IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 005194

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Kate Despot
Deceased:	Jamie Peter Nisbet
Date of birth:	9 January 1974
Date of death:	Between 29 and 30 September 2021
Cause of death:	1(a) Compression of the neck 1(b) Hanging
Place of death:	2 William Street, Rochester, Victoria, 3561
Keywords:	Bendigo Health; Echuca Community Mental Health; Recommendations; Patient Discharge

INTRODUCTION

1. On 30 September 2021, Mr Jamie Peter Nisbet **(Mr Nisbet)** was 47 years old when he was found deceased at his residence in Rochester.

THE CORONIAL INVESTIGATION

2. Mr Nisbet's passing was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* **(the Act)**. Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

3. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

4. Victoria Police assigned Leading Senior Constable Russell Locke **(LSC Locke)** to be the Coroner's Investigator for the investigation of Mr Nisbet's passing. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses and submitted a coronial brief of evidence. Further inquiries were conducted directly via the Court.

5. This finding draws on the totality of the coronial investigation into the passing of Jamie Peter Nisbet, including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[1]

BACKGROUND

6. Mr Nisbet was the oldest of six children to parents Des and Lynette Nisbet **(Mrs Nisbet)**.

7. Mr Nisbet had a long-term relationship with Ms Tracy Coady and together they had two children.

[1] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

8. Mr Nisbet later partnered with Ms Danielle Storey, and together they had a child.

9. Sadly, in December 2020, Mr Nisbet's father passed away. Mrs Nisbet stated her son took the loss of his father "*very hard*," and upon reflection, believed that this loss had a greater impact on Mr Nisbet than she initially realised. According to his sister, Ms Demi Nisbet **(Demi)**, after his father's passing, her brother's mental health began to deteriorate and he *"began to hear voices*."[2]

10. Mr Nisbet was admitted to the Bendigo Acute Assessment Unit (**AAU**) from 12 to 21 January 2021 for an acute psychotic episode in the context of methamphetamine use. During this inpatient stay, a diagnosis of antisocial personality disorder was confirmed, and Mr Nisbet was commenced on the antipsychotic medication, olanzapine.

11. According to Mrs Nisbet, she observed her son's mental health significantly deteriorate in the week prior to his passing; Mr Nisbet was "*quiet talking, not making any sense, very strange, apologising to everyone even neighbours over the road."*[3]

12. At the time of his death, Mr Nisbet was prescribed risperidone 2mg twice daily, indicated for psychosis, and buprenorphine-naloxone 24/6mg indicated for opioid replacement therapy. The evidence suggests that Mr Nisbet was not compliant with his prescribed risperidone.

Hospital admissions

13. On 10 September 2021, Mr Nisbet contacted emergency services and requested an ambulance. He reported to emergency services that he was suffering a panic attack and experiencing suicidal ideation.

14. Mr Nisbet was transported to Echuca Regional Health Emergency Department **(ED)**. He reported to the Enhanced Crisis Assessment Team (**ECAT**) that he had used 'Ice' three days prior and was experiencing auditory hallucinations. Mr Nisbet further reported that he had attempted suicide via hanging earlier that day and requested admission to the psychiatric ward. He was later assessed as not requiring admission and was discharged from the ED. A referral was made on behalf of Mr Nisbet to the Echuca Community Mental Health Team (**ECMHT**) for engagement with community mental health services.

[2] Coronial Brief of Evidence (**CB**), Statement of Demi Nisbet, page 14.
[3] CB, Statement of Lynette Nisbet, page 12.

15. On 14 September 2021, Mr Nisbet was contacted by the ECMHT by phone. He was noted to be angry, swearing, and unhappy that he was not admitted on 10 September 2021. Mr Nisbet denied experiencing auditory hallucinations and paranoia, and an appointment with Consultant Psychiatrist Dr Jennifer Ellix was made for 20 September 2021.

16. On 19 September 2021, Mr Nisbet self-presented to the Echuca Regional Health ED. He appeared psychotic and paranoid and voiced suicidal and homicidal thoughts. As a result of his presentation, he was referred for assessment to the Regional Triage Service (**RTS**). The assessment occurred over the phone.

17. During this assessment, Mr Nisbet reported that he was at "*breaking point*" and requested admission to the psychiatric ward. Mr Nisbet further reported that if he was discharged home, he would harm himself or commit a crime as he would feel safer in prison. Medical records from the RTS clinician who conducted the assessment noted that Mr Nisbet was able to give a reasonable history recount, and answer questions appropriately. It was also noted that Mr Nisbet did not present as distractible and was responsive to internal stimuli.

18. Mr Nisbet was subsequently transferred to Bendigo ED for further assessment. He was first assessed by an ECAT Nurse who did not identify any clear psychotic features and formed the opinion that he was threatening to harm others to gain admission to the psychiatric unit.[4]

19. At 10.06pm, Mr Nisbet was reviewed by Psychiatry Registrar Dr Rachel Drummond **(Dr Drummond)**. Mr Nisbet reported he had been suicidal and had unsuccessfully attempted self-harm. He described hearing voices through the wall and that his neighbours wanted to hurt him as they "*knew things they should not know*."[5]

20. Dr Drummond stated that Mr Nisbet denied thoughts of harming his neighbours or himself. She noted that Mr Nisbet's speech was of normal rate and that throughout the assessment he engaged well and answered questions appropriately.

21. As per the Bendigo Health medical records, Dr Drummond's impression of Mr Nisbet was:

> *"Overall it was my impression that much of what Jamie* [Mr Nisbet] *reported was said in an attempt to be admitted to the AAU, the way in which his reports were inconsistent*

[4] CB, Statement of Brendan Watson, page 24.
[5] Ibid, page 22.

and not in line with what one would expect with true psychotic experiences gave the impression that this was what Jamie needed to say in order to get an admission".

22. Dr Drummond was under the impression that Mr Nisbet had a court appearance the following day and that Mr Nisbet "*may have been attempting to avoid an upcoming court date.*"[6]

23. A review of Mr Nisbet's Court Outcomes Report, as included in the Coronial Brief, indicates that Mr Nisbet did not have any pending criminal matters in the lead up to his death[7].

24. Dr Drummond opined that an inpatient admission was not warranted, and community treatment seemed the most appropriate option, especially given Mr Nisbet already had an appointment with Dr Ellix the following day. Dr Drummond confirmed her assessment with consultant psychiatrist Dr Anu Dissanayake, who agreed with her assessment.

25. On 20 September 2021, Mr Nisbet was contacted by the ECMHT. He was first contacted by Senior Lead Clinician Brendan Watson **(Mr Watson)**, who coordinated a review with Dr Ellix via a video conference for 2.30pm that afternoon.

26. The videoconference review with Dr Ellix was brief as the video connection dropped out within the first 30 seconds. Dr Ellix phoned Mr Nisbet to try and conduct the review by telephone. Dr Ellix stated: *"Mr Nisbet was very abusive towards me, swearing at me. He terminated the phone call when I informed him that swearing at me and abusing me was unacceptable."*[8]

27. During the phone review, Mr Nisbet demanded a psychiatric inpatient admission. Dr Ellix stated this subsequent phone call with Mr Nisbet lasted less than a minute. Following the call, Dr Ellix wrote to Mr Nisbet's General Practitioner (**GP**) in a letter dated 20 September 2021 to inform them what had transpired.

28. Following the review with Dr Ellix, Mr Nisbet phoned Mr Watson and was verbally abusive and threatening. Mr Nisbet reported he was travelling to the ECMHT to bomb the building. Police were notified, but Mr Nisbet did not attend the ECMHT as threatened.

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6 CB, Statement of Dr Rachel Drummond, page 22.

7 On 12 August 2021 at the Bendigo Magistrates Court, Mr Nisbet was found guilty of the charge 'Breach Alcohol Interlock Condition' and was placed on a Community Correction Order with the condition to attend the Echuca Justice Service Centre by 16 August 2021. The evidence is unclear on whether Mr Nesbit complied with this condition and if this may have been the source of apprehension regarding court dates.

8 CB, Statement of Dr Ellix, page 30.

29. On 21 September 2021, a clinical team meeting was held with ECMHT staff, and a decision was made to discharge Mr Nisbet from ECMHT services. Dr Ellix stated the file was closed "*on the basis Mr Nisbet was not presenting with active psychiatric illness*," citing the assessment by Dr Drummond, and because "*Mr Nisbet was not able to engage with ECMHT in a safe and therapeutic manner*.*"*[9]

30. On 23 September 2021, a letter was sent to Mr Nisbet advising him of his discharge.

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

31. At approximately 5.30pm on 29 September 2021, Mr Nisbet texted his mother and informed her that he had sold her ring. This text message confused Mrs Nisbet, and she messaged her son seeking clarification. The evidence suggests she did not receive a response.

32. According to Demi, throughout the evening of 29 September, her brother was consistently coming and going from home. Demi stated she last saw Mr Nisbet at approximately 8.30pm in the driveway. The evidence suggests this was the last time he was seen alive.

33. On 30 September 2021, Mrs Nisbet worked an early shift and returned home at approximately 10.30am. As she entered the house, Mrs Nisbet noticed her son had not come inside the house to make his morning coffee, which was unusual. She checked the caravan in the backyard where her son resided and discovered he was not there, but his wallet was. She continued to look for Mr Nisbet, and at approximately 11.00am she discovered him in the shed having hanged himself.

34. Mrs Nisbet contacted emergency services and Ambulance Victoria Paramedics arrived shortly afterwards. Mr Nisbet was formally pronounced deceased at 11.34am on 30 September 2021.

35. Victoria police did not identify any suspicious circumstances surrounding Mr Nisbet's passing.

Identity of the deceased

36. On 30 September 2021, Jamie Peter Nisbet, born 9 January 1974, was visually identified by his mother, Lynette Nisbet, who signed a formal Statement of Identification.

[9] Ibid.

37. Identity is not in dispute and requires no further investigation.

Medical cause of death

38. Pathologist Dr Matthew Lynch from the Victorian Institute of Forensic Medicine, conducted an examination upon the body of Mr Nisbet on 3 October 2021 and provided a written report of his findings dated 5 October 2021.

39. The post-mortem examination was consistent with the stated circumstances.

40. Toxicological analysis of post-mortem samples identified the presence of buprenorphine[10] (~1 ng/mL) and norbuprenorphine[11] (~12 ng/mL). No ethanol (alcohol) was detected.

41. Dr Lynch provided an opinion that the medical cause of death was 1(a) Compression of the neck; 1(b) Hanging.

42. I accept Dr Lynch's opinion.

FAMILY CONCERNS

43. In her statement in the coronial brief, Mr Nisbet's mother expressed concerns regarding the mental health care received by her son. Mrs Nisbet stated she felt the mental health system had "*let him* [Mr Nisbet] *down*."

CPU REVIEW

44. Having reviewed the coronial brief and noting the concerns raised by Mr Nisbet's mother, I referred the matter to the Coroners Prevention Unit (**CPU**)[12] for review, inviting input about the appropriateness of the mental health care provided to Mr Nisbet.

45. With respect to Mr Nisbet's presentation to the Echuca ED on 10 September 2021, the CPU noted that he requested an admission and subsequently agreed to the recommended community treatment. The CPU found as Mr Nisbet presented voluntarily, he did not meet the

[10] Buprenorphine is indicated for moderate to severe chronic pain and maintenance therapy in opiate addicts. Trade names include Suboxone and Norspan.
[11] Buprenorphine is biotransformed to the active metabolite norbuprenorphine
[12] The Coroners Prevention Unit (**CPU**) was established in 2008 to strengthen the prevention role of the Coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the Coroner. The CPU is comprised of health professionals with training in a range of areas, including medicine, nursing, public health and mental health.

criteria for involuntary treatment under the *Mental Health Act 2014*. The CPU found this assessment and treatment plan was appropriate since Mr Nisbet was accepting of community mental health treatment.

46. During Mr Nisbet's presentation to the Echuca ED on 19 September 2021, the CPU noted the ED doctors opined he presented as psychotic. This contrasted with the telephone review by the RTS clinician, who believed he did not present as psychotic. The decision was made to transport Mr Nisbet to the Bendigo ED. Given the differing opinions regarding his presentation, the CPU found this course of action was appropriate.

47. At the Bendigo ED, Mr Nisbet was assessed by the ECAT clinician, who did not consider that he presented as psychotic. Nonetheless, the ECAT clinician escalated a referral to the on-call Psychiatric Registrar, Dr Drummond. The CPU found this review and subsequent escalation was appropriate.

48. Following a review of the available evidence, the CPU considered that Dr Drummond conducted a thorough review and mental state examination of Mr Nisbet. During this assessment, Mr Nisbet did not report any suicidal ideation, and Dr Drummond opined that he did not present as psychotic. Given this, and the fact Mr Nisbet had a scheduled appointment with Dr Ellix the following day, the CPU found it was appropriate that Mr Nisbet was not admitted on this occasion pending further review from Dr Ellix.

49. Dr Ellix's review of Mr Nisbet on 20 September 2021 did not occur as planned, with the brief phone review being terminated as a result of Mr Nisbet's aggressive behaviours. Accordingly, a thorough review of Mr Nisbet's mental state and risks were unable to be conducted during this contact.

50. Mr Nisbet was discharged from ECMHT the following day. The CPU identified that prior to Mr Nisbet's discharge, there was no contact with his family to seek further information regarding Mr Nisbet's mental state. Outside of the letter posted on 23 September 2021, Mr Nisbet nor his family were advised of his discharge.

51. The CPU considered that the mental health assessments and treatment provided to Mr Nisbet on 10 and 19 September 2021 were appropriate.

52. The CPU recommended further information be obtained from Dr Ellix to provide clarification regarding the decision to discharge Mr Nisbet on 21 September 2021.

53. The CPU also recommended further information be obtained from Dr Drummond to elaborate on her assessment that Mr Nisbet did not present as psychotic.

54. On the advice of the CPU, I requested and obtained further statements from Dr Ellix and Dr Drummond. Having reviewed these statements, I referred the matter to CPU for their appraisal of Mr Nisbet's care and clinical management in light of the further information.

55. In Dr Drummond's subsequent statement, she provided clarification on the reasons she believed Mr Nisbet was seeking admission to the psychiatric unit. Dr Drummond believed Mr Nisbet had a court attendance the following day, however, was unsure what the source of that information was. In a subsequent review, Dr Drummond noted that Mr Nisbit advised his pending court date was in October. The evidence suggests there was a lack of clarity regarding Mr Nisbet's court matters.

56. Dr Drummond also formed the impression that Mr Nisbet was experiencing family conflict, was displeased about living in the caravan, was concerned that the community had become aware of his forensic history, and that ultimately, he wanted a break.[13]

57. In relation to her assessment that Mr Nisbet's presentation was not in line with what one would expect with true psychotic experiences, Dr Drummond stated:

> *"Throughout the review it was as if he was trying to say what he thought was expected of him rather than his true experiences. What he said did not come across as genuine and his ability to provide a clear description did not come across as thought disordered or guarded but more that he did not have any more information to give. Following my review, it was my impression that Jamie was not experiencing psychotic symptoms.*
>
> *Overall, I considered that Jamie's underlying personality and social circumstances were leading to his presentation and to his request for inpatient admission. Admission would not have addressed his needs and would not have been in his best interests*."

58. In considering the appropriateness of admission, Dr Drummond stated that she considered Mr Nisbet's prior admission to the AAU between 12 to 21 January 2021. Dr Drummond stated

[13] Court File (CF), Subsequent statement of Dr Drummond dated July 2022.

his last admission "*was characterised by aggression towards others*" and therefore, she considered the "*risks associating with admitting Jamie were not outweighed by the benefits*."[14]

59. The CPU confirmed their initial views that it was reasonable that Mr Nisbet was not admitted to the psychiatric unit on 19 September 2021

60. Mr Nisbet was discharged on 21 September 2021, with Dr Ellix unable to complete a comprehensive mental state examination and risk assessment. Dr Ellix stated the decision to discharge was made on the basis:

> *"The first reason was that Mr Nisbet was not presenting with active psychiatric illness per the mental health assessments conducted by the RTS clinician, the PACER clinician and Dr Drummond and as such, there was a lack of clinical indication for ongoing mental health case management. The second reason was that staff jointly agreed that a continuous therapeutic relationship was now untenable moving forward in light of the sustained abuse towards clinicians and serious bomb threat made by Mr Nisbet, in contravention of Bendigo Health's no tolerance for violence policy. Staff were incredibly frightened by Mr Nisbet's threats, particularly given his violent criminal history, and we all felt very unsafe at the time."*[15]

61. The CPU acknowledged the reasons why Mr Nisbet was discharged were appropriate. Dr Ellix stated that Mr Nisbet did not present with a psychiatric illness, and previous health assessment did not identify the need for ongoing mental health case management, coupled with his abusive and threatening presentation to staff.

62. The CPU noted that at the time of his discharge, Mr Nisbet had not had any meaningful engagement with ECMHT. The CPU also identified the initial reasons for the referral to ECMHT, being monitoring of mental state and risks, re-commencing medication and linkage with alcohol and drug supports, were not achieved. The CPU considered that Bendigo Health staff were aware that Mr Nisbet was prescribed risperidone which he was not actively taking[16].

63. The CPU commented that a risk assessment is informed by the quality of the clinical assessment, collateral information, protective factors, and is a clinical opinion formed by a clinician and is relevant at the time of assessment and completion. The CPU found ECMHT's reliance on risk assessments from two days prior to the discharge of Mr Nisbet on the basis

[14] CF, Subsequent statement of Dr Drummond dated July 2022.
[15] CF, Subsequent statement of Dr Ellix dated 3 August 2022.
[16] This is supported by the post-mortem toxicology results, which did not detect risperidone.

he had no ongoing psychiatric needs requiring specialist mental health input in the context of him having ceased risperidone and displaying an escalation in behaviour the day prior, was not best practice.

64. Following Dr Ellix's brief assessment of Mr Nisbet and prior to the decision to discharge him, the evidence suggests no further options to assess Mr Nisbet were explored. The CPU suggested an option could have been to arrange an assessment at a safer site with security and code response in place, such as the Bendigo Hospital, where he had previously been assessed and was not aggressive. The CPU further identified engagement with his family, and a telehealth appointment could also have assisted in facilitating an assessment.

65. The CPU found that while it was more than reasonable to believe that the therapeutic relationship with ECMHT was irreparable, it should not have resulted in a decision to transfer care to his GP without further exploring of care options within the Bendigo Health mental health services.

66. There is also no evidence to suggest ECMHT's decision to discharge Mr Nisbet was escalated to Bendigo Health senior mental health staff or leadership.

67. The CPU identified no evidence that any substantive contact was made with Mr Nisbet's family. The only contact was with Mr Nisbet's mother on 20 September 2021, when Mr Watson contacted her and immediately handed the phone to her son. Dr Ellix stated contact did not occur at discharge as it was not usual practice or required by Bendigo Health policy.[17]

68. Upon discharge, Bendigo Health policy required Mr Nisbet to be contacted seven days after the last contact. The policy says if the patient is not contactable at this time, a clinician is to contact their next of kin. A letter was posted to Mr Nisbet dated 23 September 2021 however, Dr Ellix stated the required seventh-day contact did not occur.

69. Bendigo Health policy also required a letter be sent to Mr Nisbet's General Practitioner, Dr Togno, advising him of discharge within seven days of last contact. A letter was sent by Dr Ellix to Dr Togno on 20 September 2021 regarding his presentations on 19 and 20 September 2021, being that no evidence of psychosis was observed, Mr Nisbet was extremely hostile, and admission was not required. Dr Togno was not informed of the discharge, as this letter

[17] Subsequent statement of Dr Ellix dated 3 August 2022.

was pre-discharge. The CPU identified the letter to Dr Togno did not address the significant issue that Mr Nisbet had ceased risperidone and the advice that he recommence it.

70. Dr Ellix stated she was unaware that the oversights occurred at the relevant time and that she was unaware why they occurred.

71. The CPU advised me that the lack of family contact throughout and at the point of discharge from ECMHT, the lack of communication with the GP at the point of discharge, and the decision by the ECMHT to discharge Mr Nisbet without escalation to Bendigo Health about alternate and safe assessment options were areas of concern regarding the care provided.

CONCLUSION

72. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the *Briginshaw* gloss or explications.[18] Adverse findings or comments against individuals in their professional capacity, or against institutions, are not to be made with the benefit of hindsight but only on the basis of what was known or should reasonably have been known or done at the time, and only where the evidence supports a finding that they departed materially from the standards of their profession and, in so doing, caused or contributed to the death under investigation.

73. I accept ECMHT's position that the wellbeing and safety of their staff is their paramount consideration. I accept that Mr Nisbet's presentations throughout his latest episode of care, in particular, his presentation on 20 September 2021 with Dr Ellix and ECMHT staff, was extremely challenging in terms of balancing the risks to the health and safety of staff and Mr Nisbet's medical management.

74. However, I accept and adopt the CPU's advice that there were deficiencies with Mr Nisbet's clinical management. The ECMHT's decision to discharge without escalating to Bendigo Health to explore alternative avenues of care and the lack of engagement with Mr Nisbet's family and General Practitioner were suboptimal. However, I do not consider that these deficiencies caused or contributed to Mr Nisbet's passing.

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

75. It is ultimately unclear as to whether a review on 20 September 2021, if able to be conducted, would have led to a risk assessment materially different to that of Dr Drummond.

FINDINGS

76. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    a) the identity of the deceased was Jamie Peter Nisbet, born 9 January 1974;

    b) his death occurred on between 29 and -30 September 2021 at 2 William Street, Rochester, Victoria, 3561, from compression of the neck arising from hanging; and

    c) his death occurred in the circumstances described above.

77. Having considered all the circumstances, I am satisfied that Mr Nisbet intentionally took his own life.

RECOMMENDATIONS

Pursuant to section 72(2) of the Act, I make the following recommendations to Bendigo Health:

When a community mental health team patient who has been assessed as requiring a mental health assessment and risk assessment by a consultant psychiatrist and a comprehensive assessment was unable to be undertaken by a consultant psychiatrist due to aggressive behaviours and threats to the safety of staff (and in circumstances where an involuntary hospital admission is not a consideration):

1) Review its Mental Health Service's escalation policy/protocol for its community mental health team to escalate the above circumstances to mental health senior/leadership for advice on how to address the clinical risks and needs of the client and to ensure appropriate information and training is undertaken to ensure that senior staff are familiar with the policy;

2) In circumstances where the decision is made to discharge the patient to the care of another practitioner that all reasonable attempts are made to directly contact that practitioner to ensure that they are aware of the patient's current presentation; and

3) In circumstances where the decision is made to discharge the patient, that the community mental health team or other member of Bendigo Health, contact the patient's family or next of kin about the implications of the decision (subject to the patient's consent to their personal health information being released to their nominated family member / next of kin).

I convey my sincere condolences to Mr Nisbet's family and loved ones for their loss.

Pursuant to section 73(1A) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

Zack Nisbet, Senior Next of Kin

Dr Jennifer Ellix, c/o Avant Law

Bendigo Health

Senior Constable Russell Locke, Coroner's Investigator

Signature:

Coroner Kate Despot

Date : 16 April 2025

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.