IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 007196

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	AUDREY JAMIESON, Coroner
Deceased:	David Greville Edward Horne
Date of birth:	5 June 1976
Date of death:	28 December 2023
Cause of death:	1a: Unascertained
Place of death:	Maroondah Hospital 1/15 Davey Drive Ringwood East Victoria 3135

INTRODUCTION

1. On 28 December 2023, David Greville Edward Horne was 47 years old when he died at Maroondah Hospital, where he was a compulsory inpatient.

2. David had a history of bipolar and schizoaffective disorders, substance use disorder, and severe obstructive sleep apnoea. He required CPAP (continuous positive airway pressure)[1] but was reportedly noncompliant with this. He had a history of heavy smoking. David was adamant that he also had ADHD and displayed traits of the disorder but this was not formally diagnosed.

3. David had several inpatient admissions to hospital for mental health management since his diagnosis of schizoaffective disorder in 2001, including being placed on compulsory treatment orders.

4. From January 2023, David was a voluntary client of the Maroondah Continuing Care Team. He lived at Jasmin Lodge, a supported residential service in Ringwood.

THE CORONIAL INVESTIGATION

5. David's death 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.

6. In addition, David was 'a person placed in custody or care' as defined in section 3 of the Act, because he was subject to a temporary treatment order[2] pursuant to the *Mental Health Act 2022*. The death of a person in care or custody is a mandatory report to the Coroner, even if the death appears to have been from natural causes.

7. 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

[1] CPAP is a mode of delivering non-invasive ventilation. The use of continuous positive pressure to maintain a continuous level of positive airway pressure. CPAP uses mild air pressure to keep an airway open. CPAP typically is used for people who have breathing problems, such as sleep apnoea.

[2] An inpatient temporary treatment order is made by an authorised psychiatrist after assessing a person on an assessment order that enables the person who is subject to the inpatient temporary treatment order to be compulsorily taken to, and detained and treated in, a designated mental health service.

purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

8. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

9. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of David's death. The Coronial Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

10. This finding draws on the totality of the coronial investigation into the death of David Greville Edward Horne 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.[3]

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

Circumstances in which the death occurred

Admission to Maroondah Hospital

11. In the leadup to his admission to Maroondah Hospital, David had reportedly self-ceased his prescribed flupenthixol[4] depot.

12. On 5 December 2023 David was conveyed to the Maroondah Hospital Emergency Department (**ED**) by police after allegedly assaulting a member of the public. He presented as labile in affect, overfamiliar, agitated and disinhibited. He responded to internal stimuli and expressed delusional thoughts.

[3] 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.

[4] Flupenthixol decanoate is a slow release antipsychotic, requiring regular injections

13. David was placed on an Assessment Order which was upheld by the consultant psychiatrist in the ED to an Inpatient Temporary Treatment Order. He was administered 60mg diazepam[5], 20mg olanzapine[6] and 10mg droperidol[7].

14. That evening David became obtunded[8], with the clinical impression of 'type 2 respiratory failure in setting of sedating medications and Obstructive Sleep Apnoea'. He was reviewed by the Intensive Care Unit (**ICU**) registrar but recovered in the ED after the administration of BiPAP (bilevel positive airway pressure)[9]. He was deemed suitable for a mental health inpatient bed.

15. On 6 December 2023, David was admitted to the high dependency area of the inpatient unit. He required brief seclusion shortly after his admission after his behaviour escalated and he pushed another patient. A physical examination showed normal respiratory observations.

16. David was reviewed by consultant psychiatrist Dr Christopher Cunningham on the morning of 7 December 2023. Dr Cunningham had the impressed of 'manic/psychotic relapse of BPAD[10]'. He planned to commence David on chlorpromazine[11] and noted the ICU registrar's recommendation to avoid benzodiazepines where possible.

17. During the afternoon, David displayed severe aggression towards a staff member, grabbing her by the neck and throwing her to the ground. Two code greys were called, and David was moved to seclusion. He was commenced on olanzapine instead of chlorpromazine in order to minimise the number of different antipsychotic agents used[12]. Sodium valproate[13] was commenced to treat his manic symptoms.

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[5] Diazepam is a long acting benzodiazepine with anxiolytic, sedative, hypnotic, muscle relaxant and antiepileptic effects.

[6] Olanzapine is a second-generation antipsychotic indicated in the treatment of schizophrenia and related disorders, and bipolar disorder.

[7] Droperidol is an antiemetic medication that is indicated to produce tranquillisation and reduce the incidence of nausea and vomiting in surgical and diagnostic procedures. In psychiatry, it is approved for the management of severe agitation, hyperactivity, or aggressiveness in psychotic disorders.

[8] A dulled or reduced level of alertness or consciousness.

[9] BiPAP is a form of non-invasive ventilatory support in which a pre-set inspiratory positive airway pressure (IPAP) and expiratory positive airway pressure (EPAP) are delivered. BiPAP can be described as a continuous positive airway pressure (CPAP) system with a time-cycled or flow-cycled change of the applied CPAP level. BiPAP, CPAP and other non-invasive ventilation modes have been shown to be effective management tools for chronic obstructive pulmonary disease and acute respiratory failure. Another term for BiPAP is non-invasive positive pressure ventilation (NIPPV) or non-invasive ventilation (NIV).

[10] Bipolar Affective Disorder.

[11] Chlorpromazine is an antipsychotic medication indicated in the long-term treatment of psychotic disorders (for example, schizophrenia, mania, psychotic depression). It is also used for the short-term treatment of severe behavioural disturbance and aggressive behaviour.

[12] Intramuscular olanzapine is often used in the setting of severe agitation or refusal of oral medications.

[13] Valproaic acid is an anticonvulsant. Valproic acid is used alone or with other medications to treat seizures. In addition, it is used to treat mania in people with bipolar disorder.

18. At 3:05am on 8 December 2023, while David was still in seclusion, a code blue was activated due to an episode of unresponsiveness and low oxygen saturation levels. He recovered quickly after ventilation, and it was decided he did not require transfer to a medical unit.

19. Later that morning, it was decided that the safest way to treat David was in seclusion with mechanical restraints with the bed at an incline to avoid obstruction and further desaturation.

20. Psychiatry staff liaised with respiratory physician Dr Tu, who completed a 'file review' of David the same day. Dr Tu considered that there was 'no current indication for NIV[14] or CPAP'.

21. On 9 December 2023, David's CPAP machine was brought in by Jasmine Lodge staff.

22. On the morning of 11 December 2023, Dr Tu consulted with David, during which he reviewed the CPAP machine. He noted that trialling the CPAP machine was not possible at this time given David remained non-complaint due to his acute psychiatric illness. He made several suggestions including administering the lowest dose of antipsychotic medication (if possible) to reduce the risk of respiratory depression, and to encourage David to sleep in the lateral position.

23. That day, David was stepped down out of seclusion and then out of restraints and was managed in the general area of the high dependency unit (**HDU**).

24. Over the following days, David was transitioned from olanzapine to paliperidone[15] and his sodium valproate dose increased. There were discussions about trialling him in the low dependency area, but due to his fluctuating agitation and verbal aggression[16] he remained in the HDU due to the potential risk to patients and staff.

25. David's respiratory health remained stable and there were no further episodes of low oxygen saturation between 8 December 2024 and his death.

Day of death

26. Nursing handover notes on 28 December 2023 recorded that David had been elevated in mood on the previous evening shift but without significant behavioural concerns.

[14] Non-invasive ventilation.
[15] Paliperidone is an antipsychotic and indicated in the treatment of schizophrenia, acute exacerbations of schizoaffective disorder and bipolar disorder. It is available in oral and slow-release depot injection.
[16] Another code grey was called on 18 December 2023 due to David's verbal aggression towards security staff.

27. At 9:30am, nursing staff observed David to be sleeping, with audible snoring and his chest rising and falling.

28. At 9:50am, David's treating doctors entered his room for a planned review. He was unresponsive with a GCS[17] of 3, appeared not to be breathing and no pulse was detected. A code blue was called and CPR commenced.

29. Despite medical intervention, David showed no signs of life and CPR was ceased. David's time of death was recorded as 10:22am.

Identity of the deceased

30. On 3 January 2023, the right thumb print of the deceased was positively matched to the corresponding print on Police file for David Horne.

31. On 4 January 2023, Coroner Paul Lawrie considered the available evidence and considered that the cogency and consistency of all evidence relevant to identification of the deceased supported a finding that the deceased was David Greville Edward Horne, born 5 June 1976. Accordingly, he completed a Determination by Coroner of Identity of Deceased (Form 8).

Medical cause of death

32. Forensic Pathologist Dr Victoria Francis from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on the body of David Horne on 2 January 2024. Dr Francis considered several materials including the Victoria Police Report of Death (Form 83), post mortem computed tomography (**CT**) scan and medical records and E-Medical Deposition Form from Eastern Health and provided a written report of her findings dated 7 June 2024.

33. The autopsy showed a small pericardial effusion, single vessel moderate-severe atherosclerosis and a heart weight of 503 g with mild perivascular fibrosis.

34. There was some pulmonary emphysema and some mild patchy acute bronchopneumonia which was insufficient to have had any major contribution to the death.

35. Toxicological analysis of post mortem blood samples identified the presence of hydroxyrisperidone and olanzapine.

[17] The Glasgow Coma Scale (**GCS**) is a neurological scoring system used to assess conscious level. The GCS is comprised of three categories; best eye response, best vocal response and best motor response. The GCS is scored out of 15, with a score of 15 indicating a normal level of consciousness.

36. Dr Francis commented that there was no significant anatomical or toxicological cause of death identified. In cases such as these, possible mechanisms of death include cardiac arrhythmias, seizures and metabolic disturbances. She opined that the most likely event in David's case was the sudden onset of a cardiac arrhythmia, characterised by a sudden disruption to the conducting system of the heart. Cardiac arrhythmias may be triggered by more obvious pathological processes such as coronary atherosclerosis, hypertension, or cardiomyopathies.

37. Dr Francis noted that David had a history of severe obstructive sleep apnoea and suffered several episodes of respiratory failure during his admission to Maroondah Hospital. Obstructive sleep apnoea is associated with an increased risk of sudden death by provoking a cardiac arrythmia or when normal breathing does not resume following an apnoeic episode during sleep. The postmortem examination showed no significant right ventricular hypertrophy and there is minimal evidence of pulmonary hypertension. However, Dr Francis was unable to exclude complication of obstructive sleep apnoea.

38. Dr Francis further commented that it is recognised that people with schizophrenia/schizoaffective disorder have an increased risk of death (thought to be almost twice the risk of the general population). While a natural disease process may be identifiable in some people, a proportion of these deaths have no identifiable medical or toxicological cause of death. It is possible in these cases that death may be due to altered autonomic physiology and possible interactions with psychotropic medications.

39. Dr Francis provided an opinion that the death was due to natural causes and ascribed the medical cause of death as 1(a) UNASCERTAINED.

REVIEW OF CARE

40. Having considered the available evidence and noting that David experienced two incidents of respiratory distress during his admission, I requested that the Coroners Prevention Unit (**CPU**)[18] review the medical management of his respiratory condition while he was a compulsory inpatient. In completing their review, the CPU had regard to all materials held by

[18] 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.

the Court including the medical record, coronial brief and questions regarding David's care submitted by his mother, Gillian.

41. The CPU advised me that David's case was complex, with a particularly challenging balance to be struck between managing David's mental health and behaviours of concern, which were the reason for his compulsory admission, and his respiratory condition.

42. It was thought that David's episodes of respiratory distress on 5 and 8 December 2023 were probably contributed to by sedative medications that were reducing his respiratory drive in the setting of a hypopnoeic/apnoeic obstructive sleep apnoea patient. Indeed, after benzodiazepines were ceased, David did not experience any further episodes of respiratory distress or low oxygen saturations.

43. Psychiatric staff sought appropriate input from respiratory clinicians and a respiratory physician conducted both a file review and a physical consult with David. Dr Tu provided appropriate suggestions for the management of David's respiratory condition in the HDU. He considered whether it would be appropriate to resume use of David's home CPAP machine but noted that this was difficult due to his non-compliance due to his mental ill-health and it could be recommenced when his mental health was more stable. The CPU considered that this was an appropriate approach.

44. Overall, the CPU considered that Maroondah Hospital's approach to managing David's respiratory condition was appropriate and managed the difficult balance between his medical condition, his mental illness and the safety of staff and patients. The CPU highlighted that David experienced no further significant medical events between 8 December and his unexpected death on 28 December 2024 and noted that there was no pathological evidence of the complications of severe respiratory disease and sleep apnoea identified at autopsy.

FINDINGS AND CONCLUSION

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

   a) the identity of the deceased was David Greville Edward Horne, born 5 June 1976;

   b) the death occurred on 28 December 2023 at Maroondah Hospital, 1/15 Davey Drive, Ringwood East, Victoria 3135;

   c) I accept and adopt the medical cause of death ascribed by Dr Victoria Francis and I find that David Greville Edward Horne's cause of death is unascertained;

2. AND, having considered the available evidence, I find that Maroondah Hospital clinicians acted reasonably and appropriately in balancing David Greville Edward Horne's medical conditions, his mental health and the safety of staff and patients;

3. AND FURTHER, because David Greville Edward Horne's death was due to natural causes and the care provided to him was reasonable and appropriate, I have determined that it is appropriate to finalise the investigation without an inquest pursuant to section 52(3A) of the Act.

I convey my sincere condolences to David's family for their loss.

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

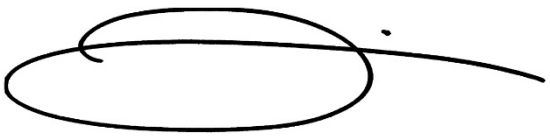
I direct that a copy of this finding be provided to the following:

Gillian Brown, Senior Next of Kin

Eastern Health

Sergeant Tomas Garcia-Mulder, Coronial Investigator

Signature:



AUDREY JAMIESON

CORONER

Date: 13 October 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.