submissions on behalf of PH for my consideration.

219. Having perused the written submissions made by the interested parties, I listed the matter for a Submissions Hearing.

Submissions Hearing

220. On 21 November 2023, I convened the Submissions Hearing.

221. At the commencement of proceedings, I heard the Coronial Impact Statements of Jacob's mother, Linda, his sister, Sherrie, his brother Adrian and his stepfather Graham Hartle. The interested parties then presented their oral submissions to the Court, elaborating on their written submissions.

222. I heard the family's Coronial Impact Statements, which reflected their abiding love of Jacob, and their enduring loss. I consider the dignity displayed by the family was remarkable.

223. I take this opportunity to acknowledge the significant contribution the Aboriginal Engagement Unit has made to our Court. We are fortunate to have the leadership of Jessica Gobbo – we recognise the need to continually learn and improve our engagement with the Aboriginal community in Victoria.

224. I wish to make special mention of the role of Joseph ('Joey') Yugumbari, for his dedication throughout the course of my investigation into Jacob's passing.

225. My task has been greatly assisted by the respective submissions of CA, and counsel for interested parties. I have carefully reviewed all submissions and convey my gratitude to counsel, and their instructing solicitors.

226. I now consider my investigation to be complete and I am satisfied that the available evidence now enables me to discharge my statutory obligations under the Act.

COMMENTS

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

1. In evaluating the evidence in this matter, have made pertinent comments on the items of Scope of my Inquest throughout my finding. I will not repeat those comments here but will endeavour to make general comments connected with Jacob's passing.

2. While I acknowledge Jacob's family's concerns about recommencing his Methadone Therapy treatment without their consent and while I acknowledge their further concerns about not recommencing his Methadone Therapy because he about to be admitted to a voluntary drug rehabilitation facility, the evidence indicates that the decision to recommence Jacob's Methadone Therapy was at his own request and was taken after a clinical assessment was conducted by Dr Chan.

3. On the evidence available to me, while it would have been desirable, in the circumstances, for Jacob's treating clinicians to have contacted his family to ascertain his medical and pharmaceutical history or to have obtained his medical records and history from his treating doctors in the community, I am satisfied the clinical decision to recommence Jacob's Methadone Therapy was not unreasonable in the circumstances.

4. With regard to the clinical practices adopted by PH clinicians in their psychiatric unit at the relevant time, the evidence indicates that patients in an inpatient psychiatric unit

who are receiving multiple antipsychotic medications in addition to Methadone Therapy require an ECG to be conducted to properly monitor their vital signs, given the associated risks with administering multiple antipsychotic drugs to patients simultaneously. The available evidence does not support a finding that the outcome for Jacob would have been different if an ECG was conducted. However, given relevant provisions of PH's own Guideline, the weight of the available evidence supports a conclusion that conducting an ECG should have been performed. Further, given that the available evidence indicates that Jacob's treating clinicians did not follow PH's Guideline and that their non-compliance with the Guideline remained undetected and unaccounted for, I am satisfied that the failure by PH clinicians to follow the existing PH Guideline is indicative of a systemic deficiency in the management of inpatients, admitted to the PH psychiatric unit, who were undergoing Methadone Therapy treatment and to whom multiple antipsychotic drugs have been administered.

5. In respect to the monitoring regime, canvassed at length in foregoing paragraphs, in my view, the weight of the available evidence does not however, support a conclusion, that the lack of adequate monitoring by PH staff was a cause of Jacob's passing.

6. Culturally safe care should be the bedrock within hospital settings. AHLOs must receive the respect and support their important role demands. Treatment teams must ensure the invaluable contribution AHLO is always sought and considered. The provision of culturally safe and culturally appropriate care is not the sole domain of AHLO staff. Jacob's family were not invited to participate in his meetings with his treating team The evidence does not support a conclusion that the lack of appropriate cultural care contributed to his passing. However, there were unintentional shortcomings in the provision of culturally safe care, including the family were not and should have been invited to participate in team meetings and to participate in the cleansing ceremony after his passing.

7. I now make appropriate findings in this matter.

CONCLUSIONS AND FINDINGS

1. The standard of proof for coronial findings of fact is the civil standard of proof, *on the balance of probabilities*, with the *Briginshaw* gloss or explication.[209] 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.

2. Having applied the applicable standard to the available evidence, I find that:

   i. The identity of the deceased is Jacob William Kennedy, born on 24 February 1980;

   ii. Jacob William Kennedy passed at Frankston Hospital, Victoria, on 4 February 2017;

3. Pursuant to section 67(1)(b) of the Act, if possible, I must find the cause of death which usually refers to the medical cause of death. As the evidence indicates, Forensic pathologist Dr Lynch was unable to determine the medical cause of Jacob's death and ascribed the medical cause of death as Undetermined. To advance my investigation into Jacob's passing, I have interrogated this aspect of my investigation fully at Inquest. I am unable to dismiss any of the 3 possible causes of death, identified by Dr Lynch. Further, I do not consider the evidence sufficiently cogent to find that one possible cause is the more likely, and accordingly am unable to make a definitive findings on the cause of death.

4. I endorse the cause of death as formulated by Dr Lynch as 1(a) Undetermined.

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[209] *Briginshaw v Briginshaw* (1938) 60 CLR 336 esp at 362-363. "The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters 'reasonable satisfaction' should not be produced by inexact proofs, indefinite testimony, or indirect inferences…"

5. Having considered the broader concerns of Jacob's medical management identified by my investigation into his passing, the evidence indicates that the observation practices of Jacob's treating clinicians in monitoring sedated patients in their care and the nursing staff who considered monitoring a sedated patient's vital signs to be optional was inconsistent with PH's Monitoring Recommendations in their Guideline. In this regard, the weight of the available evidence supports a finding that PH's Monitoring Recommendations contained in their Guideline was mandatory and further, that PH did not manage staff adherence to or compliance with their own Guideline. Therefore, on the evidence available to me, I am satisfied that the non-compliance by PH staff with their own Guideline indicates a systemic deficiency at the time of Jacob's passing.

6. I find that:

   i. The established practice of treating clinicians and the nursing staff failing to comply with the monitoring provisions for sedated patients, contained in the Monitoring Recommendations in PH's Guideline and the resultant failure to adequately monitor Jacob, a sedated patient, was a significant systemic error.

   ii. In respect to the aforesaid systemic failure, I make no criticism of individual medical or nursing staff, who performed their professional duties in respect to the management and observations of Jacob, pursuant to established practice at PH at the relevant time.

   iii. The failure to appropriately monitor Jacob, was potentially a missed opportunity to avoid his tragic passing. Had he received appropriate monitoring, in compliance with hospital policy, he may have survived.

RECOMMENDATIONS

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

1. In the interests of public health and safety and with the aim of preventing like deaths, I recommend that the MBA, as supported by the AHPRA, develop guidelines for treating clinicians working in inpatient psychiatric units to follow when prescribing or administering multiple medications to their patients which have a sedative effect. The guidelines should consider and admonish treating clinicians of the cumulative effect, if any, of multiple sedating medications.

2. In the interests of public health and safety and with the aim of preventing like deaths, I recommend that the MBA, as supported by AHPRA, implement policy or protocol to admonish clinicians of the importance of adhering to health service provider guidelines aimed at ensuring that clinicians monitor sedated patients more closely and on a more frequent basis until they are ambulant.

3. In the interests of public health and safety and with the aim of preventing like deaths, I recommend that the Nursing and Midwifery Board of Australia implement policy or protocol to admonish nursing staff of the importance of adhering to health service provider guidelines aimed at ensuring that nursing staff monitor sedated patients more closely and on a more frequent basis until they are ambulant.

4. In the interests of public health and safety and with the aim of preventing like deaths, given the benefits of using an oximeter to monitor sedated patients in an inpatient psychiatric unit, as indicated by the evidence before me, I recommend that the MBA, as supported by AHPRA, consider implementing policy or protocol to advise clinicians to

consider the benefits of using an oximeter to monitor heart rate and oxygen saturation levels of sedated patients.

5. In the interests of public health and safety and with the aim of preventing like deaths, I recommend that the MBA, as supported by AHPRA, develop guidelines to reflect the use of an oximeter as an achievable, practical and reasonable measure for clinicians to take in observing or monitoring sedated patients in inpatient psychiatric units.

6. In the interests of public health and safety and with the aim of preventing like deaths, I recommend that PH consider reviewing their policy or protocol to ensure compliance with the Monitoring Recommendations in their Guideline which mandate vital sign observations for sedated patients admitted to their inpatient psychiatric units.

7. AND FURTHER, in the interests of public health and safety and with the aim of preventing like deaths, I recommend that PH initiate and undertake regular staff training measures for its mental health care workers to ensure the enforcement of a uniform monitoring regime to observe the vital signs of sedated patients.

8. AND FURTHER, in the interests of public health and safety, I recommend that PH undertake an external review of all policies and training that relate to culturally competent and safe care, to ensure that they are fit for purpose.

   That review be led by an external, First Nations-identified individual or organisation.

   PH implement the recommendations of that review.

   PH introduce, and make publicly available on an annual basis, compliance monitoring for cultural competency and safety training, and statistics concerning complaints about the provision of such care

I acknowledge the tragic circumstances in which Jacob had passed and I express my condolences to his family.

To enable compliance with section 73(1) of the Act, I direct that the Findings be published on the internet.

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

Jacob's family;

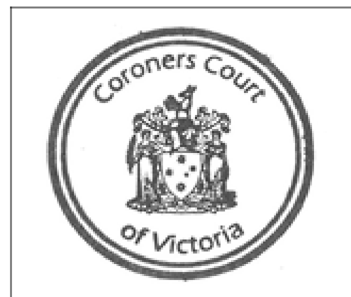
Peninsula Health

The Royal Australian and New Zealand College of Psychiatrists;

The Medical Board of Australia; and

The Nursing and Midwifery Board of Australia.

Signature:



Coroner John Olle
Date: 24 May 2024