IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2021 003492

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 63(1)

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

INQUEST INTO THE DEATH OF SHANE ANTHONY PAPPAS

Findings of:	Coroner Audrey Jamieson
Delivered On:	29 July 2024
Delivered At:	65 Kavanagh Street Southbank, Victoria, 3006
Hearing Dates:	29 July 2024
Assisting the Coroner:	Samantha Brown, Principal Inhouse Solicitor
Representation:	Ms Kate Mellier on behalf of Grampians Health (Lander & Rogers), via WebEx Mr Daniel Lewis on behalf of St Vincent's Health (Meridian Lawyers) Ms Bridget Linton on behalf of the Chief Commissioner of Police (MinterEllison)

Catchwords	Sequential presentations to ED for mental health crisis, clinical management of mental health crises, *Mental Health Act* 2014, Inpatient Assessment Order, collapse in police presence, death in care or custody

TABLE OF CONTENTS

SUMMARY

1. Shane Anthony Pappas[1] was 54 years old when he died on 3 July 2021 at Angliss Hospital in Upper Ferntree Gully, Victoria, of quetiapine toxicity in a man with ischaemic heart disease.

2. Shane had collapsed in the presence of Victoria Police members at a residential property in Ballarat late on 29 June 2021.

3. For several hours before Shane's collapse, Victoria Police members across several service areas had been trying to locate and apprehend him pursuant to section 352 of the *Mental Health Act 2014* (**MHA**) after an Inpatient Assessment Order[2] was made by a registered medical practitioner due to Shane's risk of self-harm.

THE CORONIAL JURISDICTION

4. Shane's death clearly falls within the definition of a *'reportable death'*[3] in section 4 of the *Coroners Act 2008* (**the Act**), satisfying both section 4(2)(a) of the Act which includes (relevantly) a death that appears to be unexpected, and section 4(2)(c) which captures deaths where a person immediately before death was a person placed 'in custody or care'. By virtue of being subject to an Inpatient Assessment Order, Shane was 'in care' and, once apprehended by police to facilitate his transfer to a designated mental health service, he was 'in the custody of a police officer' at the time of his death.[4]

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[1] At the request of his family, Shane Anthony Pappas was referred to as "Shane" throughout the Inquest. For consistency, I have also referred to him as Shane throughout the Finding, save for where formality requires me to use his full name.

[2] Section 30 of the *Mental Health Act 2014*.

[3] The term is exhaustively defined in section 4 of the Act *2008*. Apart from a jurisdictional nexus with the State of Victoria a reportable death includes deaths that appear to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from an accident or injury; and, deaths that occur during or following a medical procedure where the death is or may be causally related to the medical procedure and a registered medical practitioner would not, immediately before the procedure, have reasonably expected the death (section 4(2)(a) and (b) of the Act). Some deaths fall within the definition irrespective of the section 4(2)(a) characterisation of the 'type of death' and turn solely on the status of the deceased immediately before they died – section 4(2)(c) to (f) inclusive.

[4] See the definition of a 'person placed in custody or care' in section 3 of the Act.

5. The Coroners Court of Victoria is an inquisitorial jurisdiction.[5] Coroners independently investigate reportable deaths to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[6] The *cause* of death refers to the *medical* cause or mechanism of death. For coronial purposes, the *circumstances* in which death occurred refers to the 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.[7]

6. 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.[8] 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.[9] These are effectively the vehicles by which the prevention role may be advanced.[10]

7. 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.

8. All coronial findings must be made based on proof of relevant facts on the balance of probabilities.[11] In determining whether a matter is proven to that standard, I should give effect to the principles enunciated in *Briginshaw v Briginshaw*.[12] These principles state

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

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

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

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

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

[10] 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.

[11] *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152.

[12] (1938) 60 CLR 336.

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.

9. 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.

Mandatory inquest

10. Shane's status as a *person placed in custody or care*[13] at the time of his death meant that an inquest was mandatory under section 52(2)(b) of the Act.

11. At the conclusion of my investigation, I was satisfied I was able to make findings about the deceased's identity, the cause of death and the circumstances in which death occurred, so this case was listed for inquest in accordance with the Act. The Inquest was a Summary Inquest – one conducted without oral testimony – as there were no evidentiary conflicts or discrepancies that would justify calling witnesses.

Sources of Evidence

12. This Finding draws on the totality of the product of the coronial investigation into Shane's death. That is, the court records maintained during the coronial investigation, the Coronial Brief prepared by Detective Acting Sergeant (**D/A/Sgt**) Patrick Derksen of the Homicide Squad and further material sought and obtained by the Court, the evidence adduced during the Inquest and any submissions provided by Interested Parties.

[13] As this phrase is defined in section 3 of the Act.

13. In writing this Finding, I do not purport to summarise all the evidence but refer to it only in such detail as appears warranted by its forensic significance and the interests of narrative clarity. The absence of reference to any particular aspect of the evidence does not infer that it has not been considered.

BACKGROUND

Personal History

14. Shane was the eldest of four children born to William and Renee Pappas. He was raised in the outer eastern suburbs of Melbourne, completing Year 12 at Scoresby High School. For most of his adult life, Shane was employed as a medical equipment sales representative.[14]

15. Shane married Shelley Maxwell when aged in his mid-20s. The couple had five children together, Katherine, Alison, Alexander, and twins Megan and Jessica. Shane and Ms Maxwell separated and ultimately divorced in about 2015 or 2016.[15] The breakdown of their relationship was acrimonious[16] and according to family members Shane found it particularly stressful[17] and at times appeared very depressed and expressed feelings of hopelessness.[18]

16. Indeed, Shane appears to have experienced a decline in mental health after separating from his wife. An antidepressant (escitalopram) was initiated by his general practitioner (**GP**) in 2015 and he was referred to a psychiatrist whom Shane appears to have seen only a few times between 2015 and 2018.[19] In 2016, Shane reported ongoing depression and chronic insomnia;[20] escitalopram was re-prescribed, and zolpidem was commenced to assist with sleep.[21] After early 2018, there are no references in Shane's GP records to referrals relating to management of his mental health nor further

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[14] Coronial Brief [CB], page 79.

[15] CB, page 96.

[16] CB, pages 81 and 111.

[17] CB, page 81.

[18] CB, page 96.

[19] Shane's Kew Junction Medical Centre record, pages 16-18.

[20] Shane's Kew Junction Medical Centre record, page 17.

[21] Shane's Kew Junction Medical Centre record, pages 3-4 (prescribing history).

prescription of psychiatric medication; however, zolpidem was last prescribed in May 2021.[22]

17. After their marriage ended, Shane and Ms Maxwell shared parenting responsibility for their children who chose with which parent they would live from time to time. At the time of his death, Shane's daughter Alison ordinarily lived with him in Balwyn.[23]

18. In 2019, Shane experienced acute myocardial infarction (heart attack).[24] His ischaemic heart disease was treated with the insertion of a stent and daily medication to manage hypertension.[25]

19. In about November 2020, Shane commenced a romantic relationship with Simone Naus, a woman he had known for several years.[26] Ms Naus lived in Ballarat and would sometimes stay with Shane in Balwyn during the week, and he would sometimes spend weekends with Ms Naus at her home.[27] Ms Naus characterised her relationship with Shane as 'intense'[28] and stated that he was sometimes 'controlling.'[29]

20. On Thursday, 24 June 2021, Shane ended the relationship in the context of Ms Naus having lunch with a former partner that day. Ms Naus packed her belongings and drove home to Ballarat.[30]

21. On the morning of Friday, 25 June 2021, Shane's daughter saw him as he left home, saying that he was going to see Ms Naus.[31]

22. Throughout that day, Shane contacted Ms Naus via text attempting to talk to her or arrange a meeting. Ms Naus was disinclined to engage and told him so.[32] Shane also

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[22] Shane's Kew Junction Medical Centre record, pages 7 (prescribing history).

[23] CB, page 82.

[24] Shane's Kew Junction Medical Centre record, page 2.

[25] Shane's Kew Junction Medical Centre record, pages 7 (prescribing history).

[26] CB, page 116.

[27] CB, page 97; 122.

[28] CB, page 116.

[29] CB, page 117.

[30] CB, page 117.

[31] CB, page 97.

[32] CB, page 117.

contacted Ms Naus' friend, Vicki Papasiliou[33] though little else is known about how and where he spent 25 June 2021.[34]

CIRCUMSTANCES IN WHICH DEATH OCCURRED

Saturday, 26 June 2021

23. At about 10am on Saturday, 26 June 2021, Shane visited his maternal aunt Karen Connell who lives in Wendouree.[35] Ms Connell's impression was that Shane was 'stressed and worried' but not that he would 'do anything to himself' and assumed when he left after coffee that he would return home to Balwyn.[36]

24. According to Ms Naus, she received 'constant' text messages throughout the day from Shane.[37] Shane also tried to speak with Ms Papasiliou.[38]

25. Ms Papasiliou returned Shane's call after she finished work. Shane was ruminating about Ms Naus' relationship with her former partner and Ms Papasiliou told him to 'calm down and leave it alone for the weekend.'[39]

26. Around 6pm, Shane sent Ms Naus a text message stating that he 'had about 15 minutes' left.[40] He then called Ms Papasiliou saying that 'it was all going to be over in 15 minutes.'[41] She told him not to be ridiculous and then Shane ended the call.[42] Afterwards, Ms Naus and Ms Papasiliou spoke,[43] Ms Naus relaying that she could see Shane on CCTV cameras at her home, pacing up and down outside.[44] Both Ms

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[33] CB, page 123.

[34] However, Willam Pappas in his statement and Ms Naus (in an account given to WNB203 members) refer to Shane having spent time in/around Ballarat and Wendouree and sleeping in his car: CB, pages 89, 136 and 140.

[35] CB, page 112.

[36] CB, page 112.

[37] CB, page 118.

[38] CB, page 123.

[39] CB, page 123.

[40] CB, page 118.

[41] CB, page 123.

[42] CB, page 123.

[43] CB, pages 118 and 123-4.

[44] CB, pages 123-4.

Papasiliou[45] and Ms Naus[46] called Triple Zero to alert the emergency services to their concern that Shane was suicidal.[47]

27. At 6.31pm, Senior Constable (**SC**) Inkson and Constable (**C/**) Baines of Ballarat North Police Station, callsign WNB203, were tasked to respond to the 'threat of suicide' job arising from the Triple Zero calls about Shane.[48] The members attended Ms Naus' address. She recounted Shane's recent text, that she had observed on CCTV footage that he been hanging around her home for the last couple of days; she also described his clothing and appearance. Police collected the car keys Shane had thrown at Ms Naus' front door and used them to identify his car parked in the street about 20 metres away.[49]

28. Police established that Shane was not in his car, nor in yards, waterways or a nearby pub before hearing over Police Communications (**D24**) at 6.55pm a 'welfare check' job about 200 metres away in Essex Street. Given its proximity, the supervising sergeant for the shift, Sergeant (**Sgt**) Collins, tasked WNB203 to attend.[50]

29. The WNB203 members found a man matching Shane's description unconscious but breathing on the footpath. Shane was placed in the recovery position and SC Inkson requested an ambulance.[51] Meanwhile, Sgt Collins searched Shane's car and returned to Essex Street with two empty medication boxes,[52] Shane's phone, glasses and car keys and gave these items to paramedics.[53]

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[45] CB, page 246: Ms Papasiliou called Triple Zero at 6.12pm on 26 June 2021.

[46] CB, page 256: Ms Naus called Triple Zero at 6.16pm on 26 June 2021.

[47] CB, pages 246-255 and 256-259 (transcription of the calls to Triple Zero on 26 June 2021).

[48] CB, pages 136 and 140.

[49] CB, pages 136 and 140.

[50] CB, page 137.

[51] CB, page 137. The Ambulance was requested at 6.57pm according to the Patient Care Record (#11305 dated 26/6/21) which appears in Shane's Grampians Health (GH) Medical Records (MRs) #1, pages 98-102.

[52] CB, page 146: the medication boxes were labelled 'Stilnox' (zolpidem, used in the short-term treatment of insomnia) and 'Valpam' (diazepam, a benzodiazepine).

[53] CB, page 137.

30. Paramedics observed Shane had an altered conscious state – Glasgow Coma Scale (**GCS**) score of 10[54] – but was breathing spontaneously and maintaining his airway.[55] He was transferred by ambulance to the Emergency Department (**ED**) of Ballarat Base Hospital, now known as Grampians Health Ballarat (**GH**),[56] with WNB203 following in the divisional sedan.

31. On arrival at the ED, SC Inkson overheard the paramedics handover to GH clinicians that Shane had intentionally overdosed on medications in a suicide attempt.[57] The maximum possible dose was noted as '? 70mg zolpidem + 500mg diazepam.'[58]

32. Clinicians advised WNB203 that the police presence was no longer required and so SC Inkson and C/ Baines left the ED.[59] On a later date, SC Inkson completed a Mental Disorder Transfer Form (**MDTF**) relating to the WNB203 interaction with Shane on 26 June 2021.[60] The MDTF is ordinarily used by police when a mentally ill person is transferred to hospital.[61]

Management at GH following Shane's intentional medication overdose

33. On examination in the ED, Shane was unconscious (GSC score of 6) and although he was breathing spontaneously, he was unable to maintain his airway so his breathing was obstructed. Initially jaw thrusts and naso-pharyngeal airways were sufficient to

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[54] The Glasgow Coma Scale is a tool used clinically to assess consciousness (usually after brain injury) based on the sum of best response scores across three domains: eye opening, verbal and motor responses. Glasgow Coma Scale scores range from 3, indicating complete unresponsiveness, to 15 which indicates responsiveness. A score of 8 is usually indicative of coma. Lower scores are correlated with higher risk of death.

[55] Shane's GH MRs #1, pages 98-102.

[56] I will use the abbreviation 'GH' to refer to both the Ballarat Base Hospital and the health service Grampians Health which appeared as an interested party during the investigation and inquest into Shane's death. It will be evident from the context whether I am referring to the hospital or the health service.

[57] 137. This characterisation of Shane's presentation/history appears in the Ambulance Victoria Patient Care Record (PCR) included in Shane's GH medical records (GH MRs), though I note the PCR is timestamped 8.09pm, about 40 minutes after triage documentation was completed by a member of GH staff. That said, the triage notes include that Shane had threatened to 'end it,' suggesting that his intention had been conveyed: Shane's GH MRs #1, page 104.

[58] Shane's GH MRs #2, page 115. The maximal possible dosage was recorded as '? 70mg zolpidem + 500mg diazepam' in an ICU progress note in Shane's GH MRs #2, page 195.

[59] 137

[60] The Mental Disorder Transfer Form relating to WNB203's interaction with Shane on 26 June 2021 was completed by SC Inkson at about 9am on 2 July 2021.

[61] The MDTF may also be used when police have been involved in a 'welfare referral – by consent' but usually relates to police involvement to return an involuntary psychiatric patient to a designated mental health service or when police exercise their power under section 351 of the MHA to apprehend a person to prevent serious/imminent harm and transfer them to a designated mental health service for assessment.

maintain Shane's airway but by 9pm he had been intubated. Blood tests were performed, and sedation, medication and fluids administered intravenously.[62] Arrangements were made for Shane to be transferred to the Intensive Care Unit (**ICU**) with a plan for ongoing monitoring of arterial blood gasses, continuation of fluids and sedation and mental health 'clearance.'[63]

Sunday, 27 June 2021

34. Shane was admitted to the ICU a little before 1am on Sunday, 27 June 2021 under the care of the general medical unit and ICU clinicians. He remained haemodynamically stable, and a brain CT scan was unremarkable.[64] Shane received supportive care including ventilatory support overnight in the ICU; sedation was ceased around 8.40am and he was extubated just after 9am.[65]

35. At about 10am, when Shane asked a nurse 'what is going to happen to [me]' he was told he would be reviewed by the Psychiatry Team before he could be discharged home.[66] For the rest of the morning, Shane slept intermittently but woke to minimal stimulus.[67]

Psychiatric Assessment by GH Consultant Psychiatrist

36. At 12.15pm on 27 June 2021, Shane was reviewed by the on-call[68] GH Consultant Psychiatrist (**Psychiatrist**) in the ICU. The assessment and handover to the Community Mental Health Team (**CMHT**) was completed in less than 15 minutes.[69] The assessment is captured by the following clinical note (extracted in full):

> 27/6/21 PSYCHIATRY 1215pm

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[62] Statement made jointly by Drs Danvers and Lalitha dated 18 November 2021, page 2.

[63] Statement made jointly by Drs Danvers and Lalitha dated 18 November 2021, page 2; Shane's GH MRs #1, page 186.

[64] Statement made jointly by Drs Danvers and Lalitha dated 18 November 2021, page 3.

[65] Statement made jointly by Drs Danvers and Lalitha dated 18 November 2021, page 3. Shane's GH MRs #1, page 164.

[66] Shane's GH MRs #1, page 164.

[67] Shane's GH MRs #1, page 164.

[68] Shane's GH MRs #1, page 13.

[69] The psychiatrist's note is timed 1215, a nursing note records the review being underway at 12.20pm and another that the review has been completed by 12.30pm: Shane's GH MRs #1, pages 186, 164, and 13 respectively.

> No past records on CMI.[70] BIBA[71] after benzodiazepine and alcohol[72] overdose after his girlfriend broke up with him/has gone back to previous partner. Spoke about distress as he moved to Ballarat for her, planned to spend the rest of his life with her etc. Mental state: aware of context, distressed due to breakup, denies suicidal ideation, plans, actions. Wants to go for grandmother's birthday today. He has accommodation with his Aunty in Wendouree. Willing for support from MH [mental health] Team. Impression: SITUATIONAL CRISIS/ADJUSTMENT DISORDER. Plan: 1 Await transfer from ICU to ward (medical) 2 Plan follow up by Community Team on 28/6/21.
>
> [Signed] CONSULTANT PSYCHIATRIST[73]

37. An ICU nursing note at 12.20pm anticipated follow up by Psychiatry 'on ward tomorrow'.[74] The CMHT Screening Register confirmed follow up that day by 'CL'[75] – Consultation Liaison – that is, the mental health team involved in assessments of adults admitted to a medical ward.

38. While undergoing a nursing procedure at about 12.45pm, Shane told the nurse he 'felt like a fool' because his attempted suicide was unsuccessful.[76] The nurse tried to reassure him.[77]

39. The incoming afternoon ICU nurse received a handover from her predecessor and assessed Shane. Among other things, she noted he was emotional and 'crying when talking about his partner' and was focused on contacting her.[78] The nurse noted that Shane had been 'medically cleared for [the] ward' with a psychiatry review planned the next day.[79]

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[70] CMI is the Client Management Interface which records public mental health service client contacts.

[71] BIBA is an abbreviation of 'brought in by ambulance'.

[72] I note that the amount of alcohol detected was negligible (~0.014%) according to Shane's GH MRs #1, page 204. Shane's antemortem (26/6/21) blood sample was also available for analysis by the Victorian Institute of Forensic Medicine (VIFM) and no alcohol was detected (noting that the reporting limit at VIFM for alcohol is <0.01g/100mL): CB, page 64.

[73] Shane's GH MRs #1, page 186. The names of GH clinicians involved in Shane's assessment and treatment have been omitted as none provided a statement to the coronial investigation.

[74] Shane's GH MRs #1, page 164.

[75] Shane's GH MRs #1, page 13.

[76] Shane's GH MRs #1, page 164.

[77] Shane's GH MRs #1, page 164.

[78] Shane's GH MRs #1, page 163.

[79] Shane's GH MRs #1, page 163.

40. Shane was noted to be 'lethargic, sleeping/snoring on and off' and, when awake, was using his phone.[80] At about 2pm, he expressed concern about his partner not replying to his messages and told the nurse that he wanted to attend his grandmother's birthday lunch with other family members.[81]

41. At 2.45pm, Shane requested discharge, saying that he could stay with his aunt, Ms Connell. His request was escalated to the ICU Medical Officer (**MO**) who contacted the Psychiatrist who had reviewed Shane.[82] The Psychiatrist advised that Shane was 'cleared for discharge from [a] mental health point of view' with follow up by 'Community Mental Health in the community tomorrow.'[83]

42. After a discussion with the ICU's Registrar and Consultant during which Shane was 'cleared for home,'[84] the ICU MO contacted Ms Connell.[85] She confirmed her address and that she was happy for Shane to stay with her.[86]

43. The ICU MO then contacted the GH CMHT to alert them to Shane's discharge to his aunt's residence with the Psychiatrist's agreement.[87] The CMHT duty clinician noted Shane would be followed up by the Acute Response Team (**ART**) the next day.[88]

Discharge from GH ICU

44. When Shane's father William Pappas arrived to collect him from GH at about 3.30pm, he was 'up and dressed and wanting to leave' but was otherwise 'subdued and

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[80] Shane's GH MRs #1, pages 162.

[81] Shane's GH MRs #1, page 162. Shane also told the nurse he wanted to sit on his grandmother's grave and speak to her because she was the only person who had not 'betrayed' him: Shane's GH MRs #2, page 163. Although this information was noted, there's no evidence that it was relayed to the doctors making decisions about Shane's discharge from GH on 27 June 2021(that is, the ICU MO and his superiors, and the Psychiatrist). Information of this kind might be useful to a mental health clinician assessing Shane's overall presentation (but not necessarily determinative), I am mindful that the nurses involved were not mental health nurses and so am not critical of them (either for not relaying the information or not documenting it if it was relayed).

[82] Shane's GH MRs #1, page 160.

[83] Shane's GH MRs #1, page 160.

[84] Shane's GH MRs #1, page 160.

[85] Shane's GH MRs #1, page 160.

[86] Shane's GH MRs #1, page 160: Neither the ICU MO's note nor Ms Connell's statement (CB, page 112) suggest there was any specific discussion between them relating to risk mitigation/management or any need for Shane's supervision contrary to the account provided in the statement made jointly by Drs Danvers and Lalitha dated 18 November 2021, page 4.

[87] Shane's GH MRs #1, pages 160 and 14.

[88] Shane's GH MRs #1, page 14.

uncommunicative'.[89] A nursing note at about the same time recorded that Shane was 'dozing when not directly' engaged.[90]

45. The ICU MO told Mr Pappas that Shane had been 'cleared by [a] Psychiatrist' and was 'not considered to be a risk to … himself;' the ART would review him on 28 June 2021.[91]

46. Shane was given written discharge instructions which included that he 'avoid alcohol and substances' and 'avoid driving while drugs are still in [his] system' and confirming that ART would contact him the next day.[92]

47. As they left GH at about 4pm, Shane asked his father to take him to his car, which remained parked near Ms Naus' home. Mr Pappas did so. He then followed Shane as he drove his own car to Ms Connell's house.[93]

48. Upon arrival, Ms Connell observed that Shane was 'unsteady on his feet and really drowsy.'[94] Shane appeared 'drug affected' and kept drifting off to sleep.[95] Both Mr Pappas and Ms Connell tried to confiscate Shane's keys to prevent him from driving while apparently impaired but were unsuccessful.[96]

49. Around 7pm, Shane left Ms Connell's home without warning, taking his phone, wallet and car keys with him.[97] As Ms Connell was 'worried about what Shane would do,' she called police.[98] Among the information relayed to responding members was that Shane

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[89] CB, page 83.

[90] Shane's GH MRs #1, pages 162.

[91] Shane's GH MRs #1, page 160 and CB, page 83.

[92] Shane's GH MRs #1, page 178.

[93] CB, page 84. I note that in her statement, Ms Connell suggests that Shane's car remained parked near Ms Naus' home at this time: CB, page 112.

[94] CB, page 112.

[95] CB, page 84.

[96] CB, page 112. I note that in his statement, Mr Pappas states his belief that Shane's car keys were confiscated: CB, page 84.

[97] CB, pages 112; 150.

[98] CB, page 112.

was unsteady on his feet and had 'made another threat of suicide' in words to the effect that 'Plan A didn't work, but Plan B would.'[99]

50. At about 7.24pm, D24 broadcast a 'welfare check' job linked with Ms Naus' address.[100] SC Inkson was on shift again with C/ Baines and C/ Kempers, with callsign RUBY821 and, recognising the particulars, diverted from Covid-19 tasking to respond to the job.[101] On arrival, SC Inkson found Shane's car parked directly outside Ms Naus' home, unlocked,[102] and spoke to Ms Connell's partner, Ken Keller, who was driving around looking for Shane.[103] SC Inkson asked Mr Keller to remain near Shane's car while RUBY821 patrolled the area.

51. RUBY821 patrolled in the vicinity of Ms Naus' home and the most direct route between it and Ms Connell's home and checked parks and train tracks along the way.

52. Meanwhile C/ Baines tried calling Shane, leaving several messages asking him to call police.[104] He also called Ms Naus, who was not at home, and said she had not heard from Shane.[105] Given the RUBY821 members' concerns for Shane, C/ Baines alerted the supervising sergeant for the shift, Sgt Atkins.

53. Sgt Atkins joined the effort to locate Shane. Members returned to Ms Naus' home and determined it was secure, searched Shane's car and continued to patrol the surrounding area. Sgt Atkins requested additional units to assist and, around 8pm directed the RUBY821 members to compile a missing person report.[106]

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[99] CB, page 142. The formulation of 'Plan A' and 'Plan B' appears to have originated in comments Shane made to a friend he called on 27 June 2021, Katina Stefanidis, who relayed them to Ms Connell the same day: Statement of Katina Stefanidis dated 4 September 2023.

[100] CB, page 137.

[101] CB, page 137.

[102] CB, page 151.

[103] CB, page 137.

[104] CB, page 143.

[105] CB, page 143.

[106] CB, pages 151 and 143.

Missing person investigation 27 June 2021

54. C/ Kempers compiled the missing person report on the Law Enforcement Assistance Program (**LEAP**).[107]

55. Police members ascertained that Shane had not contacted other family members and obtained a recent photograph of him together with permission to plan a media appeal for information.[108]

56. C/ Baines arranged for D24 to broadcast a Keep A Look Out For (**KALOF**) alert to police members in the Ballarat and Boroondara police service areas.[109]

57. RUBY821 was redeployed to other duties but at about 9.30pm patrolled near Ms Naus' home, observing that Shane's car remained parked outside. When RUBY821 returned towards the end of their shift at 10pm the car was no longer present. SC Inkson broadcast via D24 a KALOF in relation to Shane's car.[110]

58. At about 10.30pm, D24 broadcast that Shane had returned to Ms Connell's home in his car. The RUBY821 members attended to speak to Ms Connell and Shane.[111]

59. C/ Baines attempted to engage Shane in a conversation about his mental state during which Shane expressed themes of hopelessness and helplessness. When asked if he had spoken to GH clinicians about these feelings, Shane replied, 'I was out for 24 hours. I just didn't have enough on me to take. If I had more, I would have taken it.'[112] When asked directly if he was still thinking about harming himself, Shane replied, 'I just want

[107] The significance of the missing person report being available on LEAP is that the fact that Shane had been reported missing, and the circumstances relating to his disappearance, are available to any Victoria Police member performing a name search.

[108] LEAP Incident 210213577 Sub-incident 210385920 (Missing Person Report) dated 27 June 2021, Case Narrative. SC Inkson's BWC footage captures the discussion with Ms Connell: Exhibit 7, file 3, file position 1.47 (9.06pm).

[109] LEAP Incident 210213577 Sub-incident 210385920 (Missing Person Report) dated 27 June 2021, Case Narrative and CB, page 143.

[110] CB, page 138.

[111] CB, page 138.

[112] Exhibit 10, BWC of C/ Baines, file commencing 10.30pm, file position 1.51.

a coffee and go to sleep. I feel like there's nothing left. Nothing. … She won't take my calls; she won't text me.'[113]

60. C/ Baines formed the view that Shane remained at risk to himself and so apprehended him pursuant to section 351 of the MHA.[114] When he called for an ambulance to transfer Shane to a designated mental health service at about 11pm, he was informed that no ambulance was available.[115] After liaising with the shift supervisor, arrangements were made for the RUBY812 members to be relieved by another unit.[116]

61. At about 11.23pm, the RUBY821 members were relieved by C/ Booth and First Constable (**1C**) Martland.[117] Ambulance Victoria paramedics arrived around 11.50pm and found Shane to have an unsteady gait, slurred speech and difficulty differentiating timelines.[118] Shane's account of recent events, captured by police members' Body Worn Cameras (**BWC**), minimised his self-harming behaviour and asserted he 'was not having suicidal thoughts and did not wish to end his life when he took the overdose' the previous night.[119]

Monday, 28 June 2021

62. Just after midnight on Monday, 28 June 2021, Shane was transferred by ambulance to GH ED with 1C Martland and C/ Booth following in their police vehicle.[120]

63. Shane's Ambulance Victoria Patient Care Record appears in his GH medical record.[121] Among the information noted is 'according to family, pt [patient] was intending to end

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[113] Exhibit 10, BWC of C/ Baines, file commencing 10.30pm, file position 8.20.

[114] CB, page 144. Section 351 of the *Mental Health Act* 2014 empowered police members to apprehend a person who appears to have a mental illness if satisfied that the person needs to be apprehended because of their apparent mental illness to prevent serious and imminent harm to themselves or to another person. The section required the apprehended person to be assessed by a doctor or mental health clinician 'as soon as possible' to determine whether to make an Assessment Order (that is, an order made by a medical practitioner under the MHA requiring the person to be compulsorily examined by an authorised psychiatrist in an inpatient setting to determine if the treatment criteria apply): s351(5) MHA. Section 351 also prescribed when the apprehended person was released from police custody and entered the care of a hospital: s351(6) MHA.

[115] Exhibit 10, BWC of C/ Baines, file commencing 10.30pm, file position 31.00.

[116] Exhibit 10, BWC of C/ Baines, file commencing 10.30pm, file position 31.00.

[117] Exhibit 13, BWC of 1C Martland.

[118] CB, page 159 and Exhibit 14, BWC of C/ Booth, file position 25.00 and Shane's GH MRs #1, pages 85-90.

[119] CB, page 160.

[120] Exhibit 13, BWC of 1C Martland, file position 37.51.

[121] PCR 11655 dated 27 June 2021; Shane's GH MRs #1, page 85-90.

his life however pt states he just wanted to "relax". Pt denies any current suicidal ideation however aunt states he told her he had a plan to end his life.'[122]

64. When Shane was triaged at 12.20am, the GH clinician noted 'BIBA: 351[123] told Aunt was going to attempt OD[124] again. In ICU overnight due to OD … Discharged today. Denies suicidal ideation now.'[125]

65. C/ Booth completed a MDTF[126] and recalled that police were 'dismissed' when Shane was 'seen by a doctor.'[127] Although a name (presumably of a clinician)[128] is printed on the form, no signature, date or time accompanies it, nor does a copy appear in Shane's GH medical record.[129]

Mental Health Assessment by GH ED Registrar

66. Sometime after a nursing assessment performed at 1.20am,[130] Shane was seen by an ED Registrar.[131] It is not apparent whether this clinician or another spoke to Ms Connell, or when that conversation occurred in relation to when the ED Registrar examined Shane.

67. Ms Connell received a call from GH at about 2.30am in which she was 'asked questions about Shane.'[132] She told the caller that Shane had attempted to take his own life the night before and told her that if he had more tablets, he would try again.[133]

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[122] Shane's GH MRs #1, page 85.

[123] The reference to '351' relates to the section of the MHA under which police apprehended Shane, indicating he was at the designated mental health service for a mental health assessment.

[124] 'OD' is an abbreviation referring to an overdose.

[125] Shane's GH MRs #1, page 91.

[126] The MDTF relating to police interactions with Shane on 27-28 June 2021 was completed by C/ Booth at 12.26am on 28 June 2021.

[127] CB, page 157.

[128] The name on the MDTF is not the name of the clinician who assessed Shane in the GH ED on 28 June 2021.

[129] The MDTF relating to police interactions with Shane on 27-28 June 2021 was completed by C/ Booth at 12.26am on 28 June 2021.

[130] Shane's GH MRs #1, page 91.

[131] The clinician's position/qualification was not apparent from Shane's medical record but was clarified in the Statement made jointly by Drs Danvers and Lalitha dated 18 November 2021, page 5.

[132] CB, page 113.

[133] CB, page 113.

68. The ED Registrar's examination, in so far as it relates to the mental health assessment performed because of Shane's apprehension pursuant to section 351 MHA, was recorded as follows:

> BIB AV under section 351 for ?safety issues reported by aunt Karen
> As per Aunt, Shane left home + didn't come back until 1-2 hours so she called police
> As per Shane, went to get a coffee + then decided to walk to partner's home to take car back to aunt's home … DC [discharged] home today afternoon, after ICU trip for Temazepam + Stillnox OD [overdose]
> GCS 15
> tired, wants to go home
> calm, compliant
> 0 distress …
> Imp[ression]: ?false alarm
> relatives worried about safety
> P[lan]: mental health opinion
> Home
> Red flags
> Community MH [mental health] f/up [follow up][134]

69. Around 3am, the ED Registrar consulted a GH Mental Health Triage (**Triage**) clinician.[135] The Triage clinician documented that Shane had been seen by a Psychiatrist on 27 June 2021 with a plan for him to 'stay and be reviewed by psych liaison,' however, he had been discharged home at his request with ART follow up in the community.[136] The note refers to Ms Connell's report of Shane talking about a 'Plan B' and that Shane had denied any suicidal thoughts, plans or intent, denied he was depressed and presented with no delusions nor psychiatric symptoms and remained agreeable to ART follow up.[137]

70. The Triage clinician noted that 'risk [assessment was] not completed as [Shane was] not seen by ECATT,'[138] referring to that part of a mental health service that undertakes emergency assessments in the ED and community. He also noted 'nil change to mse [Mental State Examination] according to referrer so CRAAM-C would be the same as

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[134] Shane's GH MRs #1, page 92.

[135] It is an assumption that the assessing ED Registrar spoke directly to a Mental Health Triage Clinicians as no name, only 'medical officer' 'emergency department' appears in the Screening Register Shane's GH MRs #2, page 39.

[136] Shane's GH MRs #2, page 39.

[137] Shane's GH MRs #2, page 39.

[138] Shane's GH MRs #2, page 39.

last contact.'[139] However, it is not clear to what mental state assessment (**MSE**) and CRAAM-C[140] (risk assessment) the Triage clinician (or ED Registrar) referred given the Psychiatrist had not documented a complete MSE nor any formal risk assessment.

71. Following this discussion with the Triage clinician, the ED Registrar advised Shane to go home, on the basis his story was reliable, he disclosed no current suicidal thoughts and CMHT follow up was planned.[141]

72. Shane was discharged from the ED around 3.25am,[142] arriving at Ms Connell's house a short time later and falling asleep on the couch.[143]

73. Around 10am, William Pappas returned to Ms Connell's home. According to Mr Pappas, Shane remained drowsy and non-communicative, becoming 'hostile' towards him when he tried to engage him in conversation.[144]

74. When at around 10.15am, an ART clinician tried unsuccessfully to contact both Shane and Ms Connell, an unscheduled home visit was planned.[145]

Mental Health Intake Assessment by GH ART

75. Two ART clinicians[146] attended Ms Connell's home at about 11am on 28 June 2021.[147] Shane did not want to speak to the clinicians in front of family members and so the assessment was conducted outside.[148] The duration of the assessment is not clear. Mr Pappas estimated a period of 'about half an hour' before Shane returned inside, and he went outside to speak to the clinicians who 'appeared frustrated with Shane.'[149]

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[139] Shane's GH MRs #2, page 39.

[140] The CRAAM-C or 'Clinical Risk Assessment and Management Tool – Community' is a risk assessment tool used by the GH CMHT to assess risk.

[141] Shane's GH MRs #1, page 95.

[142] Statement made jointly by Drs Danvers and Lalitha dated 18 November 2021, page 6.

[143] CB, page 113.

[144] CB, page 85.

[145] Shane's GH MRs #1, page 15.

[146] The clinicians were designated 'Mental Health Clinician' and a Registered Psychiatric Nurse: see Shane's GH MRs.

[147] Shane's GH MRs #2, page 28.

[148] CB, page 85.

[149] CB, page 85.

76. The assessment performed by the ART clinicians was a Mental Health Intake Assessment comprising of (among other things) a MSE and risk assessment.[150] In clinical practice, both MSE and risk assessment involve structured assessment of, respectively, a person's emotions, thoughts and behaviour[151] and their static and dynamic psychosocial risks[152] at the time of observation. While the MSE is designed to capture the objective and subjective aspects of mental illness to aid diagnosis, both MSE and risk assessment are used to monitor the signs and symptoms of mental illness and inform planning and treatment.

77. During the assessment, Shane confirmed engagement with a psychiatrist six years earlier in the context of divorce, and though antidepressants had been prescribed, he denied taking them because he did not believe he needed them.[153]

78. Shane's unsteady gait and pronounced hand tremor were noted along with evidence of 'personality vulnerabilities (Cluster C).'[154] He denied suicidal ideation, plans or intent and said that he was 'safe.'[155] However, it appears that rapport was not easily established with Shane, the clinicians referring to the superficiality of his engagement,

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[150] The clinicians' assessment was ultimately recorded in the Mental Health Intake Assessment and Clinical Risk Assessment and Management (CRAAM-C) Community forms: Shane's GH MRs #1, pages 24-27 and 20-23 respectively.

[151] The MSE can be divided into the broad categories of appearance, behaviour, motor activity (movements), speech (amount, fluency, rate, rhythm, volume, tone), mood (the person's subjective description of their feelings in their own words), affect (clinician's interpretation of the person's expression through body language), thought process (how the person organises and expresses their thoughts), thought content (subject matter of thought), perceptual disturbances (what the person perceives – presence/absence of hallucinations), cognition (alertness, orientation, concentration, memory, abstract reasoning), insight (person's understanding of their illness and functionality) and judgement (person's ability to make good decisions).

[152] Risk Assessments typically seek to identify and assess static (background) and dynamic (current) risks of suicide and self-harm (SASH), aggression and general vulnerability. Static indices of SASH include previous suicide attempts, family history of suicide, self-harm history, chronic pain, relationship issues, psychiatric diagnosis, financial or other stressors while dynamic indicators of SASH include suicidal ideas, intent or plan, availability of means, substance use, changeability, actual/thoughts of self-harm, psychosis, etc. Static indicators of aggression include a history of aggression, use of weapons, forensic history, drug/alcohol use, intervention orders while dynamic indictors include expressions of intent to harm others, paranoia, command hallucinations, anger/frustration, substance use and reduced ability to control behaviour. Static indicators of general vulnerability include cognitive impairment, previous diagnosis of mental illness, history of exploitation, trauma or abuse and dynamic indices include self-neglect, medication non-compliance/side effects, delusions, intrusive behaviour, disorganisation, exploitation, etc.

[153] Shane's GH MRs #1, page 24.

[154] Shane's GH MRs #1, page 26. Cluster C personality disorders include Avoidant, Dependent and Obsessive-Compulsive personality disorders.

[155] Shane's GH MRs #1, page 26.

dismissiveness of the acute psychosocial stressors that led to his overdose, and his reluctance to discuss these issues.[156]

79. Notwithstanding these limitations, the clinicians characterised Shane's judgement as intact and that he identified his children as protective factors. The clinicians assessed Shane as demonstrating 'future planning' when he mentioned speaking to his children about the break-up, returning Ms Naus' belongings and rearranging his house. Further, the intake assessment referred to Shane's father as being actively involved.[157]

80. Notably, the assessment documents that 'biological symptoms of depression clouded by recent overdose and patient rumination preventing exploration of symptomology.'[158] Throughout the assessment, Shane had ruminated about his recent breakup from Ms Naus and that from his ex-wife as 'betrayals.'[159] The need for further assessment was noted.[160]

81. Shane's risk of harm was assessed as medium.[161]

82. The assessment acknowledged that safety planning was limited because Shane insisted upon returning to Melbourne and was unwilling to remain in Ballarat for ongoing support and review by ART.[162]

83. Ultimately the clinicians concluded[163] that they were 'not able to apply MHA'[164] (that is, subject Shane to compulsory assessment under the MHA) as he was 'not displaying

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[156] Shane's GH MRs #1, page 26.

[157] Shane's GH MRs #1, page 26.

[158] Shane's GH MRs #1, page 26.

[159] Shane's GH MRs #1, page 26.

[160] Shane's GH MRs #1, page 27.

[161] Shane's GH MRs #1, page 22.

[162] Shane's GH MRs #1, page 26.

[163] The ART clinicians formulated the overall clinical impression of Shane (which was duplicated verbatim into the Risk Assessment) as: '55 y.o. divorced male experiencing a recent relationship breakdown presenting with an overdose of benzodiazepines secondary to rejection and abandonment feelings. Displaying personality vulnerabilities (cluster C), no past history of self-harm, patient denies same, stating no suicidal ideation plan or intent. Patient indicating, he is safe, though showing only superficial engagement with mental health assessment not able to apply MHA as not displaying a mental illness, denying risk and accepting community mental health follow up. Patient showed protective factors in regards to his children x5 aged between 17 to 24; expressing need to speak to them concerning the break up, planning around ex-partner's belongings and rearranging his house to assist him with moving on (future planning). Patient's father actively involved and is planning to drive his son back to Melbourne to ensure safety and will monitor this and willing to contact 000 if

a mental illness, [was] denying risk and accepting community mental health follow up.'[165]

84. Shane's provisional diagnosis was 'acute stress reaction – situational crisis/crisis reaction.'[166] The initial management plan consisted of Mr Pappas transporting Shane home to Balwyn and monitoring his safety; Shane arranging to see his GP for medical review and a mental health plan/referral to a psychiatrist; and the GH CMHT referring Shane to his local area metal health service, St Vincent's Hospital (**St V's**) Crisis Assessment Treatment Team (**CATT**).[167]

85. According to Mr Pappas, when he spoke to the ART clinicians after their assessment, they told him 'they wanted Shane to check into the Ballarat Mental health facility but he wanted to go to a Melbourne one.'[168] Shane's GH medical records do not reveal any consideration of a voluntary psychiatric admission.

86. Around 4pm, Shane was referred to St Vincent's CATT by phone with relevant clinical information provided some time later.[169]

87. A St V's CATT clinician attempted to contact Shane by phone to arrange a home visit the following day, leaving a message for a return call as soon as possible.[170]

88. Sometime that afternoon, GH Triage called Mr Pappas to confirm the referral to St V's CATT had been made and provide the service's phone number.[171] Mr Pappas reported that Shane's physical health had not improved over the course of the day; his 'slanted

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required. Patient accepting of referral to local mental health service for follow up and engaging with his G.P. for review and organising a mental health plan for referral to past psychiatrist.

On assessment today, Patient presented with themes of hopelessness, helplessness in context of relationship breakdown. No perceptual disturbances, delusions or cognitive impairment identified. Biological symptoms of depression clouded by recent overdose and patient rumination preventing exploration of symptomology - will need further assessment. Safety planning limited as patient insists on returning to Melbourne today and not willing to stay in Ballarat for ongoing support/review by Acute Response Team'. See Shane's GH MRs #1, pages 26-27.

[164] Shane's GH MRs #1, page 26.

[165] Shane's GH MRs #1, page 26.

[166] Shane's GH MRs #1, page 26.

[167] Shane's GH MRs #1, page 27.

[168] CB, page 90.

[169] Shane's St Vincent's Hospital medical records, page 26.

[170] Shane's St Vincent's Hospital medical records, page 22.

[171] Shane's GH MRs #1, page 28.

gait, hand tremor, exhaustion' remained.[172] The Triage clinician encouraged Mr Pappas to take Shane to the ED for examination, but Shane refused to go. At his father's request, the Triage clinician spoke to Shane directly. Shane denied any health issues and refused to attend the ED because 'my ex is going to call me, and I can't not accept the call.'[173] The Triage clinician advised Mr Pappas to call Triple Zero for an ambulance if he remained concerned.[174]

89. At about 5pm, Mr Pappas obtained Shane's agreement to accompany him back to Balwyn, leaving Shane's car in Ballarat.[175] They arrived in Balwyn at about 9pm, with Mr Pappas, his partner, and two of Shane's daughters staying at the house over night to ensure Shane remained at home and safe. Medications and other items that could be used by Shane to harm himself had been removed from the house before his return.[176]

Tuesday, 29 June 2021

90. At about 9.35am on Tuesday, 29 June 2021 Shane called St V's Triage in response to the message left by St V's CATT the previous afternoon.[177] He was reportedly 'perplexed' by the linkage to St V's CATT but 'agreeable' to it.[178] He expressed a 'strong preference' against a home visit by clinicians due to the presence of his 17 year old son at home but consented to a further phone call later, after he'd attended an appointment with his GP.[179]

91. At about 10am, Shane presented to his GP at Kew Junction Medical Centre. Although a family member had made the appointment for him, and his father and one daughter accompanied him to the appointment, Shane saw the GP alone.[180] The note of the

[172] Shane's GH MRs #2, page 32.

[173] Shane's GH MRs #2, page 32.

[174] Shane's GH MRs #2, page 32.

[175] CB, page 86.

[176] CB, page 100.

[177] Shane's St Vincent's Hospital medical records, page 24.

[178] Shane's St Vincent's Hospital medical records, page 24.

[179] Shane's St Vincent's Hospital medical records, page 24.

[180] CB, page 86.

consultation is brief. It documents that Shane took an overdose of Stilnox in response to a relationship break down and that the CAT Team would follow up that day.[181]

92. Around 12.30pm, a St V's Triage clinician called Shane noting that his speech sounded slow.[182] Shane denied taking extra medication saying he was 'just very tired and wants to sleep.'[183] The clinician was suspicious that Shane was minimising the situation and was concerned that Shane was 'vague' about current risks.[184] A Telehealth appointment was scheduled for 3.30pm with the primary purpose of risk assessment.[185]

93. Shane spent the afternoon at or near his home with several family members and a friend watching over him.[186]

Phone Assessment by St V's Psychiatry Registrar

94. Shane failed to attend the Telehealth appointment at 3.30pm. The St V's Psychiatry Registrar (**Psychiatry Registrar**) waited on the audio-visual platform for 15 minutes, and then telephoned Shane.[187] He answered, stating that he did not want to have a Telehealth appointment because he might be overheard by family members but agreed to a consultation by phone;[188] it appears that Shane took the call while in the backyard.[189] The Psychiatry Registrar found Shane easy to engage and recalled that he spoke for the majority of the 50-minute consultation.[190]

95. Throughout the consultation, Shane described prominent suicidal ideation and that his life was no longer worth living.[191] He appeared fixated on the breakdown of his

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[181] Shane's Kew Junction Medical Centre Medical Record, page 27. The GP also made the following management note: 'Contact Dr Pamela Brewster through CATT,' apparently referring to the private psychiatrist with whom Shane had intermittently engaged following his divorce.

[182] Shane's St Vincent's Hospital medical records, page 24.

[183] Shane's St Vincent's Hospital medical records, page 24.

[184] Shane's St Vincent's Hospital medical records, page 24.

[185] Shane's St Vincent's Hospital medical records, page 25.

[186] CB, pages 87 and 101. This situation, of Shane being under supervision, appears to have caused him frustration.

[187] Statement of Dr Alaa Baky dated 10 November 2023, page 1.

[188] Statement of Dr Alaa Baky dated 10 November 2023, page 1.

[189] CB, page 87.

[190] Information provided by the Coroner's Investigator (see CI's summary page 12); see also Statement of Dr Alaa Baky dated 10 November 2023, page 1.

[191] Shane's St Vincent's Hospital medical records, page 19.

relationship, at one point asking the clinician to contact Ms Naus to ask her to forgive Shane.[192] He reported feeling as though he had no other option but to take his own life if Ms Naus refused to reconcile with him. He admitted that his overdose on 26 June 2021 – using Stilnox, and temazepam he had been prescribed following the breakdown of his marriage[193] – was an attempted suicide.[194]

96. Shane was extremely tearful and embarrassed (referring several times to not wanting his family to overhear him).[195] The Psychiatry Registrar noted that Shane demonstrated significant issues relating to self-worth and self-esteem in addition to prominent Cluster C personality traits (that is, dependent personality) and fear of abandonment. He spent much of the conversation ruminating over past mistakes, past wrongs perpetrated by and against him and 'catastrophizing.'[196] He also disclosed significant financial stressors.[197]

97. Shane denied having any protective factors, saying that his children 'hate him' and that he 'hates his parents;' he denied that Mr Pappas had provided good support to him since his discharge from GH.[198] The Psychiatry Registrar documented that Shane declined to engage in a discussion about safety planning or engagement with the community mental health team; although he 'reluctantly agreed' to meet the St V's CATT away from his home the next day, he refused to provide any confirmation he would attend.[199]

98. The Psychiatry Registrar's assessment was that Shane presented as a high risk of suicide, with 'acute on chronic' feelings of abandonment.[200] Her impression was of 'acute stress in crisis, Cluster C personality traits with a query over obsessive versus

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[192] Shane's St Vincent's Hospital medical records, page 19.

[193] The St V's Psychiatry Registrar noted that Shane had seen a private psychiatrist when his marriage ended. He reported that the psychiatrist had commenced him on temazepam and Seroquel (quetiapine) and that he had self-ceased Seroquel due to daytime somnolence and 'kept temazepam which he took on Friday' (26/6/21): Shane's St Vincent's Hospital medical records, page 20.

[194] Shane's St Vincent's Hospital medical records, page 18.

[195] Shane's St Vincent's Hospital medical records, page 19.

[196] Shane's St Vincent's Hospital medical records, page 19.

[197] Shane's St Vincent's Hospital medical records, page 20.

[198] Shane's St Vincent's Hospital medical records, page 19.

[199] Shane's St Vincent's Hospital medical records, page 20.

[200] Shane's St Vincent's Hospital medical records, page 20.

delusional jealousy, the latter requiring further assessment due to potential risk to Ms Naus.[201]

99. At the conclusion of her consultation with Shane, just before 5pm, the Psychiatry Registrar informed Shane that she would place him under an Inpatient Assessment Order and that St V's CATT clinicians would attend his home to transport him to hospital.[202]

100. At about this time, Shane's family members realised that he was no longer in the backyard and started looking for him.[203] Jessica Pappas called her father, who answered and said he'd 'made a mess of everything' and was going to 'drown himself.'[204]

101. At 5.02pm, Alison Pappas called Triple Zero reporting that her father had left home on foot about 10 minutes earlier threatening suicide.[205]

102. Meanwhile, the Psychiatry Registrar discussed her decision to place Shane on an Inpatient Assessment Order with a senior St V's CATT clinician and the on-call psychiatric registrar before completing the MHA 101 Form.[206] The Psychiatry Registrar based her decision to make an order under section 30 of the MHA on Shane's 'significant risk' to himself due to 'prominent thoughts of ending [his] life' that could not be managed safely at home.[207] The Inpatient Assessment Order was made at 5.30pm.[208]

Missing Person investigation 29 June 2021

103. At about 5.10pm, SC Deramo and C/ Jones of Boroondara Police were dispatched to Shane's address following Alison Pappas' Triple Zero call; the job was characterised as a 'threat of suicide.'[209] Close to the address, around 5.20pm, a friend of Shane's

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[201] Shane's St Vincent's Hospital medical records, page 20.

[202] Statement of Dr Alaa Baky dated 10 November 2023, page 1.

[203] CB, page 87.

[204] CB, page 88.

[205] CB, page 260.

[206] Statement of Dr Alaa Baky dated 10 November 2023, page 2.

[207] CB, page 229.

[208] CB, page 229.

[209] CB, page 161.

flagged down the marked police vehicle and apprised the members of recent events and provided a description of Shane.[210]

104. C/ Jones broadcast an update via D24 and requested additional units, including Airwing, to assist with the search.[211] Airwing was unavailable,[212] however, the shift supervisor, Sgt Borg directed several units based at the Kew and Camberwell police stations to join the effort to locate Shane.[213]

105. By 5.40pm, police units were deployed and searching tram and train stops in the vicinity of Shane's home, along Yarra Boulevard and around Studley Park Boathouse in Kew, and the Kew Golf Club.[214]

106. Mr Pappas and Jessica Pappas were driving around looking for Shane near bridges between Balwyn and Richmond.[215] Ms Naus, who had spoken to Shane, relayed that he had told her he was in a park near Kew Cemetery.[216]

107. Around the same time, St V's CATT clinicians were *en route* to Shane's home and had called Mr Pappas to inform him. Mr Pappas reported that Shane had 'jumped the side fence and taken off' and that the police had been called.[217]

108. Meanwhile, at 5.49pm, Alison Pappas called Triple Zero for a second time.[218] She reported that Shane had been in contact with his mother and with Ms Naus and that it was possible that he would go to a recreational park known as Hays Paddock in Kew East, the closest with a body of water.[219] Hays Paddock became a focus of the search, with several units deployed there, including a police canine unit about an hour later.[220]

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[210] CB, page 161.

[211] CB, page 162.

[212] CB, page 162.

[213] CB, pages 174-175.

[214] CB, page 161-180.

[215] CB, page 88.

[216] CB, page 88.

[217] Shane's St Vincent's Hospital medical records, page 23.

[218] CB, page 275.

[219] CB, pages 282-283.

[220] CB, page 162.

109. Around this time, 1C Roberts of Boroondara police station contacted Alison Pappas to obtain further information to formally lodge a missing person report on LEAP.[221] Having done so, 1C Roberts notified the Search and Rescue Division of Victoria Police and the Divisional Patrol Supervisor, and briefed the incoming Boroondara shift supervisor, Acting Sergeant (**A/Sgt**) Stamatakos who had relieved Sgt Borg.

110. At about 5.55pm, a St V's CATT clinician called Triple Zero to alert the emergency services to the existence of the Inpatient Assessment Order.[222] The clinician also relayed the concern that Shane was suicidal and information from Mr Pappas that Shane might be 'going to a park near the Kew Cemetery.'[223] Within minutes, a police unit from Camberwell police station was deployed to Victoria Park in Kew.[224]

111. At around 6.15pm, A/Sgt Stamatakos submitted a request for triangulation of Shane's mobile phone pursuant to section 287 of the *Telecommunications Act 1997* (Commonwealth) on the grounds it was reasonably necessary to prevent or lessen a serious and imminent threat to Shane's life.[225]

112. Triangulation of Shane's mobile phone was authorised at 7.13pm, with the first report – that his phone was in the vicinity of Rockbank train station – received at about 7.31pm. This location information suggested that Shane's intended destination might be Ballarat.[226]

113. A second triangulation report at 7.58pm placing Shane's phone near Ballan[227] appeared to confirm that Shane was heading to Ballarat. A/Sgt Stamatakos informed D24 which, in turn, notified the shift supervisor for the Ballarat police service area, Sgt Taylor, that

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[221] Statement of A/Sgt Stamatakos dated 27 December 2021, page 1 and LEAP Incident 210216024 Sub-incident 210390429 (Missing Person Report) dated 29 June 2021, Case Narrative.

[222] CB, page 287.

[223] CB, page 290.

[224] CB, page 172.

[225] CB page 235

[226] A/Sgt Stamatakos refers to Shane's phone being located in Benalla (northeastern Victoria) at the time of the second triangulation which appears to be an error given that the triangulation maps provided by my Investigator show the phone's position near Ballan (north and west of its most recent position near Rockbank): Statement of A/Sgt Stamatakos dated 27 December 2021, page 2. I note that Sgt Taylor does not refer to being told that Shane's phone was triangulated to Benalla nor that he acted on any misinformation: Statement of Sgt Taylor dated 16 July 2021, pages 1-3.

[227] Statement of A/Sgt Stamatakos dated 27 December 2021, page 2.

Shane was no longer in the Balwyn area and was possibly *en route* to Ballarat by train.[228]

114. By 8.30pm, Protective Service Officers had established that Shane was not among the passengers alighting the VLine service in Ballarat and SC Hendrix and C/ McDonald, the Ballarat North 203 members, did not see him at Wendouree train station where the train terminated.[229] There was no sign of Shane between the terminus and his aunt's home where his car remained parked.[230] When the Ballarat North 203 members spoke to her, Ms Connell confirmed that Shane did not have his car keys.[231]

115. Around this time, A/Sgt Stamatakos relayed to Sgt Taylor information from Ms Naus, whom Shane had texted, that Shane had hitchhiked to the Central Highlands region and was believed to be at a service station in Warrenheip, about eight kilometres east of Ballarat.[232] Ballarat North 203 and Ballarat West 303, comprising of SC Bolton and C/ Pha, were tasked to attend the service station but on arrival at 8.45pm did not find Shane there.[233]

116. Ballarat North 203 then patrolled the Western Highway between Warrenheip and Ballarat searching for Shane on its way to resume a static patrol at Ms Connell's home.[234] Meanwhile, Ballarat West 303 was re-deployed to the Bridge Street Mall around 9pm upon receipt of further information from Ms Naus about Shane's location.[235] However, when the members attended around 9.15pm, there was no sign of Shane at the Mall.[236]

117. Sgt Taylor left Ballarat Police station at about 9.45pm to rendezvous with the Ballarat North 203 members in Wendouree. SC Hendrix advised the sergeant that C/ McDonald

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[228] Statement of A/Sgt Stamatakos dated 27 December 2021, page 2 and Statement of Sgt Taylor dated 16 July 2021, page 1. A VLine service was scheduled to stop at Ballarat at 8.12pm.

[229] CB, pages 183-4 and 190-1.

[230] CB, pages 184 and 190-1.

[231] Statement of Sgt Taylor dated 16 July 2021, pages 1-2.

[232] Statement of Sgt Taylor dated 16 July 2021, pages 1-2, Statement of A/Sgt Stamatakos dated 27 December 2021, page 2 and CB, pages 184 and 190-1.

[233] Statement of Sgt Taylor dated 16 July 2021, page 3.

[234] CB, pages 184-5 and 190-1.

[235] Statement of Sgt Taylor dated 16 July 2021, page 3.

[236] CB, page 195.

had spoken to Ms Naus,[237] who had reported that Shane had told her he was near her house. Sgt Taylor tasked Ballarat West 303 to patrol that area.[238]

118. A/Sgt Stamatakos emailed Sgt Taylor a copy of the Inpatient Assessment Order made in relation to Shane[239] and, shortly before 10pm, relayed that the most recent triangulation report indicated Shane's phone was in the Redan/Newington area, suburbs not far from Ms Naus' home.[240] Sgt Taylor then directed the Ballarat West 303 members to attend and speak to Ms Naus and search her property. Ballarat North 203 and Sgt Taylor redeployed to Ms Naus' address.[241]

Events immediately proximate to death

119. Ballarat West 303 arrived at Ms Naus' home just after 10pm, where SC Bolton obtained Ms Naus' permission to search her home and yard for Shane.[242] Within minutes, the police members had established that Shane was not inside the house and had begun a search of the garden by torchlight.[243]

120. SC Bolton located Shane hiding under a lemon tree in the north-west corner of the backyard.[244] There was a bag about a metre from where Shane was sitting. Shane complied with police members' directions to come towards them, identify himself and submit to a pat-down search. SC Bolton observed Shane's movements to be slow, his demeanour 'docile' and that while he was speaking quietly, his speech was not slurred.[245]

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[237] Ms Naus is inaccurately referred to as 'Ms Wilson' in Sgt Taylor's statement.

[238] Statement of Sgt Taylor dated 16 July 2021, page 3.

[239] Email from Sgt Stamatakos to Sgt Taylor dated 29 June 2021 at 8.37pm. Confirmation of the existence of the Assessment Order empowered police members to use the apprehension power pursuant to section 352 of the MHA because Shane was 'absent without leave' from a designated mental health service.

[240] Statement of Sgt Taylor dated 16 July 2021, page 3.

[241] CB, page 185 and Statement of Sgt Taylor dated 16 July 2021, page 4.

[242] CB, page 196.

[243] CB, page 196.

[244] CB, page 196.

[245] CB, pages 196-7.

121. Via D24 SC Bolton advised other police units that Shane had been located[246] and then informed Shane that as there was an Inpatient Assessment Order in place he would be transported to hospital.[247] SC Bolton and C/ Pha walked Shane through Ms Naus' house and out to the front veranda where they were met by the Ballarat North 203 members and Sgt Taylor.[248] The time was about 10.08pm and each Ballarat North 203 member had activated their BWC.[249]

122. Shane complied with a more comprehensive safety search. Although he appeared to experience some difficulty following police directions, he was able to hold a conversation with members.[250]

123. At 10.11pm, Shane asked if he could sit down and was escorted to a chair a few metres from the front door.[251] He continued to speak to police for a further four minutes, providing a coherent account of recent events, before asking for his heart medication which he said was inside.[252] Sgt Taylor spoke to Ms Naus and searched where directed but found no medication, relaying this to Shane at about 10.16pm.[253]

124. At 10.18pm, Shane said that he might vomit and then asked for some water.[254] SC Hendrix went inside to get him a glass of water returning a minute later but Shane was unable or unwilling to hold the glass.[255] Around this time, SC Bolton asked Shane

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[246] Police Radio Communications 29 June 2021 (redacted extract), timed approximately 10.06pm (file position 00:01:17)

[247] CB, page 197.

[248] CB, page 186.

[249] Exhibit 21 (SC Hendrix's BWC) at file position 1.46. See also Exhibit 22 (C/ McDonald's BWC). At my direction, A/Sgt Derksen enquired of the other attending members why their BWC footage was not available to the coronial investigation. Sgt Taylor advised that he arrived after Shane had been taken into custody and saw that other members had already activated their BWC; he thought, erroneously, that he had activated his BWC when Shane collapsed. SC Bolton and C/ Pha advised that they had been involved in a critical incident prior to being tasked to assist with the search for Shane. When they left the police station to join the search for Shane, both members' BWCs were docked to upload the footage from the critical incident and neglected to collect them before leaving to attend the Priority 1 job relating to Shane: Email from A/Sgt Derksen to the Coroners Court dated 4 December 2022.

[250] Exhibit 21 (SC Hendrix's BWC) at file position 2.25-4.19 (10.09-10.11pm).

[251] Exhibit 21 (SC Hendrix's BWC) at file position 5.16 (10.12pm).

[252] Exhibit 21 (SC Hendrix's BWC) at file position 8.42 (10.15pm).

[253] Exhibit 21 (SC Hendrix's BWC) at file position 9.55 (10.16pm).

[254] Exhibit 21 (SC Hendrix's BWC) at file position 11.19 (10.18pm).

[255] Exhibit 21 (SC Hendrix's BWC) at file position 13.17 (10.19pm).

about an almost empty drink bottle containing a granular residue he had recovered in the backyard, and whether he had drunk from it.[256] Shane mumbled in response.[257]

125. At 10.20pm, SC Hendrix requested an ambulance via D24.[258] He advised that Shane had heart problems, his speech was slurred, he had drunk an unknown liquid and though he was conscious, he 'looks like he's nodding off.'[259] Over the next couple of minutes, the BWC footage shows Shane slumped in a chair, with his speech becoming less and less intelligible as police members try to engage him in conversation in an effort to keep him awake.[260]

126. Sgt Taylor directed members to check Shane's pulse.[261] SC Hendrix did so and reported Shane's pulse to be fast while C/ Pha observed that he had barely responded to painful stimuli.[262]

127. At 10.25pm, Sgt Taylor radioed D24 to ascertain if an ambulance had been dispatched.[263] He also reported that empty medication containers had been found in a bag and he feared Shane had taken the medication and had 'started to deteriorate.'[264] The D24 operator arranged for paramedics to call Sgt Taylor directly on his mobile phone.[265]

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[256] CB, page 197 and Exhibit 24 (Photographs), IMG8599 and IMG8600.

[257] Exhibit 21 (SC Hendrix's BWC) at file position 13.42 (10.20pm).

[258] Police Radio Communications 29 June 2021 (redacted extract), timed approximately 10.20-21pm (file position 00:14:43-15.29).

[259] Police Radio Communications 29 June 2021 (redacted extract), timed approximately 10.20-21pm (file position 00:14:43-15.29).

[260] Exhibit 21 (SC Hendrix's BWC) at file position 14.41-16.21 (10.21pm-10.23pm).

[261] Statement of Sgt Taylor dated 16 July 2021, page 5 and Exhibit 21 (SC Hendrix's BWC) at file position 16.36 (10.23pm).

[262] Exhibit 21 (SC Hendrix's BWC) at file position file position 17.21 (10.24pm).

[263] Police Radio Communications 29 June 2021 (redacted extract), timed approximately 10.25pm (file position 00:20:11-18).

[264] Police Radio Communications 29 June 2021 (redacted extract), timed approximately 10.25pm (file position 00:20:11-18).

[265] Police Radio Communications 29 June 2021 (redacted extract), timed approximately 10.25pm (file position 00:20:11-18).

128. The police members manoeuvred Shane into the recovery position on the veranda and continued to monitor his breathing and pulse.[266]

129. At about 10.26pm Sgt Taylor received a call from a paramedic to whom he relayed his concerns about Shane given his recent history of self-harm, the empty medication containers, and his deterioration while in police presence.[267]

130. At 10.28pm, D24 broadcast that an ambulance had been dispatched and was about three kilometres from the scene.[268]

131. At the direction of the paramedic, police members counted the frequency of Shane's respirations and, after three minutes of relayed observations, were advised to commence chest compressions.[269] As the members commenced chest compressions, Sgt Taylor alerted them to the arrival of the ambulance.[270]

132. During the first round of compressions, Ambulance Victoria Advanced Life Support (**ALS**) paramedics arrived at Shane's side and ascertained that he was in cardiac arrest.[271]

133. At 10.37pm, Sgt Taylor provided a situation report to D24 advising that Shane's condition had deteriorated, and police members had commenced CPR.[272]

134. While police members continued chest compressions, paramedics applied a defibrillator and managed Shane's airway by intubation and ventilation via a bag valve mask.[273] Fire Rescue Victoria and a Mobile Intensive Care Ambulance (**MICA**) paramedic were on scene by 10.40pm to, respectively, assist with resuscitation and manage advanced interventions.

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[266] CB, page 203 and Exhibit 21 (SC Hendrix's BWC) at file position file position 18.48 (10.25pm).

[267] Exhibit 21 (SC Hendrix's BWC) at file position file position 19.44-24.11 (10.26pm-10.30pm).

[268] Police Radio Communications 29 June 2021 (redacted extract), timed approximately 10.28pm (file position 00:23:25-33).

[269] Exhibit 21 (SC Hendrix's BWC) at file position file position 24.11- 27.19 (10.30pm-10.34pm).

[270] Exhibit 21 (SC Hendrix's BWC) at file position file position 27.26 (10.34pm).

[271] CB page 217.

[272] Police Radio Communications 29 June 2021 (redacted extract), timed approximately 10.37pm (file position 00:32:49-33.00).

[273] CB page 217.

135. At approximately 11pm, Shane's circulation was restored.[274] ALS paramedics planned his extrication from the scene and transfer to an ambulance.[275]

Admission to GH ED

136. Shane was transferred by ambulance to the GH ED, arriving at 11.35pm on 29 June 2021.[276] C/ Norman and 1C Forbes escorted Shane to hospital and provided the MDTF prepared by 1C Forbes to GH staff.[277]

137. A history was provided by paramedics of asystolic arrest in the setting of a medication overdose[278] with a period of approximately 30 minutes "down time" before circulation was restored.[279]

138. On initial examination, Shane was unconscious, with sluggish pupillary responses, low blood pressure, a high heart rate and good oxygen saturation with artificial ventilation. Examination of his chest revealed bilateral basal crepitations but good air entry. While a bedside echocardiogram showed good ventricular function with no effusion, an electrocardiograph initially showed widespread anterolateral ST depression and prolonged QT interval which later resolved.[280]

139. Shane was placed on a mechanical ventilator and several intravenous treatments commenced including noradrenaline to support his blood pressure. Charcoal was administered via nasogastric tube to inhibit the absorption of the medications Shane was believed to have ingested.[281]

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[274] CB page 218.

[275] CB page 218.

[276] Statement made jointly by Drs Danvers and Lalitha dated 18 November 2021, page 10.

[277] CB, pages 215 and 245.

[278] GH understood that Shane had taken an overdose of the antipsychotic quetiapine, the antidepressant escitalopram and an opiate analgesic, oxycodone: Statement made jointly by Drs Danvers and Lalitha dated 18 November 2021, page 10.

[279] Statement made jointly by Drs Danvers and Lalitha dated 18 November 2021, page 10.

[280] Statement made jointly by Drs Danvers and Lalitha dated 18 November 2021, page 11. ST depression and prolonged QT interval are abnormal results detected by ECG, the latter indicating an irregular heart rhythm (involving the lower chambers of the heart).

[281] Statement made jointly by Drs Danvers and Lalitha dated 18 November 2021, page 11.

140. Around 3am on 30 June 2021, Shane's family arrived at the GH ED and were informed of his critical condition and guarded prognosis.[282]

141. On review at about 7.30am, Shane's pupils were noted to be fixed and dilated,[283] with a brain CT demonstrating diffuse hypoxic ischaemic injury and early indications of herniation.[284] CT scanning of Shane's chest revealed likely aspiration pneumonia.[285]

Transfer to Angliss Hospital on 30 June 2021

142. As no ICU beds were available at GH, Shane was transferred by the Adult Retrieval Service to Angliss Hospital (**Angliss**) in Upper Ferntree Gully and admitted to the ICU at 5.45pm on 30 June 2021.[286]

143. On admission, Shane was unconscious (though a sedative had been administered to ensure his safe transport) and intubated, with oxygenation and ventilation satisfactory on the mechanical ventilator. His blood pressure was supported by noradrenaline and a chest x-ray confirmed lung consolidation.

144. On 1 July 2021, having been advised that Shane may be the subject of an Assessment Order, a psychiatry registrar sought to confirm his status under the MHA without success.[287] An echocardiogram performed the same day demonstrated diminished heart function.[288]

145. Shane's condition persisted without change or any purposeful movement after withdrawal of sedation. Discussions between clinicians and Shane's family about his condition and very poor prognosis were ongoing. Shane's brain function was assessed on 2 and 3 July 2021, both assessments indicating brain death.

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[282] Shane's GH MRs #1, page 44.

[283] Shane's GH MRs #1, page 49.

[284] CB, page 48 and Statement made jointly by Drs Danvers and Lalitha dated 18 November 2021, pages 11-12.

[285] CB, page 48.

[286] CB, pages 47-48.

[287] CB, page 48: a search of the statewide mental health Client Management Interface [CMI] and Eastern Health's electronic databases, and liaison with Grampians Health ICU registrar, failed to confirm the existence of the Assessment Order made by a St Vincent's Health clinician on 29 June 2021.

[288] CB, page 48.

146. Shane was pronounced dead at 8.36am on 3 July 2021. Shane's family generously consented to donation of his organs, with life support ceased after the organ donation procedure was concluded.[289]

IDENTITY OF THE DECEASED

147. Shane Anthony Pappas, born 3 August 1966, late of an address in Balwyn, was visually identified by his son.[290]

148. Identity was not in dispute and required no further investigation.

MEDICAL CAUSE OF DEATH

149. On 12 July 2021, Forensic Pathologist Dr Hans de Boer of the Victorian Institute of Forensic Medicine (**VIFM**) reviewed the circumstances of Shane's death as reported by police to the coroner and post-mortem CT scans of the whole body,[291] and performed an autopsy.[292]

150. Dr de Boer provided a written report of his findings dated 20 September 2021.[293] Among his anatomical findings were advanced hypoxic-ischaemic brain injury with marked oedema and evidence of herniation,[294] fibrosis of the posterior wall of the left cardiac ventricle indicative of a remote myocardial infarction,[295] stenting of the left circumferential coronary artery[296] and mild atherosclerosis of the remaining fragments of the coronary arteries.[297] The distal small bowel and large bowel contained a black

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[289] CB, page 52.

[290] Statement of Identification dated 3 July 2021.

[291] Dr De Boer also reviewed the Medical Deposition prepared by clinicians at Angliss Hospital, Shane's Grampians Health medical records, organ transplantation documents and the request from Victoria Police for an immediate autopsy: CB, page 51.

[292] The autopsy occurred following organ donation: Dr de Boer noted the absence of the lungs, liver, kidneys and major vessels, and that heart valves had been excised.

[293] CB, pages 50-62.

[294] CB, page 52.

[295] CB, page 53: remote myocardial infarction refers to a previous heart attack.

[296] CB, pages 52-3: a stent is used to treat severe stenosis (narrowing) of blood vessels; the stent and major coronary arteries were sufficiently patent (open) at the time of autopsy.

[297] CB, page 52: atherosclerosis is a thickening or hardening of the arteries caused by a buildup of plaque.

substance consistent with the therapeutic administration of active charcoal,[298] and there were no significant injuries that might have caused or contributed to death.[299]

151. Dr de Boer opined that fibrosis alters the electrical conductivity of the heart muscle and so predisposes the development of cardiac arrhythmias and sudden death. Although such arrhythmias may occur spontaneously, the probability of them occurring may be increased by medication or illicit drug use and by an increased heart rate.[300]

152. Routine toxicological analysis of ante-mortem blood samples collected about two hours after Shane's collapse[301] detected the antipsychotic quetiapine (~1.5mg/L),[302] opiate analgesic oxycodone (~0.2mg/L),[303] methylphenidate (~0.02mg/L),[304] metformin (~2.3mg/L),[305] benzodiazepines temazepam (~0.04mg/L)[306] and diazepam (~0.2mg/L)[307] together with the active metabolite of the latter, nordiazepam (~0.2mg/L),[308] and atropine[309] and midazolam.[310]

153. VIFM's reporting Forensic Toxicologist commented that the level of quetiapine was consistent with excessive use and that the combination of drugs detected may cause death in the absence of other contributing factors.[311]

154. Dr de Boer observed that the level at which quetiapine was detected was slightly below the toxic range for the drug (1.8-2.0mg/L).[312] In addition to potentially causing

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[298] CB, page 52: active charcoal reduces absorption of substances in the stomach and intestines and is typically indicated for treatment of swallowed poisons.

[299] CB, page 52.

[300] CB, page 53.

[301] The specimens were collected at 00:05 on 30 June 2021: CB, page 63.

[302] CB, page 64.

[303] CB, page 64.

[304] Methylphenidate is a potent nervous system stimulate used medically to treat attention deficit hyperactivity disorder and narcolepsy.

[305] Metformin is the main first-line medication used for the treatment of type 2 diabetes.

[306] CB, page 64.

[307] CB, page 64.

[308] CB, page 64.

[309] Atropine is an antimuscarinic agent often used to treat bradycardia (a low heart rate).

[310] Midazolam is a benzodiazepine used foe anaesthesia and procedural sedation.

[311] CB, page 65.

[312] CB, page 53.

dizziness, hypertension and tachycardia, quetiapine affects the electrical conductivity of the heart (QT interval prolongation), which is associated with an increased risk of sudden cardiac death. The forensic pathologist noted that Shane's QT interval was prolonged when he was admitted to hospital.[313]

155. Dr de Boer observed that the level at which oxycodone was detected can be toxic, though therapeutic, toxic and lethal levels of the drug overlap such that its effects depend on habituation. The toxic effects of oxycodone include respiratory depression and cardiac arrest. He observed too that although methylphenidate, metformin and the benzodiazepines were detected at levels consistent with therapeutic use, the concurrent use of benzodiazepines and oxycodone increases their central nervous system-depressant effects.[314]

156. The forensic pathologist thought it likely that atropine and midazolam were administered during cardiopulmonary resuscitation.[315]

157. Dr de Boer provided an opinion that the medical cause of death was 1(a) quetiapine toxicity in a man with ischaemic heart disease.

THE CORONIAL INVESTIGATION

158. Following Shane's death at Angliss, D/A/Sgt Derksen of the Homicide Squad[316] commenced a coronial investigation with oversight provided by Professional Standards Command.[317]

159. The scene of Shane's collapse, including a bag in his possession and the "Gatorade" bottle[318] located in Ms Naus' backyard, were examined, and photographed. A search of

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[313] CB, page 53.

[314] CB, page 53.

[315] CB, page 53.

[316] Allocation of Coroner's Investigators (CI) is a matter for the Chief Commissioner of Police (CCP). However, when CI from Ballarat Crime Investigation Unit (CIU) was allocated, a Principal In-house Solicitor of the Court's Legal Services Division requested that the CCP consider allocating instead a police member from a police service area unconnected to events proximate to Shane's death to avoid any appearance of a conflict of interest. It was following that request that D/A/Sgt Derksen was appointed CI.

[317] Professional Standards Command (PSC) oversight is required pursuant to Victoria Police Manual policies and guidelines when there is a death or serious injury arising from an incident involving police. I note that PSC was notified within four hours of Shane's collapse. Detective Sgt Keating, who oversaw the coronial investigation, noted that the 'local' members had processed the scene of Shane's collapse and that all relevant crime scene actions and required initial actions were undertaken: Statement of Detective Sgt Keating dated 24 August 2022 and its annexure (Victoria Police Oversight Investigation Framework).

the bag revealed a wallet, a mobile phone with a red cover, and 12 empty blister packs of medication, two labelled Escitalopram Sandoz (escitalopram), nine labelled Seroquel (quetiapine) and one labelled Endone (oxycodone).[319] The "Gatorade" bottle held the remnants of an opaque orange liquid containing a granular substance.[320]

160. D/A/Sgt Derksen's investigation uncovered notes apparently written by Shane to his children explaining his reasons for taking his own life.[321]

161. The focus of my investigation into Shane's death was threefold:

    a. The appropriateness of Victoria Police's operational responses to the three incidents involving Shane in the days before his death;

    b. The adequacy of the mental health response provided by GH to Shane's presentations between his first and final collapse;

    c. The adequacy of the mental health response provided by St V's to Shane's presentation on the afternoon of his final collapse.

162. I shall address each of these issues in turn below.

163. I note that the above-mentioned lines of inquiry were foreshadowed at the directions hearing held pursuant to Practice Direction 5 of 2020,[322] in August 2021, shortly after Shane's death.[323]

164. Following service of the brief of evidence compiled by D/A/Sgt Derksen, and at my direction, the 'police contact' issues were referred to the Court's Inhouse Legal Service for review and those relating to Shane's clinical management were referred to the

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[318] Exhibit 24 (Photographs), IMG8599.

[319] Exhibit 24 (Photographs), IMG8602.

[320] Exhibit 24 (Photographs), IMG8600.

[321] CB 225-228

[322] Practice Direction 5 of 2020 is entitled 'Directions Hearings in Mandatory Inquests' dated 17 September 2020 requires that, unless there are reasons otherwise, a directions hearing will be held within 28 days of a death where an inquest is mandatory. The purpose of the hearing is for case management: the CI will be identified, a date for service of the coronial brief set and any other necessary orders will be made.

[323] The first directions hearing was held on 25 August 2021; a transcript is available.

Coroners Prevention Unit (**CPU**).[324] The CPU recommended that an expert opinion be obtained. Shane's family and other interested parties were informed of my intention to engage an expert, as well as the progress of the investigation generally, at a directions hearing in September 2023.[325]

165. Following receipt and circulation of the independent expert opinion provided by Consultant Psychiatrist Dr Jacqueline Rakov there was a further directions hearing in February 2024. Among the purposes of that hearing was to provide interested parties, particularly GH, with a further opportunity to respond to Dr Rakov's opinion, an initial invitation was made in correspondence from the Court in December 2023.

Appropriateness of Victoria Police's operational responses

166. There were three contacts between Victoria Police members and Shane in the four days prior to his final collapse. Each was initiated by friends or family members concerned about Shane's welfare and, specifically, that he was suicidal. Although preserving life and helping those in need of assistance are among the general functions of police members[326] there is no Victoria Police Manual (**VPM**) policy or guideline directly relating to what might broadly be described as "welfare checks." That said, the VPM does contain guidance on apprehensions under the MHA[327] and the safe management of people in the care or custody of police.[328] Also relevant to the police contacts with

[324] The Coroners Prevention Unit was established in 2008 to strengthen the prevention role of the Coroner. CPU assists coroners to formulate prevention recommendations and comments and monitors and evaluates their effectiveness once published. The clinical divisions of the CPU – the Health and Medical Investigation Team and Mental Health Investigators are staffed by practising physicians and nurses who are independent of the health professionals or institutions involved in a particular investigation. They assist the coroners' investigation of deaths occurring in a healthcare setting by evaluating the clinical management and care provided and identifying areas of improvement such that similar deaths may be avoided in the future. CPU's skilled researchers and investigators contribute to prevention issues not arising in health care settings.

[325] The second directions hearing was held on 26 September 2023; a transcript is available.

[326] By virtue of section 9 of the *Victoria Police Act 2013*.

[327] VPMG Apprehending persons under the Mental Health Act (version last updated 21/10/19). Also relevant to the management of people experiencing mental illness is the Department of Health and Human Services-Victoria Police protocol for mental health: A guide for clinicians and police (2016) (2016 Protocol). Relevantly, the Protocol recommends transfer of people with mental illness in the least restrictive manner possible, often by ambulance (rather than in a police vehicle where police are involved).

[328] VPMP Persons in police care or custody (version last updated 1/11/19) and VPMG Safe management of persons in police care or custody (version last updated 19/2/21). The significance of the 'P' and 'G' following 'VPM' is that 'P' signifies a policy rule encapsulating minimum standards in relation to which compliance is mandatory (and non-compliance may result in disciplinary action) while and 'G' signifies best practice guidance (ie the content is advisory not mandatory).

Shane, are the VPM guidance on missing person investigations[329] and the Chief Commissioner's Instruction (**CCI**) on the deployment of BWCs.[330] I have had regard to each of these documents when assessing the appropriateness of the police responses.

WNB203 – 26 June 2021

167. Ballarat police members' involvement with Shane on 26 June 2021 was relatively brief, lasting about an hour from WNB203's dispatch to locate Shane and when GH staff informed the members they were no longer required after escorting him to the ED.[331]

168. The members verified the details of the job with Ms Naus, liaised with the shift supervisor, attempted to contact Shane by phone and commenced a search for him in the vicinity of Ms Naus' home.[332] Somewhat fortuitously, particularly given the poor light conditions, when WNB203 attended Essex Street they found Shane, who was unconscious. Members quickly ascertained his need for medical attention and requested an ambulance. Basic life support (placing Shane in the recovery position) and monitoring occurred until paramedics arrived. Sgt Collins' search of Shane's car for information about what substance(s) he might have taken so that this information could be handed over to paramedics was appropriate in the circumstances.

169. It is unclear that Shane's apprehension pursuant to section 351 of the MHA was necessary in the circumstances; the immediate need was medical intervention to address his apparent intentional overdose rather than mental health assessment. That said, I am not critical of the WNB203 members whose conduct suggests the apprehension power was used. Notwithstanding that there was no opportunity for the WNB203 members to interact with Shane, the circumstances were such that there was a reasonable basis to exercise the power. That WNB203 escorted Shane to the GH ED suggests the members considered him to be in their custody: their actions, and its impetus, accorded with the applicable VPM.

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[329] VPMG Missing persons investigations (version last updated 17/8/15). I have also had the benefit of the 'Initial Action Guide' prepared by Victoria Police's Missing Persons Squad (version last updated 6/3/18) to assist any member having to undertake a missing person investigation.

[330] CCI 06/19 Body worn camera deployment (as reissued on 10/12/19).

[331] Based on the information contained in the MDTF prepared by SC Inkson and Shane's GH medical record #1.

[332] Exhibit 9 (C/ Baines' BWC footage).

170. SC Inkson's MDTF was completed days after her interaction with Shane on 26 June 2021 (and, unsurprisingly, no copy appears in Shane's GH medical record). The VPM anticipates that the MDTF will be completed at the time of transfer.[333] However, I note that the VPM in place at the time was not as clear as it might have been about when an MDTF is required,[334] perhaps because transfer is not mandatory[335] with an exercise of the power in s351 MHA unlike timely arrangement of a mental health assessment.[336]

171. That said, the key twin purposes of the MDTF are to document sufficient information of the circumstances of apprehension to assist the mental health practitioner conducting the examination and to document the transfer of custody/care from Victoria Police to a hospital or clinician.[337] The guidance in the VPM is congruent.[338]

172. In this instance, pertinent information – a relationship issue, the involvement of police, an intentional overdose with suicidal intent, that Shane was found on the footpath with altered conscious state – was available to GH clinicians (even if not provided by police directly).[339] While it seems that Shane's apprehension under the MHA was the only potentially relevant information not conveyed to GH clinicians, it is unlikely that this omission was material in light of what was known, and documented in Shane's GH medical record, prior to his assessment by the Psychiatrist on 27 June 2021.

173. Pursuant to section 351(6) of the MHA, Shane was not released from the WNB203 members' custody until he entered the care of the public hospital, GH ED. Accordingly,

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[333] Section 5, VPMG Apprehending persons under the Mental Health Act (version last updated 21/10/19).

[334] Section 6 of the VPM devised following the entry into force of a new MHA, the *Mental Health and Wellbeing Act 2022*, is a section entitled 'recording' and set out clearly members' recording requirements in relation to a new 'Mental Health Transfer Form,' BWCs and other LEAP forms/flags: VPMP Care and control under the Mental Health and Wellbeing Act 2022 dated 1/9/2023.

[335] An assessment may occur in a community setting in keeping with the principle of least restrictive practice underlying psychiatric care pursuant to the MHA.

[336] The clearest guidance on the use of a MDTF appears only in section 7 of the VPM entitled 'Arranging for a mental health examination within a community setting' but does not appear – nor is there any reference to the MDTF – in section 6 entitled 'Arranging for a mental health examination for apprehended person at a hospital'.

[337] I note that the MDTF completed by SC Inkson is the only one of the three relating to Shane's contacts with police proximate to his death on which the phrase 'Insert transfer of custody time & date below' does not appear in a box recording 'OUTCOME' alongside a space to record 'Name of doctor or mental health practitioner'.

[338] Sections 5-8, VPMG Apprehending persons under the Mental Health Act (version last updated 21/10/19).

[339] This information is found in Ambulance Victoria's Patient Care Record (#11305 on 26/6/21 created at 8pm), the triage and or nursing assessment and the initial notes made by an assessing MO at GH ED, all of which appear in Shane's GH MRs #1, pages 98-102, 104 and 105 respectively. The information included in the 'CIRCUMSTANCES' field of SC Inkson's MDTF would not have added materially to the information available to GH clinicians.

the members' departure when told they were no longer required was in line with the MHA and the relevant VPM.[340]

174. The members' use of their BWCs accorded with the CCI.

RUBY821 and other Ballarat police members – 27-28 June 2021

175. RUBY821 members were dispatched to the "welfare check" connected with Ms Naus' address initiated by Ms Connell around 7.25pm on 27 June 2021. Although the members' concern was no doubt heightened by their contact with Shane the previous evening, the information available at dispatch was sufficient to identify Shane's potential suicidality.

176. When RUBY821's enquiries (liaison with Mr Keller and Ms Connell, contact with Ms Naus and attempts to contact Shane, whose phone was switched off) and patrol of the vicinity did not bear fruit within 30 minutes, the situation was escalated to the supervising sergeant. In consequence, additional resources were deployed to assist the search and a missing person report was filed.

177. C/ Kempers was the 'reporting member' for the purposes of the relevant VPM and his missing person report and the case narrative describing the initial actions undertaken reflect the details[341] and investigations anticipated by the VPM.[342] Additions made to case narrative by other members involved in the missing person investigation document incoming intelligence and further dependent and independent investigative steps, and the outcome of the investigation in line with the VPM.[343]

178. Appropriate use was made of KALOF alerts in respect of Shane and his car; triangulation of his mobile phone was not feasible because it was apparently switched off.[344]

179. Upon learning of Shane's return to Ms Connell's home, the RUBY821 members attended around 10.30pm. SC Inkson and C/ Baines spent the following hour speaking

[340] Section 8, VPMG Apprehending persons under the Mental Health Act (version last updated 21/10/19).

[341] Such as, the circumstances in which Shane was reported missing, his risks and vulnerabilities, a description of him and his vehicle: see section 1.2, VPMG Missing persons investigations (version last updated 17/8/15).

[342] Sections 1.2 and 2, VPMG Missing persons investigations (version last updated 17/8/15).

[343] Sections 2, 3.1 and 3.2, VPMG Missing persons investigations (version last updated 17/8/15).

[344] Section 1.2 VPMG Missing persons investigations (version last updated 17/8/15).

with Ms Connell and Shane separately and together. C/ Baines spent most time talking to Shane in a clear effort to assess whether he remained a risk to himself. C/ Baines' use of the section 351 MHA power was reasonable in all the circumstances[345] and his request for an ambulance to transfer Shane to hospital for assessment accorded with VPM and other applicable guidance.[346] C/ Baines explained to Shane why he had been apprehended and would be taken to hospital.

180. C/ Baines provided a comprehensive hand over to C/ Booth and 1C Martland who relieved RUBY821.[347] The relieving members supervised and engaged with Shane while waiting for an ambulance.[348]

181. On arrival of the ambulance, C/ Booth provided paramedics with a detailed account of the circumstances including Shane's apprehension under the MHA.[349] Police members escorted Shane to the GH ED, did not leave until advised to do so by GH staff and C/ Booth completed a MDTF which was apparently endorsed by a clinician. I am unable to determine why no copy of the MDTF appears in Shane's GH medical record.

182. All police members used their BWCs in accordance with the CCI.

Members in Boroondara and Ballarat Police Service Areas – 29 June 2021

183. Within 30 minutes of the first Boroondara unit's dispatch to the 'threat of suicide' job, police members had escalated the situation to the shift supervisor and a relatively large-scale search to locate Shane had commenced at and between locations in Balwyn and Kew.

184. Both before and after Shane was formally listed as a missing person, Boroondara police's operational response was appropriately prompt and responsive to incoming intelligence about Shane's possible whereabouts.

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[345] The challenge for C/ Baines was the contradiction between Shane's explicit statements (I'm not suicidal) and the implicit meaning of other statements (but if I had access to more medication, I'd use it to overdose): see C/ Baines' BWC footage, Exhibit 10, file commencing 10.30pm, file position 19.30 (10.50pm).

[346] VPMG Apprehending persons under the Mental Health Act (version last updated 21/10/19) and the 2016 Protocol.

[347] C/ Baines' BWC footage, Exhibit 10, file commencing 10.30pm, file position 53.00-55.30 (11.23pm).

[348] Exhibits 13 and 14, BWC footage of 1C Martland and C/ Booth respectively.

[349] See Exhibit 14, C/ Booth's BWC footage and Shane's GH Medical record, pages 85-90. I note that the "Plan A" and "Plan B" comments attributed to Shane appear in the Ambulance Victoria PCR and this is partly replicated in the nursing assessment performed at 1.20am.

185. 1C Roberts' missing person report and the case narrative describing the initial actions undertaken reflect the details and notifications anticipated by the VPM. Additions made to the case narrative by other members involved in the missing person investigation, particularly those made by A/Sgt Stamatakos, document incoming intelligence and review of information held on LEAP, as well as subsequent investigative steps.

186. Appropriate use was made of KALOF alerts and Computer Aided Dispatch to other police service areas. Triangulation of Shane's phone proved particularly useful, allowing the search to be sensibly refocused in Ballarat by about 8pm, with direct handover between the Boroondara and Ballarat shift supervisors, including transmission of a copy of the Inpatient Assessment Order, by 8.30pm.

187. Salient intelligence was effectively relayed to police units involved in the search.

188. The search effort in Ballarat and environs involved multiple police units responding to intelligence about Shane's possible whereabouts quickly and others maintaining static patrols at his likely destination(s).

189. When Shane was found, he was informed of the Inpatient Assessment Order: section 352 of the MHA provided police with a power to apprehend as he was the subject of an Inpatient Assessment Order and 'absent without leave.'[350] Shane's initial presentation disclosed no grounds for concern about his physical health: he complied with police directions and walked independently. Although in the succeeding 10 minutes, Shane's presentation changed,[351] it was not until he appeared to be "nodding off" (and was non-responsive to questions about the contents of the "Gatorade" bottle) that his presentation was overtly concerning. Accordingly, an ambulance was requested, Sgt Taylor prompted junior members to make vital observations while he escalated his own concerns to D24 and then directly to paramedics.

190. Shane was placed in the recovery position promptly, and police sought and followed paramedic guidance, and commenced CPR when advised to do so.

191. Following the attendance of paramedics and restoration of Shane's circulation, two police members escorted him to the GH ED where the MDTF prepared by 1C Forbes

[350] Section 351 MHA.

[351] Shane asked to sit down and for his heart medication and said he might vomit. Police members responded appropriately to each development.

was provided to GH staff. The MDTF was not countersigned by a clinician nor does a copy appear in Shane's GH medical record. I note that the GH medical records do, however, reflect police involvement and the existence of a MHA order, though this information might have been gleaned from paramedics.

192. The operational responses of Boroondara and Ballarat police units on 29 June 2021 were effective, appropriate and broadly compliant with applicable VPM. Any departures from the CCI (not all members had or activated their assigned BWCs at the scene of Shane's collapse, but many members did) or MDTF procedure by Ballarat members were not significant in the circumstances.

Adequacy of Shane's mental health management

193. In the three days between his first and final collapses, Shane presented to GH in circumstances involving psychiatric assessment three times (in 40 hours)[352] and to St V's once (noting that several contacts occurred prior to his assessment by phone within 24 hours of GH's referral). Each assessment differed in terms of the context and circumstances in which it occurred, and the skills and experience of the clinician(s) who performed it.[353] Similarly, different information was known (and knowable) to each assessing clinician and, save for that which is documented in Shane's medical records, it is difficult to know with certainty *what* was known and considered and whether any deficit was the result of a lack of enquiry or response. That said, each clinician was aware that they were a link in the chain of continuity for Shane's care. I have considered these matters when assessing the adequacy of Shane's mental health management overall and have of course considered Dr Rakov's expert opinion and GH's responses to it, as well as the policies and procedures provided by GH (which were not available to Dr Rakov) when assessing the care GH provided.

[352] I am not including Shane's final presentation to GH ED when in police custody and subject to the Inpatient Assessment Order made by the St V's Psychiatry Registrar.

[353] A (consultant) Psychiatrist assessed Shane in the ICU over a period of less than 15 minutes following a significant intentional medication overdose; an ED Registrar undertook an assessment (of unknown duration) in the ED following Shane's apprehension under s351 of the MHA about seven hours after his discharge from the ICU; a Mental Health Clinician and Registered Psychiatric Nurse of the ART assessed Shane for an estimated 30 minutes outside his aunt's home; and, the St V's Psychiatry Registrar's assessment conducted by phone lasted just under an hour.

Shane's mental health management by Grampians Health

194. Dr Rakov provided an independent expert opinion about the standard of psychiatric care provided to Shane by GH.[354] Dr Rakov is a Consultant Forensic Psychiatrist by training who holds a position as a Consultant Psychiatrist at Monash Health in addition to maintaining a private practice. She has many years' professional experience throughout Victoria's public health and correctional systems assessing and treating mentally ill civilians and offenders for a variety of psychiatric conditions in inpatient and outpatient settings.[355]

195. As noted above, Dr Rakov's report was provided to Shane's family and the interested parties, and GH was invited to advise the Court of any intention to file any expert opinion or other materials in response to it, by way of rebuttal or concession.[356] Legal representatives for GH advised that it would not submit any opinion evidence but that a further statement would be filed responding to Dr Rakov's opinion and the recommendations she made in her report.[357]

196. Dr Anoop Lalitha, GH's Director of Clinical Services (Mental Health and Wellbeing) (**MHW**), provided a further statement dated 22 March 2024 directly responding to Dr Rakov's report.[358] I note that Dr Lalitha's first statement[359] which among other matters provides an account of the outcomes of an In-depth Case Review (**IDCR**)[360] conducted

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[354] Dr Rakov's report dated 7 December 2023. Dr Rakov was provided (among other things) with the coronial brief of evidence and Shane's medical records from GH and St Vincent's Hospital and asked to respond to specific questions about the adequacy of the psychiatric reviews undertaken by the Psychiatrist, ED Registrar and the ART clinicians including mental state examination, risk assessment and safety and care planning.

[355] Dr Rakov's report dated 7 December 2023, pages 1-2.

[356] Dr Rakov's report was circulated via correspondence dated 8 December 2023; the correspondence was the first invitation to the interested parties to file any response.

[357] Correspondence to the Court from Lander and Rogers, on behalf of Grampians Health, dated 15 January 2024. Grampians Health maintained this position after further correspondence inviting further submissions dated 31 January 2024 and canvassed at the directions hearing held on 1 February 2024.

[358] Statement of Dr Anoop Lalitha dated 22 March 2024.

[359] Statement of Dr Anoop Lalitha dated 4 December 2023.

[360] The IDCR was commissioned following consideration of Shane's death by GH's Mental Health Service's Morbidity and Mortality Committee (M&M) in July 2021. All deaths of 'active patients' are reviewed by the M&M irrespective of the cause of the patient's death. The purpose of the IDCR was to identify opportunities to improve care by establishing any systems or process gaps in the care provided to Shane. The IDCR involved review of Shane's medical records, discussions with clinicians involved in Shane's care, and with members of Shane's family. A final report was prepared in February 2022 and endorsed by the Operational Committee in early March 2023 with final endorsement of recommendations by the Clinical Governance Committee on 23 March 2023: Statement of Dr Anoop Lalitha dated 4 December 2023, page 3.

by GH MHW, together with the annexures to both statements, also touch upon relevant issues.[361]

Assessment, risk and management planning by the Psychiatrist – 27 June 2021

197. Dr Rakov was critical of the Psychiatrist's review of Shane: she noted the brevity of the clinical note, the apparent superficiality of the assessments of Shane's mental state and risks and the inadequacy of the care and safety planning.[362]

198. Dr Rakov opined that the accuracy and reliability of any psychiatric assessment conducted while Shane experienced the residual effects of the sedating medications he used to overdose was 'invariably compromised.'[363] She acknowledged that initial assessments can be made while an individual is intoxicated to ensure immediate safety but comprehensive mental state and risk assessments should be deferred until the individual is sober. Dr Rakov observed that although much of the zolpidem Shane ingested would have been eliminated due to its shorter half-life before the Psychiatrist's assessment, a substantial amount of diazepam would remain, with the potential to affect cognitive and emotional function and Shane's ability to report his mental state accurately.[364]

199. Dr Rakov noted that 'as a psychiatrist it is necessary to engage comprehensively with a patient to understand their experiences and concerns' to achieve an accurate assessment.[365] She considered that while the Psychiatrist's assessment noted relevant information – for instance, Shane's distress due to a breakup, denial of suicidal ideation, plans, actions – there was no exploration of these issues and documentation of 'thought content'[366] was particularly limited. Dr Rakov opined that exploration of Shane's thoughts, feelings, behaviours and stressors would have informed an

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[361] Dr Lalitha's further statement (in his own name) is dated 4 December 2023.

[362] Dr Rakov's report dated 7 December 2023, pages 6-7.

[363] Dr Rakov's report dated 7 December 2023, pages 6-7.

[364] Dr Rakov's report dated 7 December 2023, page 6.

[365] Dr Rakov's report dated 7 December 2023, page 7.

[366] A consideration of what is being said by the patient to gain insights into preoccupations, ideations (including homicidal or suicidal ideations) and delusions. Identification of the 'content' is likely to lead to further exploration: for example, to clarify if suicidal ideations are passive thoughts of wanting to be dead or active thoughts of wanting to take one's own life, which might lead to further enquiry about intentions plans, means etc.

appreciation of his current mental state, ongoing risks, the types of psychological interventions that were needed and the factors that could affect his recovery.[367]

200. The expert considered the Psychiatrist's consideration of risk 'especially scant.'[368] In her view, the Psychiatrist's assessment underestimated the severity of Shane's overdose as a potential indicator of suicidal intent and a significant risk factor for future suicide attempts, characterising it instead as a response to an acute situational crisis without adequate exploration of the possibility of underlying psychiatric conditions or a more chronic risk of self-harm.

201. Moreover, Dr Rakov considered the Psychiatrist's diagnostic impression of "situational crisis" and "adjustment disorder" 'cursory and lacking in diagnostic nouse.'[369] In her view, the assessment 'overlooked the critical step of correlating [Shane's] emotional and behavioural responses to the stressor with the diagnostic criteria.'[370] This would have involved a thorough examination of Shane's specific symptoms, their duration and intensity, and comparing them with established diagnostic criteria.[371]

202. Dr Rakov observed that 'there was some hesitation about [Shane's] psychiatric readiness for discharge' and that he was ultimately discharged 'contrary to the [P]sychiatrist's documented plan.'[372] That documented plan anticipated Shane remaining in hospital and being reviewed by the CMHT the next day. What actually occurred, after a discussion between the ICU MO and Psychiatrist, was that Shane was discharged to his aunt's home less than four hours after assessment, with ART follow-up planned on 28 June 2021.

203. I pause to note that the *medical* plan also changed following Shane's request for discharge: while he was medically cleared to leave the ICU, the plan was for admission to the medical ward. However, following relayed consultation with the ICU Consultant,

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[367] Dr Rakov's report dated 7 December 2023, page 7.

[368] Dr Rakov's report dated 7 December 2023, page 6.

[369] Dr Rakov's report dated 7 December 2023, page 7.

[370] Dr Rakov's report dated 7 December 2023, page 7.

[371] Dr Rakov's report dated 7 December 2023, page 7.

[372] Dr Rakov's report dated 7 December 2023, page 3.

Shane was 'cleared for home.'[373] While there is no definitive evidence of the appropriateness or otherwise of Shane's medical discharge around 4pm on 27 June 2021, its precipitousness – particularly considering the psychiatric context and the predictable (and actual) residual physiological effects of the overdose – causes some disquiet.

204. Returning to the Psychiatrist's plan, Dr Rakov was sceptical of the accuracy of any follow-up assessment conducted within 24 hours of a significant overdose given the persistence of drugs in Shane's body and their confounding effects on his mental state (that is, the plan as documented). However, she was particularly critical of the lack of (further) planning in response to the changed timing of Shane's discharge at his request. Given Shane's 'high-lethality attempt' to end his life, she regarded the absence of immediate and interim safeguards in place between discharge and CMHT follow-up was inadequate to address the risk posed by the recent overdose.[374] A more 'prudent plan' in her view was one involving 'continuous observation' until residual effects of the medication overdose had subsided followed by re-evaluation of Shane's mental state when sober. Arguably, that approach is more congruent with the medical and psychiatry plans as originally devised than with what ultimately occurred.

205. Nonetheless, Dr Rakov considered the plan (that documented and, implicitly, what transpired) insufficient because it lacked clarity about specific mental health interventions, safety planning and engagement with Shane's support system. A detailed, structured and documented plan outlining the steps to be taken to ensure safety, the frequency of psychiatric reviews and how Shane's care would be coordinated among other care providers was required.[375]

206. Dr Lalitha's response to Dr Rakov's criticisms of the Psychiatrist's care is telling. It does not attempt to refute the expert's comments about omissions from the clinical note or failure to adequately explore Shane's mental state and risks and concedes the lack of specificity of the plan in relation to risk mitigation, mental health interventions and

[373] The ICO MO discussed Shane's request with an ICU Registrar who, in turn contacted the ICU Consultant with the resultant note stating, 'Pt cleared for home': Shane's GH MRs #1, page 160.

[374] Dr Rakov's report dated 7 December 2023, page 7.

[375] Dr Rakov's report dated 7 December 2023, page 7.

engagement with Shane's family.[376] Instead, the response quibbles with Dr Rakov's characterisation of the Psychiatrist's diagnostic impression (as cursory/lacking in diagnostic nouse) on the grounds the impressions of situational crisis/adjustment disorder were reasonably open given the circumstances of Shane's presentation.[377]

207. Dr Lalitha suggested that the Psychiatrist gave more weight the principle of least restriction (which underpins the MHA) than other factors given Shane's denial of suicidal ideation but conceded that 'with the benefit of hindsight' it 'could' have been preferable to defer mental state and risk assessment and involuntary treatment pathways could have been given more active consideration.[378] Ultimately, the GH response fails to grapple with Dr Rakov's criticism of the fundamentals of the Psychiatrist's mental state and risk assessments and care planning.

S351 MHA assessment and management by the ED Registrar – 28 June 2021

208. Dr Rakov opined that Shane's mental health assessment and management in the ED did not meet an acceptable standard of care. She observed that there was 'essentially no information' about Shane's mental state in the ED Registrar's note and any decision-making process concluding that he did not meet the MHA criteria for an Inpatient Assessment Order occurred without comprehensive reassessment.[379]

209. The ED Registrar's use of terms like '?false alarm'[380] and 'red flags' suggested to Dr Rakov a dismissal of the seriousness of Shane's earlier ED presentation for overdose.[381] She emphasised that ED assessments should 'remain objective and exhaustive, especially when considering the discharge of patients with recent (<24H) admission for a substantial suicide attempt.'[382]

210. Although it is evident that there was contact between the GH ED and Ms Connell while Shane was at the ED, precisely what was discussed is unclear. The few notes in the

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[376] Statement of Dr Anoop Lalitha dated 22 March 2024, pages 4-5.

[377] Statement of Dr Anoop Lalitha dated 22 March 2024, pages 4-5.

[378] Statement of Dr Anoop Lalitha dated 22 March 2024, page 5.

[379] Dr Rakov's report dated 7 December 2023, page 8.

[380] I note that in her report, Dr Rakov omitted the '?' preceding the phrase false alarm which was recorded by the ED Registrar.

[381] Dr Rakov's report dated 7 December 2023, page 8.

[382] Dr Rakov's report dated 7 December 2023, page 8.

medical record, particularly the few made by the ED Registrar, suggest minimisation of family concerns: '?safety issues.'[383] Dr Rakov highlighted that collateral information from family members such as Ms Connell was 'essential' to corroborating Shane's pre-hospital condition and ensuring continuity of care post-discharge.'[384]

211. The ED Registrar sought a mental health opinion, but Shane was not assessed by psychiatric staff. Dr Rakov considered GH ECATT's failure to assess Shane 'professionally inadequate' given the gravity of his recent presentation.[385] Although the MHA enables either a registered medical practitioner or mental health practitioner to perform the assessment following apprehension under section 351, the relevant GH Guide[386] appears to anticipate assessment by a mental health clinician. Indeed, the Guide states that *attendance* at the ED *to review* individuals apprehended under the MHA will be a *priority*.[387]

212. I note that "s351 presentations" and "referrals from the ED" are both rated 'Category B' pursuant to the State-wide mental health triage scale and the GH Guide; that is, referrals requiring 'urgent face-to-face assessment' within two hours.[388] The Guide states that the mental health service will provide 'assessment and secondary consultation' in relation to referrals from the ED 'as needed.'[389] Secondary consultation appears to be a less intensive intervention[390] (requiring documentation of the presenting problem, rationale for the consult, risk issues and the advice provided) and implicitly assumes the individual is an existing patient of the mental health service, with a treatment team (and treatment plan).[391] It is possible the ED Registrar's call was treated by the Triage clinician as a referral from the ED for 'secondary consultation'[392]

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[383] Shane's GH MR #1, page 92.

[384] Dr Rakov's report dated 7 December 2023, page 8.

[385] Dr Rakov's report dated 7 December 2023, page 8.

[386] Ballarat Health Services Mental Health Services, Access and Triage Process Guide, undated.

[387] Ballarat Health Services Mental Health Services, Access and Triage Process Guide, undated, Section 6.3.

[388] Ballarat Health Services Mental Health Services, Access and Triage Process Guide, undated, Section 6.

[389] Ballarat Health Services Mental Health Services, Access and Triage Process Guide, undated, Section 6.1.

[390] That is, not actually involving ED attendance/assessment: Ballarat Health Services Mental Health Services, Access and Triage Process Guide, undated, Section 6.1.

[391] Ballarat Health Services Mental Health Services, Access and Triage Process Guide, undated, Section 6.1.

[392] Ballarat Health Services Mental Health Services, Access and Triage Process Guide, undated, Section 6.1.

– erroneously in my view – notwithstanding that Shane's apprehension under section 351 MHA was known.[393]

213. Irrespective of the intent or purpose of the contact between the ED and Triage, Dr Rakov was concerned by the content of the advice noted/provided by the Triage clinician in two respects. Firstly, the Triage clinician's note that Shane's mental state 'had not changed according to the referrer' assumed a basis for comparison that did not exist (the ED Registrar had a single interaction with Shane and it's unclear if either clinician reviewed the Psychiatrist's brief note);[394] it also assumes, in my view, that the ED Registrar had performed an assessment of Shane's mental state (which is not evident from the medical record, besides notes of '0 distress' and 'calm, compliant').

214. Secondly, Dr Rakov observed that the Triage clinician's assertion that risk assessment 'would be the same as last contact' overlooks the possibility of rapid shifts in a patient's mental state, especially following critical incidents like overdose or a major life stressor.[395] To this I would add that the Triage clinician assumed risk assessment and safety planning had already occurred. Nonetheless, Dr Rakov opined that risk assessment is a 'continuous and dynamic process' that involves regular re-evaluation not reliance on previous assessments that may no longer accurately capture current risk.[396]

215. Dr Lalitha's response to Dr Rakov's criticism of Shane's assessment in the ED on 28 June 2021 focuses on the expert's interpretation and characterisation of the use of particular terms ('?false alarm' and 'red flags') rather than her primary observation that that there was little, if any, reassessment of Shane's mental state by the ED Registrar (and none by GH ECATT).[397] The GH response does, however, agree 'with the benefit of hindsight' that 'a more coordinated approach' between the ED and psychiatry departments would have been 'preferable' and that Shane 'could have been further assessed by' psychiatric staff.[398]

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[393] Shane's GH MR #2, page 39.

[394] Dr Rakov's report dated 7 December 2023, page 8.

[395] Dr Rakov's report dated 7 December 2023, page 8.

[396] Dr Rakov's report dated 7 December 2023, page 8.

[397] Statement of Dr Anoop Lalitha dated 22 March 2024, pages 5-6.

[398] Statement of Dr Anoop Lalitha dated 22 March 2024, page 6.

216. I cannot accept, as GH would have me do, that deficiencies Dr Rakov identified in Shane's (re)assessment in the ED following his apprehension under section 351 of the MHA are only evident with hindsight.

Assessment and planning by the ART clinicians – 28 June 2021

217. Dr Rakov characterised the ART clinicians' mental state examination as 'detailed in certain respects,' but deficient because it failed to fully appreciate the gravity of Shane's suicide attempt.[399] Although the clinicians acknowledged the overdose, the expert thought they 'seemed to downplay' its significance by focussing on Shane's denial of current suicidal ideation and his superficial engagement during the assessment.[400]

218. Dr Rakov judged that the ART clinicians' conclusion that Shane did not exhibit signs of mental illness (when considering the MHA criteria for compulsory assessment/treatment) did not account for the possibility that a severe depressive episode was obscured by the residual effects of the overdose nor his understatement of significant psychosocial stressors.[401] She was also concerned that the clinicians did not assess Shane's capacity to consent to treatment or to understand the implications of his safety post-suicide attempt.[402] Dr Rakov regarded the lack of detailed investigation of Shane's history of mood disturbances and psychosocial stressors rendered their risk assessment incomplete.[403]

219. Additionally, Dr Rakov regarded the ART clinicians' safety planning to be insufficient.[404] She considered further exploration of the reasons Shane wished to return to Melbourne immediately was warranted to ascertain if it was merely a preference or an effort to remove himself from a support network or supervision that might prevent another suicide attempt. Similarly, Dr Rakov was critical of the clinicians' reliance on Shane's verbal assurance of safety, and his father's involvement, in the absence of a

[399] Dr Rakov's report dated 7 December 2023, page 9.

[400] Dr Rakov's report dated 7 December 2023, page 9.

[401] Dr Rakov's report dated 7 December 2023, page 9.

[402] Dr Rakov's report dated 7 December 2023, page 9.

[403] Dr Rakov's report dated 7 December 2023, page 9.

[404] Dr Rakov's report dated 7 December 2023, page 9.

more 'structured and immediate follow-up plan.'[405] Acknowledging the principle of least restriction in mental health care, Dr Rakov observed that treatment 'still needs to be provided if and when indicated.'[406]

220. Dr Lalitha considered that the ART clinicians' examination and assessment was 'reasonable' and that the plan, in so far as it involved referral to St V's CATT, successful.[407] The GH response accepted 'with the benefit of hindsight' that involuntary treatment could have been more actively considered by the ART clinicians but at the time, family supports and Shane's verbal assurances of safety were given greater emphasis.[408] Dr Lalitha highlighted the complexity of risk-benefit assessments performed by clinicians in "real time" when considering whether an individual requires compulsory assessment or treatment under the MHA.[409]

221. While I acknowledge the complexity of clinical decision-making about compulsory psychiatric assessment and treatment these clinical decisions do not – or do not *only* – involve a binary proposition. To put it another way, the question for clinicians is not purely whether or not to use the MHA's compulsory assessment/treatment provisions: there is a "middle course" involving consideration of a voluntary inpatient admission.[410] Granted, an offer of a voluntary psychiatric admission might be refused even after meaningful engagement between patient and clinician about its therapeutic benefits. That said, there is no evidence in Shane's GH medical records that a voluntary psychiatric admission was ever considered, let alone discussed.

222. Dr Rakov's final observation was that despite Shane's presentations to GH being very close together, there was 'too heavy reliance on cross-sectional, rather than longitudinal, data.'[411] She considered that each presentation was treated in isolation rather than as an opportunity to undertake a fresh evaluation and 'piece together the

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[405] Dr Rakov's report dated 7 December 2023, page 9.

[406] Dr Rakov's report dated 7 December 2023, page 9.

[407] Statement of Dr Anoop Lalitha dated 22 March 2024, page 6.

[408] Statement of Dr Anoop Lalitha dated 22 March 2024, page 6.

[409] Statement of Dr Anoop Lalitha dated 22 March 2024, page 6.

[410] In addition to the "middle course" the clinical decisions don't end at a decision to use/not use the MHA. Clinicians will (and the GH clinicians did) consider the need for and nature of follow-up in the community. There are further clinical decisions, too, involving interim plans – for safety and care.

[411] Dr Rakov's report dated 7 December 2023, page 9.

narrative of [Shane's] presentations.'[412] While I disagree with Dr Rakov's conclusion that this approach was taken 'in order to discharge' Shane,[413] I agree with her observation that each of Shane's presentations appears to have been considered individually rather than as part of a continuum. The *effect* of this approach, and the deficiencies of the individual assessments of Shane, was to render identification of a need for compulsory psychiatric assessment/treatment and/or provision of inpatient psychiatric care less likely.

223. Dr Lalitha disagreed with Dr Rakov's opinion that each of Shane's presentations was treated individually in order to discharge and believed that GH's clinicians did seek to provide him with the care necessary for his presentation.[414] He accepted that 'with the benefit of hindsight' there could have been a 'better piecing together' of the information arising from Shane's presentations.[415] Dr Lalitha observed that GH's comprehensive review of Shane's case has resulted in improved processes to enable clinicians better access to longitudinal information.

IDCR, Dr Rakov's recommendations & changes implemented since Shane's death

224. The IDCR identified the following 'learnings and opportunity for improvement' in health service delivery in Shane's case:

    a. The inconsistent practices and processes to support the availability of critical mental health documentation in the setting of multiple software systems;

    b. A multidisciplinary approach to care in the setting of significant overdose did not occur due to inadequate systems and processes;

    c. Communication did not support the delivery of family inclusive care;

    d. There is ambiguity about when responsibility and accountability for patient care is transferred following the patient's referral to another service.[416]

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[412] Dr Rakov's report dated 7 December 2023, page 9.

[413] Dr Rakov's report dated 7 December 2023, page 9.

[414] Statement of Dr Anoop Lalitha dated 22 March 2024, page 6.

[415] Statement of Dr Anoop Lalitha dated 22 March 2024, page 7.

[416] Statement of Dr Anoop Lalitha dated 4 December 2023, page 3. The IDCR also found that there is inconsistent support for the GH workforce in dealing with the impacts of significant adverse events.

225. The IDCR identified the 'root cause' as the absence of processes and systems to support assertive outreach follow-up in the setting of a significant overdose in a patient with multiple social stressors.[417]

226. Notwithstanding the systems-focus of the IDCR, I note some thematic similarity between its findings and the issues identified as concerns by Dr Rakov.

227. Dr Lalitha advised that five recommendations[418] relating to clinical systems improvements were made following the IDCR and described the changes planned and implemented to address them:[419]

    a. Establish and implement a framework for delivering assertive outreach strategies for mental health patients following a significant event;[420]

        i. The ART (and Intensive Outreach Team) provide 'assertive assistance' and 'holistic care' to patients based on clinical indicators and risk factors. The ART responds when the mental healthcare needs of the patient are beyond family, friend or usual care approaches;[421]

        ii. The Hospital Outreach Post-Suicidal Engagement (**HOPE**) program will be fully implemented by 2024. It will provide 'assertive community support' for patients after suicide attempt and those with suicidal ideation by increasing referrals to community-based services for ongoing support after the HOPE program service period;[422]

        iii. Since mid-2022 Peer Support Workers (**PSW**) have been introduced as part of the Lived and Living Experience workforce (**LLEW**) to all

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[417] Statement of Dr Anoop Lalitha dated 4 December 2023, page 3.

[418] A sixth recommendation was made following the IDCR relating to the development of a formal debrief for staff following a significant adverse event; now internal and external debriefing is available to GH staff with a policy in place outlining the process: Statement of Dr Anoop Lalitha dated 4 December 2023, page 7.

[419] Although expressed as strategies implemented 'as a result of' the IDCR following Shane's death it is unclear whether each of the programs outlined arose solely from the IDCR (as opposed to being a response to the broad-ranging Recommendations following the Royal Commission into Victoria's Mental Health System in 2021 and the entry into force of the *Mental Health and Wellbeing Act* 2023) given the scale of the changes and the timing of some of them in relation to when the IDCR was completed.

[420] Dr Lalitha's Statement (in his own name) is dated 4 December 2023, page 4.

[421] Statement of Dr Anoop Lalitha dated 4 December 2023, page 4.

[422] Statement of Dr Anoop Lalitha dated 4 December 2023, pages 4-5.

community mental health multidisciplinary teams to work directly with patients and carers to identify and pursue goals;[423]

b. Develop systems and processes that support a multidisciplinary approach to care in the setting of a significant overdose;[424]

    i. All clinical presentations are 'currently supported' by a multidisciplinary team (**MDT**) approach;[425]

    ii. HOPE, ART and the Consultant Liaison Team (**CLT**) confer with the 'MDT clinical governance framework' to assist their clinical approached to care;'[426]

c. Review and consider opportunities to strengthen delivery of family inclusive care in all mental health settings;[427]

    i. LLEW and PSPs play an important role in offering emotional support and sharing knowledge of resources and coping strategies with patients and their carers;[428]

    ii. GH has implemented Clinical Practice Guidelines on 'Working with Families and Carers' to promote communication between clinicians, patients and their family/carers to ensure family/carers are meaningfully included while having still regard to the patient's preferences;[429]

d. Develop internal business rules around the criteria for transfer of responsibility and accountability for patient care;[430]

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[423] Statement of Dr Anoop Lalitha dated 4 December 2023, page 5.

[424] Statement of Dr Anoop Lalitha dated 4 December 2023, page 5.

[425] Statement of Dr Anoop Lalitha dated 4 December 2023, page 5.

[426] Statement of Dr Anoop Lalitha dated 4 December 2023, page 5.

[427] Statement of Dr Anoop Lalitha dated 4 December 2023, page 5.

[428] Statement of Dr Anoop Lalitha dated 4 December 2023, pages 5-6.

[429] Statement of Dr Anoop Lalitha dated 4 December 2023, page 6.

[430] Statement of Dr Anoop Lalitha dated 4 December 2023, page 6.

i. In September 2023, GH ratified a Clinical Practice Protocol on 'Transfer of Care, Admission and Discharge – Mental Health Services.' The protocol outlines clinical and operational responsibilities and escalation pathways but has not yet been implemented;[431]

e. Identify gaps in availability of mental health documentation and develop formal processes to ensure critical documentation is available when required;[432]

i. Since December 2022, GH's MWS has ceased using a paper-based system of documentation (except for required MHA forms) which enables real time access to medical records. The CLT creates an electronic mental health record for patients on medical wards to avoid delays previously encountered by the CMHT in accessing clinical records/care plans;[433]

ii. Separately, GH has obtained funding to develop an integrated Electronic Medical Record for acute medical and surgical services.[434]

228. Dr Lalitha emphasised that GH's MWS is a developing, dynamic health service provider that is committed to an adaptable and best-practice model for the delivery of clinical care.

229. I note that in her report, Dr Rakov recommended the following practice enhancements for psychiatric care (beyond GH):

a. A mandatory protocol for comprehensive re-assessments of mental health patients presenting after significant events such as overdose, even if recently assessed;[435]

[431] Statement of Dr Anoop Lalitha dated 4 December 2023, page 6.

[432] Statement of Dr Anoop Lalitha dated 4 December 2023, page 6.

[433] Statement of Dr Anoop Lalitha dated 4 December 2023, page 7.

[434] Statement of Dr Anoop Lalitha dated 4 December 2023, page 7.

[435] Dr Rakov's report dated 7 December 2023, page 10.

b. A standard requirement that clinicians obtain collateral information from family or carers in risk assessments to verify the patient's reported mental state and risk factors;[436]

c. Higher standards of clinical documentation to ensure mental state and risk assessments are detailed and accurate reflections at a point in time;[437]

d. Strengthen interdisciplinary communication protocols between ED and mental health services to ensure information is shared and treatment plans are cohesive and continuous;[438]

e. Establish strict follow-up procedures for patients discharged from the ED after a mental health crisis, ensuring timeline and appropriate community mental health support with an expectation that arrangements change/are reviewed if a patient re-presents between planned assessments.[439]

230. Dr Lalitha observed that many of the changes implemented following the IDCR addressed the practice issues identified by Dr Rakov. However, he noted (in relation to Dr Rakov's recommendations above paragraph 229(a)-(d)):

a. GH's 'Clinical Practice Protocol – clinical Risk Assessment and Management – Mental Health Services' is under review. GH intends to use as a framework for a new guideline to ensure comprehensive mental health re-assessments post significant event clinical guideline developed by the Department of Health, 'Working with the suicidal person: Clinical guidelines for emergency departments and mental health services.'[440]

b. GH's (2022) 'Clinical Practice Protocol – Intake Assessment – Mental Health' highlights the need for clinicians to obtain collateral information from family members, treating clinicians and other relevant parties.[441]

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[436] Dr Rakov's report dated 7 December 2023, page 10.

[437] Dr Rakov's report dated 7 December 2023, page 10.

[438] Dr Rakov's report dated 7 December 2023, page 10.

[439] Dr Rakov's report dated 7 December 2023, page 10.

[440] Statement of Dr Anoop Lalitha dated 22 March 2024, page 2.

[441] Statement of Dr Anoop Lalitha dated 22 March 2024, page 3.

c. In addition, an Emergency Mental Health Assessment Referral form (**MR980**) has been developed which specifically directs clinicians to consider collateral information (notwithstanding that this is a 'standard expectation')[442] and provides a series of prompts for notes under headings to enhance clinical documentation.[443]

231. In his March 2024 statement, Dr Lalitha reiterated his support for Dr Rakov's recommendations to the extent they were not already addressed by practice changes planned or implemented by GH.[444]

Shane's mental health management by St Vincent's CATT

232. Upon receipt of the ART referral on 28 June 2021, a St V's CATT clinician promptly sought to arrange a home visit. Shane's reluctance to be assessed if family members might overhear him complicated arrangements for an assessment. However, as he had not been assessed as high risk by GH and the ART records corroborated his sensitivity about the presence of family when communicating about his mental health, it was appropriate that St V's CATT accommodated Shane's wishes and offered a Telehealth assessment.

233. When Shane failed to attend the Telehealth appointment, the Psychiatry Registrar persistently called him until he answered.[445] Although initially reluctant to participate, the Psychiatry Registrar ultimately found him 'very easy' to engage.[446]

234. The Psychiatry Registrar's notes of the assessment that ensued are lengthy, detailed and comprehensive, with frequent apparently verbatim quotation of Shane's remarks. The assessment clearly involved exploration of Shane's thoughts and feelings at the time of his medication overdose on 26 June 2021, the significance of his relationship with Ms Naus and its breakdown, and other past and current significant and familial relationships, in addition to a discussion of previous mental health challenges and current symptoms. The detail and complexity of information elicited through the

[442] Statement of Dr Anoop Lalitha dated 22 March 2024, page 3.

[443] Statement of Dr Anoop Lalitha dated 22 March 2024, page 3.

[444] Statement of Dr Anoop Lalitha dated 22 March 2024, page 4.

[445] Shane's St V's MRs, page 18.

[446] Shane's St V's MRs, page 18.

interaction facilitated a nuanced consideration of Shane's circumstances, mental state and risks.

235. In addition to the relationship stressor(s) identified in most of the assessments Shane underwent in the week before his death, the St V's assessment identified significant financial stress. Suicidal ideation was a prominent theme and notwithstanding the absence of any clear plan, the Psychiatry Registrar was very concerned about his high risk of suicide in the context of acute on chronic feelings of abandonment and his unwillingness to engage in safety planning.

236. The Psychiatry Registrar's determination that Shane could not be safely managed in the community and that an Inpatient Assessment Order was required was supported by the assessment conducted and documented. Timely liaison with St V's CATT colleagues to coordinate Shane's transfer to hospital occurred and, once it was known Shane had absconded from home, clinicians escalated their concerns about his suicidality to the emergency services.

RECOMMENDATIONS

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

237. In the interests of preventing like deaths and promoting public health and safety in the mental health setting, I recommend that Grampians Health further update the MR980 Form (and, if necessary, make consequential amendment to the Clinical Practice Protocol – Intake Assessment – Mental Health dated 19/9/2022) to ensure that, in addition to prompting clinicians to consider the need to obtain collateral information (and providing a place to document it) under a heading 'Reported Mental Health Concerns of Consumer and/or Support Person(s),'

    a. Efforts to obtain collateral information;

    b. The success or otherwise of efforts to obtain collateral information;

    c. The rationale for not attempting to obtain collateral information;

d. Collateral information relevant to the patient's psychiatric/medical/social history, current mental health symptoms, perceived risks, vulnerabilities and strengths (that is, information beyond "concerns") is sought and;

is documented.

238. In the interests of preventing like deaths and promoting public health and safety, I recommend that Grampians Health conduct a review/audit (and, if necessary, periodic audit) of the following new practices and tools to ensure their consistent use and identification of any barriers to their effective implementation:

a. The creation by the CLT of a separate electronic mental health file for patients of the mental health service admitted to medical units to optimise continuity of care and "real time" access to records; and

b. The MR980 form (particularly as it – or any subsequent iteration – relates to obtaining collateral information from a patient's family and/or carers and the documentation of efforts to obtain collateral information and that information).

239. In the interests of promoting public health and safety, I recommend that Grampians Health consider the need to adopt robust processes to ensure its staff are aware of new processes, guidelines or programs implemented following an In-depth Case Review or otherwise.

FINDINGS

Having investigated the death of Shane Anthony Pappas, and having held an inquest in relation to his death on 29 July 2024 at Melbourne, I make the following findings, pursuant to section 67(1) of the Coroners Act:

1. The identity of the deceased is Shane Anthony Pappas, born on 3 August 1966.

2. Shane Anthony Pappas died at Angliss Hospital in Upper Ferntree Gully, Victoria on 3 July 2021.

3. I accept and adopt the medical cause of death ascribed by Forensic Pathologist Dr de Boer and find that Shane Anthony Pappas died of quetiapine toxicity in a man with ischaemic heart disease.

4. Shane Anthony Pappas' death occurred in the circumstances described above in paragraphs 23-146.

5. I am satisfied, and find, that Shane Anthony Pappas intended to take his own life.

6. I find that the operational response by Victoria Police members to the incidents involving Shane Anthony Pappas on 26, 27-8 and 29 June 2021 was reasonable and appropriate in the circumstances.

7. I find that the Grampians Health Psychiatrist's assessment of Shane Anthony Pappas in the ICU on 27 June 2021 was inadequate. There is little evidence of any meaningful engagement with Shane Anthony Pappas or attempt to understand his thoughts and feelings about his relationship breakdown (or anything else) and how these might influence his ongoing risks or treatment and care needs. Given that the sedating effects of the medications Shane Anthony Pappas had taken in overdose persisted, it would have been preferrable to defer any comprehensive mental state and risk assessment until these had resolved or were less apparent.

8. I also find that the plan documented by the Psychiatrist following the assessment was insufficiently detailed to manage Shane Anthony Pappas' ongoing risk of deliberate self-harm or his care needs, particularly if he did not remain in a hospital setting. Indeed, the absence of any apparent reconsideration of the documented plan (or the assessment that had informed it) after Shane Anthony Pappas requested discharge is a particularly concerning departure from the expected standard of care.

9. I find that the mental health assessment performed by the Grampians Health ED Registrar on 28 June 2021 following Shane Anthony Pappas' apprehension pursuant to section 351 of the MHA was wholly inadequate.

10. Given Shane Anthony Pappas' re-presentation to the ED within hours of his discharge from the ICU after a significant overdose, and the circumstances of his re-presentation accompanied by police, psychiatric assessment by the ECATT was warranted, and I find that it ought to have occurred. It is unclear why it did not occur given the clinical guidance in place at the time.

11. I find that the mental state assessment performed by the ART clinicians on 28 June 2021 was adequate but not particularly comprehensive. I further find that safety

planning was inadequate given Shane Anthony Pappas' recent significant overdose, his reported superficial engagement with the clinicians, and apparent lack of enquiry about his motivations to leave the Ballarat area.

12. Beyond establishment that Shane Anthony Pappas had a place to stay in Ballarat, that his father would transport him home to Balwyn and was aware of the planned referral to St Vincent's CATT and how to contact the service, there is very little evidence that Grampians Health engaged meaningfully with Shane Anthony Pappas' family during the episode of care. Given the reliance placed on Shane Anthony Pappas' family to provide support and supervision, I find that this was unsatisfactory.

13. Similarly, I find that the absence of any (documented) consideration by Grampians Health of a voluntary psychiatric admission for Shane Anthony Pappas was unsatisfactory in the circumstances.

14. Notwithstanding the deficiencies I have identified in the assessment and management of Shane Anthony Pappas by Grampians Health, I am unable to conclude that these were causal or contributory to his death.

15. Shane Anthony Pappas' assessment and management by St Vincent's CATT was appropriate and comprehensive.

16. The St Vincent's Psychiatry Registrar's decision to make Shane Anthony Pappas the subject of an Inpatient Assessment Order on 29 June 2021 was reasonable.

ORDERS

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

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

a. Shane Pappas' family;

b. Chief Commissioner of Victoria Police;

c. Grampians Health;

d. St Vincent's Health;

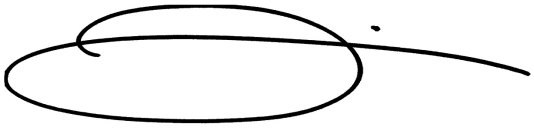
e. Dr Rakov;

f. Chief Psychiatrist;

g. Coroner's Investigator;

h. Coroners Prevention Unit.

Signature:



AUDREY JAMIESON
Coroner
29 July 2024