Coroners Act 1996
[Section 26(1)]

Western  ***Australia***

RECORD OF INVESTIGATION INTO DEATH

Ref No: 12/18

I, Evelyn Felicia Vicker, Deputy State Coroner, having investigated the death of ***Kim Martin Franker*** *with an Inquest held at Perth Coroners Court, Court 51, Central Law Courts, 501 Hay Street, Perth, on 1 March 2018 find the identity of the deceased was* ***Kim Martin Franker*** *and that death occurred on 28 February 2016 at Fiona Stanley Hospital, as the result of the* ***effects of trihexyphenidyl*** *(Artane, benzhexol)* ***and amphetamine-type stimulants and dehydration with renal impairment in a man with cardiomyopathy and morbid obesity****, in the following circumstances:-*

Counsel Appearing:

Ms S Teoh assisted the Deputy State Coroner

Ms S Fox (State Solicitors Office) appeared on behalf of the North Metropolitan Health Service and Dr Pyszora

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INTRODUCTION

On 28 February 2016 at around 1.38 pm, police officers found Kim Martin Franker (the deceased) lying on a park bench in Collie Street, Fremantle. He appeared to be intoxicated and dehydrated and was found with a number of different prescription medications. An ambulance was requested to attend.

The deceased began to deteriorate and lost consciousness. He was taken by ambulance to Fiona Stanley Hospital (FSH) while paramedics performed CPR. He arrived at FSH and was declared deceased soon after arrival.

The deceased was 36 years of age.

Pursuant to the provisions of the *Coroners Act 1996* (WA) (the Act) the deceased was a person held in care (section 3) due to his being subject to a community treatment order (CTO) under the *Mental Health Act 2014* (Mental Health Act). The CTO made the deceased an involuntary patient for the purposes of compulsory medication while in the community.

The death of an involuntary patient under the Mental Health Act mandates the holding of an inquest (section 22(1)(a)). By section 25(3) of the Act a coroner holding that inquest must comment on the quality of the supervision, treatment and care of that person while in that care.

The evidence before the court comprised two volumes of documentary evidence, exhibited as exhibits 1 & 2, and the oral evidence of Dr Anthony Mander, a reviewing consultant psychiatrist, Dr Natalie Pyszora, the deceased's treating community forensic mental health psychiatrist, Dr Ian Wood, the deceased's known treating general practitioner (GP) and Professor David Joyce, expert toxicologist.

BACKGROUND

The Deceased

The deceased was born on 17 January 1980 in Perth. He was the youngest of four children and was reported as an average student at school but enjoyed playing sport. The deceased participated in cricket, rugby, football and martial arts. He left high school at the end of year 11 and held various jobs including his own card business, working as a cabinet maker and as a bouncer.[1]

The deceased had been unemployed since he was 21 and his finances controlled by the Public Trustee as a result of his being on a disability support pension due to his extensive mental health issues. By the time of his death the deceased lived alone in state housing, however, had good family support in the community,[2] despite the use of violence restraining orders (VROs) from time to time when he became difficult to manage.

[1] Ex 1, tab 20
[2] Ex 1, tab 23

Medical Treatment

The deceased had an extensive history of polysubstance abuse including alcohol, intravenous (IV) amphetamines, ecstasy, LSD and marijuana dating back to when he was 16 years of age.

The deceased was first admitted to a psychiatric hospital in 2001 where he was diagnosed with amphetamine induced psychosis. Following that he had many admissions to psychiatric facilities, predominantly Graylands Hospital (GH) and Fremantle Alma Street Centre (ASC). He self-reported regular cannabis use and more regular amphetamine use. His use was limited by the control of his finances through the Public Trustee. The deceased was assessed as having limited insight into his illness which caused him to refuse to engage in substance abuse treatment.[3]

The deceased was managed under the Mental Health Act for many years, both in the community by various Community Forensic Mental Health Services (CFMHS) and as an inpatient in hospitals. His diagnosis was of schizoaffective disorder and mental and behavioural disorder due to multiple substance abuse.[4]

The deceased also suffered from a significant number of physical health problems including recurrent skin abscesses

[3] Ex 1, tab 3
[4] Ex 1, tab 23

due to his IV drug use, hepatitis C, hypertension, gastric reflux, hypercholesterolemia, morbid obesity and fluctuating left atrial enlargement. He would often refuse medical tests, treatment and advice while in hospital.

The deceased's known GP was Dr Ian Wood whom he saw on a regular basis and who prescribed him with a substantial amount of medication for both his physical and psychiatric illnesses.[5] The deceased had been a patient of Dr Ian Wood for 8 years.[6] He was known to use other medical practitioners such as the street doctors[7] from time to time of which Dr Wood was unaware.[8]

The deceased had a significant history of misusing prescription medication and 'doctor shopping' until the time of his death. It was evident to his CFMHS team the deceased obtained various medications for physical health complaints from which he did not suffer, and at the time of his death the team were in the process of applying for a guardianship order for the deceased as a means of limiting this behaviour which was detrimental to his mental welfare.[9]

His treating team found the deceased had a tendency to separate his physical and mental health issues and was not compliant with medication for his mental health issues, while

[5] Ex 1, tab 25 B
[6] t 01.03.18, p51
[7] t 01.03.18, p29
[8] t 01.03.18, p52
[9] Ex 1, tab 23

concentrating on his physical health. Towards the end of his life this was causing some concern for his team who were trying to engage his known GPs in their treatment regime. The deceased's CFMHS case worker was Iain Hindle who had a good rapport with the deceased and his family, all of whom were trying to coordinate his appropriate ongoing management.

When not an inpatient in a facility the deceased was frequently placed on a CTO. These were usually supervised by a consultant psychiatrist of his CFMHS, which for the last four and half years of his life was Dr Natalie Pyszora. CTOs are under the supervision of the Mental Health Review Board and generally reviewed three monthly for their ongoing necessity.[10]

In August 2014 his CFMHS team found the deceased was becoming increasingly aggressive and his then current CTO was revoked. He was admitted to Graylands Hospital. On admission it was recorded he was prescribed a variety of medications for physical ailments without having those ailments. His medication was refined and he was discharged on a CTO with a weekly fluphenazine depot injection on 2 October 2014.[11]

[10] t 01.03.18, p25, 26
[11] Ex 2, tab 1

The deceased presented to Fremantle Hospital (FH) emergency department (ED) on 22 October 2014 after overdosing on clonidine. An ECG indicated the deceased had borderline prolonged QTc interval and he was monitored until his QTc returned to normal. A discharge letter outlining this information was sent to Dr Wood.

Days later the deceased was again taken to FHED by ambulance after he was found wandering in a confused and sedated state with track marks on his arms. Amphetamines were detected on his toxicology screen. His CTO was revoked and he was admitted to FH as an involuntary patient recorded as being from 27 October 2014 – 18 February 2015.[12]

During this period of hospitalisation the deceased refused a number of diagnostic tests and his psychiatric team believed he was consuming excessive amounts of benzhexol (Artane, trihexyphenidyl) a medication designed to prevent tardive dyskinesia, a side effect of antipsychotic medication exhibiting as uncontrolled and unnatural movements. A discharge letter indicating a number of the deceased's medications had been ceased, including benzhexol, was provided to Dr Wood.[13] It is not clear when or if the discharge letter was received by Dr Wood. None of the discharge letters prior to the deceased's death appear in his GP record at

[12] Ex 2, tab 1
[13] Ex 2, tab 2

Attadale Medical Group where Dr Wood is not currently practicing.[14]

Contemporaneously the Attadale GP record notes[15] the deceased saw Dr Wood on 17 February 2015 regarding his diagnosis of schizophrenia and Dr Wood ceased the deceased's Catapres (clonidine tablet) and prescribed him clonidine hydrochloride injection, oral olanzapine and gabapentin.[16]

Two days later the deceased revisited Dr Wood for back pain and was prescribed aspirin, ranitidine, Duromine and Ventolin.[17] Thereafter the deceased continued to visit Dr Wood monthly through to August 2015 and continued to be prescribed a variety of medications including on 1 and 14 April 2015 benzhexol 5mg 2 b.d. pick up 100 every 25 days, after ceasing his Duromine and Catapres.[18] The dispensing restriction was an attempt to control the availability of benzhexol which can be used as a drug of abuse.

On 3 May 2015 the deceased was again admitted as an involuntary patient at FH and complained of chest pain, but declined to have an ECG or blood test to assist with diagnosis. He was prescribed aspirin and a dose of GTN and

[14] Ex 1, tab 25
[15] Ex 1, tab 25C
[16] Ex 1, tab 25C notes indicate injection of clonidine hydrochloride but in evidence Dr Wood stated this was an error - t 01.03.18, p66
[17] Ex 1, tab 25C
[18] Ex 1, tab 25C

the following day allowed testing for his troponin level which came back as negative.[19] The deceased was discharged on 11 June 2015 with a discharge letter provided to Dr Wood.

Three days later on 15 June 2015 the deceased again saw Dr Wood, this time for erectile dysfunction and insomnia. Dr Wood noted a number of physical ailments for which he referred the deceased for a number of tests including testosterone levels. He provided the deceased with scripts for benzhexol 5mg 2 b.d. to be dispensed at 100 every 25 days, aspirin, gabapentin, sildenafil (Viagra) daily and a nasal ointment.[20]

On 6 July 2015 Dr Pyszora wrote to Dr Wood indicating her concerns with the deceased's history of abusing prescription medication. There was no mention of benzhexol specifically. She asked that Dr Wood contact her if he had any concerns about the deceased or felt there was information of which Dr Pyszora should be aware, but did not receive any response. Dr Pyszora was concerned the deceased had obtained scripts for various medications some of which were contraindicated.[21] In evidence Dr Wood indicated that while he did not respond to the letter he took note of its content and did not believe he had prescribed GTN and Viagra at the same time. Dr Wood believed the deceased may have been provided with medication by other doctors, but was not aware

[19] Ex 2, tab 1
[20] Ex 1, tab 25C
[21] Ex 2, tab 2

of that before the deceased's death,[22] although the letter did refer to the street doctors and 'doctor shopping'. The Mental Health Review Board continued the deceased's need to remain on a CTO.

During August the deceased saw Dr Wood for insomnia and as a result of an assault and he was again prescribed various medications including benzhexol at 5mg 2 b.d. 100 to be dispensed every 25 days.

In September 2015 the State Administrative Tribunal (SAT) renewed the deceased's Administration Order for 5 years and on 24 September 2015 Mr Hindle visited the deceased at home where he appeared psychotic, delusional and paranoid. He informed Mr Hindle he was carrying a knife because he was paranoid and had been in a fight the night before. He was concerned people would break into his home and disclosed he had been taking benzhexol at 10mg twice daily, Viagra and GTN (contraindicated) as well as using the antidepressants prescribed by Dr Wood. As a result Dr Pyszora revoked the deceased's CTO and he was to be admitted to hospital as soon as a bed became available.[23]

Last Admission as Involuntary Patient

The deceased was admitted from 26 September 2015 to 14 December 2015. This was his last admission to FH as an

[22] t 01.03.18, p64
[23] Ex 2, tab 2

involuntary patient following the relapse of his schizoaffective disorder.

The deceased was placed on regular antipsychotic medication and started on atorvastatin due to his hypercholesterolemia. The deceased tested positive for methylamphetamines and was weaned off benzhexol prior to discharge, with his dose being reduced from 10mg twice daily to 5mg twice daily.

On 2 December 2015 a case conference was held between the Alma Street Centre (ASC) and the CFMHS team, but not Dr Wood, where it was agreed a guardianship order should be sought for the deceased upon discharge, and that his CTO conditions be very narrow to manage his mental state and the risks thereof. The deceased appeared delusional and paranoid during the part of the meeting for which he was in attendance. He was still insisting he did not have a mental illness.[24]

The deceased eventually improved and he was discharged on 14 December 2015 on a CTO due to expire on 13 March 2016. He was required to report to ASC triage on a daily basis before 2.00 pm for his oral olanzapine, to ensure his compliance, and he was to receive weekly home visits on a Wednesday from CFMHS team for his depot medication of fluphenazine decanoate.[25]

[24] Ex 2, tab 3
[25] Ex 2, tab 1

In an effort to continue his withdrawal from benzhexol the deceased was provided with 14 tablets of 5mg benzhexol to last him a week on discharge, without a prescription for renewal. The expectation was he would cease the benzhexol completely after that week. The deceased's script for aspirin for his cardiovascular disease prevention and enalapril for his hypertension were continued, however, he was not prescribed salbutamol (Ventolin) because there was no evidence he was asthmatic.[26]

A discharge letter was sent to Dr Wood advising him the deceased's benzhexol dose had been decreased from 10mg to 5mg twice daily. It is not clear when Dr Wood received the discharge letter but he acknowledged in evidence he received discharge letters.[27]

POST DISCHARGE ON 14 DECEMBER 2015 ON A CTO

The deceased breached his CTO the day following discharge by failing to attend at ASC triage for his daily olanzapine. He was issued with a Form 5E breach of CTO.[28] He attended the following day, 16 December 2015, for his daily olanzapine.

The deceased visited Dr Wood on 16 December 2015 and the practice records indicate Dr Wood noted the deceased had been in ASC for three months and that his blood pressure and pulse when sitting were 134/116 and 130 regular,

[26] Ex 2, tab 1 & 2
[27] t 01.03.18, p52
[28] Ex 2, tab 2 16.12.2015 & Tab 3 17.12.2015

respectively. The deceased was complaining about his hypertension and insomnia and Dr Wood recorded prescribing him with aspirin, ranitidine, enalapril, gabapentin, sildenafil (Viagra) and Artane (benzhexol) at 5mg 2 b.d, 100 to be dispensed every 25 days. Dr Wood ceased the prior paroxetine, Augmentin Du Forte, Bactroban nasal ointment, Catapres, gabapentin, Nitro-dur (GTN), Seroquel (quetiapine) and sildenafil capsules.[29]

The deceased again breached his CTO on 17 December 2015 by not attending ASC for his olanzapine and he was again issued with a Form 5 with an order to attend the following day.[30]

Dr Pyszora also varied the terms of the CTO to clarify the deceased was to attend ASC triage and take his olanzapine in front of ASC staff, excluding Wednesdays when the CFMHS were to supervise his olanzapine on his home visit for his depot injections.[31]

On 18 December 2015 the deceased attended at ASC for his olanzapine and explained he had presented to the pharmacy, rather than the ASC triage for his medication, where it was not available. He was informed he needed to present at ASC triage in future for his daily olanzapine.[32] The deceased

[29] Ex 1, tab 25C
[30] Ex 2, tab 1
[31] Ex 2, tab 1
[32] Ex 2, tab 3

complied with this instruction on 19, 21, 22 December 2015 and was polite and cooperative.

The Mental Health Tribunal confirmed the deceased's continuing CTO on 22 December 2015.[33]

The deceased received both his olanzapine and depot injection on 23 December 2015 at his home where the CFMHS team found him easy to deal with and agreed he did not need to attend ASC triage on Christmas day.[34]

The deceased attended ASC triage on 26 December 2015 and appeared settled, however, he contacted ASC triage on 27 December 2015 to say he was physically unwell and unable to attend. The CFMHS arranged a home visit and he was provided with his daily olanzapine.[35]

There were no concerns raised for the deceased's CTO compliance between 28 December 2015 and 5 January 2016.

On 6 January 2016 CFMHS team visited the deceased at home and he appeared well. It was agreed he could attend ASC triage at any time up until 5.00 pm. He was advised of the SAT guardianship application and left with information.[36]

[33] Ex 2, tab 1
[34] Ex 2, tab 2
[35] Ex 2, tab 1
[36] Ex 2, tab 2

His CTO conditions were varied to reflect the more flexible time tabling for his daily medication.

The deceased appeared to be relatively compliant through to 2 February 2016 without issue.

The SAT application for guardianship was listed for hearing for 21 March 2016 on 16 January 2016, and on 2 February 2016 the deceased attended Fremantle Court in relation to various charges.[37]

The deceased was next reviewed by Dr Pyszora and his case manager on 3 February 2016. The deceased admitted to ongoing THC use and occasionally methamphetamine. He appeared reasonably stable although he became irritable when he realised his CTO conditions were not going to be changed and advised he was avoiding the daily olanzapine by spitting it out as he left ASC triage. His CTO was maintained without change.[38] He was administered his fluphenazine depot and oral olanzapine on that date.

Following that review the deceased was visited at home by Dr Lyn Bennett and his case manager on 9 February 2016 where the deceased admitted he was still using THC and amphetamines. It was the team's view he appeared clinically stable and Dr Bennett made a note in the CFMHS file that

[37] Ex 2, tab 2
[38] Ex 2, tab 2

the team needed to have a discussion with the deceased's GP, Dr Wood, regarding his current medications.[39]

On 12 February 2016 Dr Pyszora changed the terms of the deceased's CTO so he did not have to attend ASC triage on Sundays due to transport difficulties and he was to be provided with two doses of oral olanzapine on Saturdays.

Dr Bennett also attempted to call Dr Wood to discuss the deceased's current medications but was unable to make contact.[40] The deceased appeared to be continuing to comply with the terms of his CTO as varied, and appeared relatively stable on the assertive CTO conditions.

On 18 & 19 February 2016 the deceased failed to comply with his oral olanzapine, however, had advised he was unwell. He next attended ASC triage for his olanzapine on Saturday 20 February 2016 by which time Dr Pyszora was on leave and Dr Petch was the deceased's treating psychiatrist in her absence. The deceased was notified of this by letter.[41]

The deceased visited Dr Wood on 23 February 2016. Dr Wood recorded him as being depressed and he prescribed benzhexol 5mg 2 b.d. 100 to be dispensed every 25 days, renitec tablets and the gabapentin.[42]

[39] Ex 2, tab 2
[40] Ex 2, tab 3
[41] Ex 2, tab 2
[42] Ex 1, tab 25C

There is no documentation in the ASC outpatient notes for the next week and the next entry as far as CFMHS is concerned surrounding the deceased's compliance with the CTO was when they visited him at home on 24 February 2016 for a scheduled review with Dr Bennett, the team's psychiatric registrar.

Dr Bennett and the deceased's case manager believed the deceased presented well on 24 February 2016, but suspected he was intoxicated with THC and he admitted to having recently used both cannabis and methamphetamine.[43]

The deceased advised them he had obtained various prescriptions from his GP including Viagra, benzhexol (to assist with his shakes) gabapentin, salbutamol and GTN spray. This is not in accordance with Dr Wood's medical note and may indicate the involvement of another GP.

There remained a concern from the clinicians' perspective over the GTN spray and Viagra. Dr Bennett decided she would not change the deceased's medications, but she attempted unsuccessfully to call Dr Wood to discuss medications for the deceased, and again planned to send Dr Wood a letter when she could not speak with him.

[43] Ex 2, tab 3

The deceased attended at ASC triage for his daily olanzapine on both 25 & 26 February 2016 and was noted to be polite and pleasant.[44]

The CFMHS file indicated Dr Bennett wrote to Dr Wood on 26 February 2016 asking him to notify her of the medications he was prescribing to the deceased, as well as providing him with information as to the CFMHS prescriptions. She stated she was concerned there may be contraindicators between some of the medications and asked Dr Wood to fax through the information.[45]

There is no indication a response was ever received, however, it is worth noting the letter was not posted until 29 February 2016 (Monday), after the death of the deceased.[46] The Attadale Medical Group notes indicate Dr Wood was not notified of the death of the deceased until 8 March 2016.[47]

Saturday 27 February 2016

There is no record in the ASC outpatient notes the deceased attended ASC triage on the Saturday to take his olanzapine but I note there was not always an entry indicating compliance.

[44] Ex 2, tab 1
[45] Ex 2, tab 2 & 3
[46] t 01.03.18, p31
[47] Ex 1, tab 25C

During the morning police officers spoke with the deceased in the Fremantle mall due to reports he was dealing in drugs. When the police checked they found the deceased to be in possession of a glass pipe, which had not been used, and two small clip seal bags containing what appeared to be drugs. These were later identified as MDMA and pseudoephedrine. The deceased was advised he would be summonsed in relation to the drugs and was issued with a move on notice (MON).[48] He behaved appropriately throughout the interaction and the police officers dealing with him did not have any concerns for his welfare.[49]

Sometime later on 27 February 2016 the deceased was at a bar and café in South Terrace in Fremantle where he was asked to leave after spending a long period of time in the toilets. He was seen to walk out of the café and then sit on a bench where he appeared to be breathing heavily and sweating slightly. One of the Community Safety Officers for the City of Fremantle recognised the deceased after he was contacted by another worker with concerns about the deceased's welfare while sitting on the bench.[50] Nothing further was noted with respect to the deceased.

Sunday 28 February 2016

On the Sunday the deceased was in a restaurant in Fremantle where he was believed to be intoxicated and had

[48] Ex 1, tab 19
[49] Ex 1, tab 12, 14 & 15
[50] Ex 1, tab 21

defecated. Police were called and First Class Constable Jeromy Jones (Jones) and Constable Adam Evans (Evans) on bicycle patrol attended at the restaurant where the deceased was pointed out to them. He was lying on a park bench opposite the restaurant. As Jones and Evans approached the deceased they noted he was lying on his right hand side on the bench with pale lips and tongue and appeared to be very dehydrated. He had again soiled himself and his eyes were closed. Alongside the bench was a smashed prescription tub and white tablets scattered on the ground. There was also a packet of blue pills in his hands which the police later identified as Viagra.[51]

At approximately 1.37 pm the police officers requested the attendance of an ambulance to the location of the deceased, prior to approaching him.

The two officers introduced themselves to the deceased and asked if he needed help to which he replied he was fine, although when he opened his eyes they were very blood shot and the police officers were concerned. They attempted to speak with the deceased, but had difficulty understanding him due to his slurred speech. They searched a wallet which the deceased had dropped on the ground in an attempt to identify him. The police officers checked his identity with the South Metropolitan District Control Centre (SMDCC) for any information and were advised the deceased was on bail.

[51] Ex 1, tab 16 & 17

The deceased stood up and started to walk away and the two police officers walked with him to make sure he was safe as he walked across oncoming traffic. The deceased then sat on a park bench on the other side of the road when he again lay down on a bench.

The deceased asked the police officers for water which they obtained, however, the deceased was unable to drink it all and was very uncoordinated.

At that point the two police officers requested the attendance of an ambulance with an upgraded priority.

The deceased denied he was in pain, but the police officers believed he was deteriorating and were concerned for his welfare. His breathing became heavy and he appeared to lose consciousness, before recovering and speaking with the two police officers. Jones and Evans moved him to a shadier bench and an ambulance arrived very shortly thereafter and assessed the deceased. They asked if he would like to attend hospital for a check-up, but the deceased refused.[52]

The deceased then slumped forward and again appeared to lose consciousness with cyanosed lips and nystagmus noted. The police officers, paramedics and a bystander then placed

[52] Ex 1, tab 16 & 17

the deceased onto a stretcher and wheeled him into the ambulance.[53]

One of the police officers drove the ambulance so both paramedics could treat the deceased in the back of the ambulance. They were unable to obtain an IV line, intraosseous access or his blood pressure due to his obesity. The paramedics commenced CPR, but the deceased remained in asystole.[54]

The deceased arrived at Fiona Stanley Hospital (FSH) emergency department (ED) at 2.33 pm on 28 February 2016 and handover was completed at 2.36 pm.[55]

The FSH triage notes record the deceased as being triaged at 3.30 pm and that his presenting history was cardiac arrest. His glasgow coma score (GCS) was 13/15 when the ambulance initially arrived at the Fremantle mall, but the deceased was in full arrest by 2.20 pm.[56]

The deceased was pronounced deceased at 2.42 pm before the triage form was completed.[57]

Following the deceased's death on 28 February 2016 and Dr Wood's notification of that fact on 8 March 2016, there is

[53] Ex 1, tab 11 & 16
[54] Ex 1, tab 11
[55] Ex 1, tab 11
[56] Ex 2, tab 1
[57] Ex 1, tab 26

a retrospective entry in the deceased's general practice medical notes for Friday 1 April 2016 indicating the reason for contact with the deceased was tardive dyskinesia and a note that the prescription for Artane (benzhexol) tablet 5mg 1 b.d. m.d.u. had changed to 5mg 2 b.d. m.d.u. orally to be swallowed.[58]

In evidence Dr Wood explained the retrospective entry was an explanation for his previous prescribing of benzhexol where he had not given a reason for the prescription. It was entered shortly before he completed his report to the Office of the State Coroner (OSC) and noted the reason for the deceased's contact with him on 23 February 2016 was for tardive dyskinesia.[59] Dr Wood was adamant it was not an attempt to correct the record after the event, but rather was an explanation for his earlier prescriptions without explanation. It is accepted benzhexol is an appropriate and standard treatment for tardive dyskinesia, although 20mg per day is a high dose.

It became clear during the course of the inquest from the Attadale Medical notes Dr Wood had prescribed the deceased with 5mg benzhexol 2 b.d. rather than 5mg b.d. as erroneously stated in his letter of 4 April 2016.[60]

[58] Ex 1, tab 25C
[59] t 01.03.2018, p56 - 59
[60] Ex 1, tab 24 & 25 t 01.03.2018, p56

POST MORTEM REPORT

The post mortem examination of the deceased was carried out on 2 March 2016 by Dr J White, Forensic Pathologist, PathWest Laboratory of Medicine WA.[61]

At post mortem examination Dr White noted the deceased as a young adult male, morbidly obese with some decompositional changes. The lungs were congested and the liver slightly fatty with granular kidneys. The heart appeared softened and dilated.

At that stage Dr White was unable to determine a cause of death for the deceased and organised a number of further investigations including histology, biochemistry, toxicology and a review of his medical history.

Following the results of some of those investigations, on 18 October 2016, Dr White determined an opinion the cause of death for the deceased was '*methylamphetamine effect and dehydration with renal impairment in a man with cardiomyopathy and morbid obesity*'.[62] Histology had confirmed her original physical findings at post mortem examination and toxicology revealed multiple prescription type medications as well as an alcohol level of 0.019% in the blood and an amphetamine level of 0.20mg/L.[63]

[61] Ex 1, tab 7
[62] Ex 1, tab 6
[63] Ex 1, tab 8

Dr White noted the deceased's past medical history included schizoaffective disorder with mental and behavioural disorder due to multiple substance abuse, sleep apnoea, hepatitis C, hypertension, high cholesterol and morbid obesity. The biochemistry results indicated renal impairment.[64]

Due to the number of drugs detected in the deceased's toxicology the opinion of Professor David Joyce, Physician, Clinical Pharmacology and Toxicology, was sought in an attempt to elicit the effect of the various drugs and their combinations upon the death of the deceased. An additional toxicology report targeting benzhexol was requested from the Chemistry Centre and was received by Dr White on 15 March 2017.[65]

Toxicology

On 21 April 2017 Professor Joyce provided a report to the OSC and Dr White outlining his review of the circumstances relevant to the death of the deceased.[66]

Professor Joyce noted the medical and mental health history of the deceased and the fact he had been located on 28 February 2016 at 1.38 pm on a bench in Fremantle and appeared intoxicated. The deceased was able to sit up, lay down and walk and was given water following which he appeared to fall in and out of consciousness.

[64] Ex 1, tab 7
[65] Ex 1, tab 9
[66] Ex 1, tab 10

The ambulance records began at 1.56 pm and recorded the deceased as having a weak pulse and pale dry skin with laboured breathing. He had to be moved by the ambulance crew and police and his GCS was still 13/15 indicating he was largely conscious. He was tachycardic with increased respiratory rate and an unobtainable blood pressure due to his obesity. His glucose was in the normal range and no body temperature was recorded. Within 10 minutes the deceased's GCS had dropped to 3/15, his pulse rate increased and his respiratory rate dropped. The ambulance record continued to show a decline in his condition and he was handed over to the emergency department at FSH at 2.36 pm.[67] It was noted the police reported he had taken at least one Viagra tablet in their presence and other tablets were found on his person. On arrival at FSH Professor Joyce noted the clinical record indicated no cardiac rhythm was detected and that resuscitation was not successful. Blood was not taken for screening at that time.

From that history Professor Joyce indicated the relevant facts were the early incontinence, apparent incoordination and altered consciousness, the rapid deterioration in his GCS, the subsequent rapid progression to cardiopulmonary collapse and respiratory and cardiorespiratory failure, with a history of the observed ingestion of at least one oral drug. The other point Professor Joyce noted was that the deceased's obesity presented problems to his treatment for the attending

[67] Ex 1, tab 11

officers, and the speed of his deterioration meant they were unable to gather the detailed information necessary for a precise clinical diagnosis on causation for his collapse.[68]

Professor Joyce noted the deceased's prescribed medications from his CFMHS were fluphenazine decanoate 100mg weekly injection, which is an antipsychotic, olanzapine 30mg daily also an antipsychotic taken orally, benzhexol (trihexyphenidyl, Artane) 5mg 2 b.d. prescribed to offset the side effects of his antipsychotics, atorvastatin 40mg daily to fight cholesterol, aspirin 100mg daily a blood thinner for his cardiac disease, enalapril 20mg daily for high blood pressure, gabapentin 600mg twice daily as a pain or neuropathic relief, paracetamol 500mg and codeine 30mg 1-2 tablets as needed for knee pain, effectively Panadeine Forte as an analgesic.[69]

It was apparent the deceased had also been prescribed glyceryl trinitrate (GTN patches) for angina, Viagra (sildenafil) and a concern had been raised by Dr Pyszora, as his treating psychiatrist, that some of these medications were contraindicated and unnecessary.

All his medical practitioners were aware of a history of the abuse of amphetamine type drugs and a smoking implement was recovered from his person after death.[70]

[68] Ex 1, tab 10
[69] t 01.03.18, p13-14
[70] Ex 1, tab 10

Professor Joyce noted the deceased had no lung disease other than congestion at post mortem examination, minimal atherosclerosis and no thrombosis and that the stomach did not indicate obvious tablet residual. Professor Joyce calculated the deceased's BMI as 51 kg/m^2.

Dr White's given cause of death on 18 October 2016 was before the benzhexol result had been obtained from the Chemistry Centre on 15 March 2017. Professor Joyce noted olanzapine was not detected in the post mortem bloods which one would have expected if he had been compliant with his prescribed dose. Benzhexol would not be expected to be listed unless a request it was specifically targeted had been provided.

Professor Joyce noted concerns with post mortem redistribution in altering the post mortem blood concentrations of various drugs depending upon the drugs or tissues in issue. He also considered the alcohol level recorded post mortem was probably due to post mortem artefact and did not support alcohol being present in life.[71]

Professor Joyce was not concerned at the level of paracetamol located in the deceased and believed it to be consistent with the ingestion of one to two tablets in the morning. The codeine and morphine levels found in the deceased's system were within the range which may be found post mortem in a

[71] t 01.03.18, p15

person regularly taking an analgesic such as Panadeine Forte. Professor Joyce suspected the morphine was through the metabolism of the codeine and at levels sufficient for managing moderate to severe pain. He considered they might cause minor depression of breathing which would not be a threat to the life of a healthy person, and the observations for the deceased at the time of his deterioration did not indicate suppression of breathing before his terminal collapse. Professor Joyce concluded the codeine and morphine probably did not play any material role in the deceased's death.[72]

With respect to the deceased's depot injection of fluphenazine decanoate, Professor Joyce stated the levels post mortem were consistent with his prescription of 100mg weekly, and noted that at that level it was probable the deceased had suffered an adverse effect by way of a dystonia (muscle spasm). Professor Joyce noted the deceased's prescription of benzhexol was a common one to counter the effects of dystonia and also, a rarer disorder of malignant neuroleptic syndrome. The deceased's history of benzhexol prescription made it less likely he was suffering malignant neuroleptic syndrome, although it did include signs of confusion, elevated temperature, muscle stiffness, tachycardia and cardiovascular collapse and death, some of which the deceased had displayed. Professor Joyce was not of the view

[72] t 01.03.18, p16

the current empirical evidence provided a good guide to fluphenazine poisoning.[73]

Professor Joyce stated the deceased's level of sildenafil was consistent with the observation he had ingested a single tablet of Viagra. It can lower blood pressure and may have contributed to the cardiorespiratory collapse, but Dr Joyce did not believe that was as significant as the effects of a number of other drugs identified at post mortem in the deceased's system.[74]

Professor Joyce considered the levels of phentermine present in the deceased's system were consistent with a prescription for weight control, however, the levels of methylamphetamine and amphetamine were consistent with the recent ingestion of a typically intoxicating dose of methamphetamine either orally, IV or by the inhalation of smoke. The levels could also be attributed to a larger amount taken some time earlier. To a naïve user the levels recorded would induce elevated mood, increased confidence, propensity to violence, risk taking, talkativeness, increased physical activity and maybe paranoia. The level of phentermine located may have served to increase the degree of stimulation from the methylamphetamines. On their own Professor Joyce did not believe that those levels would be a threat to life of a person with a healthy heart.

[73] Ex 1, tab 10
[74] t 01.03.18, p17

Professor Joyce was most concerned with the level of benzhexol (trihexyphenidyl, Artane) in the deceased's system. He described it as antimuscarinic drug used to reverse the side effects of drugs such as the deceased's depot injection. It was prescribed to the deceased for that purpose and his prescribed dose should have been 5mg twice a day (10mg daily). Professor Joyce noted the blood concentration in the deceased was approximately 20-times higher than he would have expected for a person taking that dose.[75]

In Professor Joyce's view it pointed to the ingestion of an excessive dose despite the possibility of other factors. He noted it was well above the serum concentration for patients hospitalised for benzhexol poisoning and within the range associated with a lethal outcome. The liver concentration for the deceased was slightly lower, but still within the range of the liver concentration for the only other reported case Professor Joyce could find for lethal benzhexol poisoning.[76]

Professor Joyce concluded *'The blood analysis in this case therefore points very strongly towards ingestion of an overdose of trihexyphenidyl. Trihexyphenidyl is a recognised drug for abuse, though its adverse effects are unpleasant enough to make it relatively unattractive one.'*[77]

[75] t 01.03.18, p16
[76] t 01.03.18, p18
[77] Ex 1, tab 10

Professor Joyce indicated its effects are similar to those of atropine or belladonna and signs of poisoning arise through its antimuscarinic (anticholinergic) effects in the brain and periphery. These include a dry mouth, confusion, sedation, gastrointestinal and bladder disturbances, muscular weakness and incoordination, elevated body temperature, disturbed vision, enlarged pupils, dry skin, flushing and accelerated heart rate, with death ultimately occurring through cardiovascular collapse, hyperthermia or seizures.[78]

Professor Joyce indicated that while the deceased's clinical evaluation was hindered by his build and his rapid deterioration, some of those signs were diagnostic of benzhexol poisoning. The deceased's obesity may have increased his risk of upper respiratory obstruction with impaired consciousness and contributed to his rapid cardiorespiratory collapse.

Professor Joyce was prepared to consider some environmental and medical factors may have explained the deceased's sudden collapse, but the overall circumstances did not provide for those as contributors other than poisoning and cardiac disease.

Professor Joyce believed the deceased's presentation, physical manifestations and rapid evolution to death were consistent with severe poisoning with an antimuscarinic

[78] t 01.03.18, p20

drug. The fact benzhexol had been detected in the deceased's blood and tissues at levels which indicated severe toxicity, with the risk of lethal outcome, were sufficient to conclude the deceased's benzhexol poisoning was severe enough to warrant inclusion in the deceased's cause of death.[79]

In addition, the deceased's previously unrecognised heart disease, the benzhexol and the amphetamine based drugs should all be included as playing a part in the deceased's rapid death. As a result of the additional toxicology screen and Professor Joyce's analysis, Dr White refined her cause of death for the deceased on 12 June 2017 as;

> '*Combined effects of trihexyphenidyl toxicity, amphetamine-type stimulants and dehydration with renal impairment in a man with cardiomyopathy and morbid obesity.*'[80]

Professor Joyce was quite clear the benzhexol levels at post mortem reflected that the deceased had taken an overdose of benzhexol.[81] Benzhexol was 20-times higher in the deceased's post mortem blood than one would expect at the alleged dosages of 5mg b.d. This supported benzhexol had been taken in substantial overdose and one would expect toxicity from that level of drug in the system.[82]

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[79] t 01.03.18, p21
[80] Ex 1, tab 7
[81] Ex 1, tab 10
[82] t 01.03.18, p16

In evidence Professor Joyce clarified the difficulty raised by Dr Pyszora in her communication with Dr Wood as to the prescription of Viagra and glyceryl trinitrate patches. When given together they can lower a person's blood pressure excessively which is of particular concern with people who have obstructed coronary arteries (minimal in deceased's case)[83] resulting in angina and heart attacks. Due to the fact the glyceryl trinitrate had not been targeted for the deceased's post mortem toxicology it was impossible to say whether he had been taking it.[84]

The levels of amphetamine in the deceased's system post mortem indicated he was suffering intoxication with the potential for causing abnormal cardiac rhythms and other indicia of toxicity, especially in a person with underlying heart disease and other drugs causing cardiotoxicity. That, plus his morbid obesity, had cardiovascular effects.[85]

There are limited reported liver concentrations for benzhexol toxicity, however, the targeted analysis indicated a very high concentration, approaching a concentration from a verified benzhexol death.[86] Any stimulant drugs should be avoided with people who have cardiac conditions.[87]

[83] Ex 1, tab 5
[84] t 01.03.18, p14
[85] t 01.03.18, p17
[86] t 01.03.18, p18
[87] t 01.03.18, p19

The fact the post mortem examination disclosed the deceased's undiagnosed cardiomyopathy indicated the deceased was susceptible to the toxic effects of the drugs which were located in his system. People with cardiomyopathy are more likely to experience abnormal lethal rapid rhythm disturbances in the presence of stimulant drugs such as methylamphetamine and benzhexol which increased the susceptibility for an arrhythmia.

5mg of benzhexol twice daily was a conventional prescribed dose in Professor Joyce's view, however, 10mg benzhexol twice daily was high. Nevertheless, the deceased's post mortem levels indicated an overdose regardless of the prescription.[88]

CONCLUSION AS TO THE DEATH OF THE DECEASED

I am satisfied the deceased was a 36 year old male on a disability pension whose finances were controlled by the Public Trustee. He had a diagnosis of schizoaffective disorder and mental and behavioural disorder due to multiple substance abuse. He was in denial over his mental health issues and his behaviour could be very difficult to manage.

The deceased was managed under the Mental Health Act by way of inpatient admissions and CTOs managed by CFMHSs. His supervising psychiatrist while subject to a CTO over the last few years was Dr Natalia Pyszora, with Iain Hindle as his

[88] t 01.03.18, p23

case manager, with whom he had a good rapport. His regular GP in the community was Dr Ian Wood.

The deceased had a number of physical medical conditions in addition to his psychiatric issues and these were generally dealt with by his GP in the community, although it appears the deceased was also receiving prescriptions from the street doctor and possibly others unbeknown to his GP. While an inpatient the deceased's medications, both psychiatric and physical, were dispensed by the facility in which he was a patient, generally ASC.

Due to concerns with the difference in prescribing outcomes between the deceased's mental health carers and his general practitioners a letter had been written by his supervising psychiatrist to Dr Wood on 6 July 2015 outlining his CFMHS team's concern with the deceased's tendency to abuse medication and seek medication which was unnecessary. The letter did not mention benzhexol specifically. Dr Pyszora implied Dr Wood could communicate with the team so they could work together in providing the best medical care to the deceased in all the circumstances. She also informed Dr Wood the deceased was thought to use the street doctor.

Dr Wood did not respond to Dr Pyszora's letter, but believed he took note of its contents when prescribing for the deceased concerning medication which may affect a cardiac condition.

Dr Wood next prescribed benzhexol for the deceased on 15 August 2015 and maintained his prior prescription of 5mg 2 b.d. to be dispensed with 100 tablets every 25 days. Professor Joyce considered this to be a very high prescription. Dr Wood did not discuss it with CFMHS before prescribing. It was the amount the deceased had been prescribed by Dr Wood consistently to treat his tardive dyskinesia, although Dr Wood had restricted the dispensing to 100 tablets every 25 days. This meant on 15 August 2015 the deceased had available to him 100x5mg tablets of benzhexol.

The deceased was readmitted on 26 August 2015.

The deceased's involvement with illicit drugs and the abuse of prescription medication, which provided him with some effects similar to, or enhanced the effects, of those of illicit drugs while in the community, made it very difficult for those interested in managing his behaviours to ensure he was medication compliant.

The deceased lived alone and although his family were supportive of his situation, there were difficulties as a result of his behaviour which interfered with the care his family were able to provide him, despite their being supportive of his situation and his treating physicians.

During the deceased's last admission to ASC in late 2015 the physicians, in conjunction with his treating CFMHS team,

were able to stabilise the deceased and wean him from all unnecessary medications. By the time he was again discharged on a CTO under the supervision of Dr Pyszora his prescribed medications consisted of an oral dose of olanzapine daily dispensed by ASC triage and weekly home visits by CFMHS for his depot medication, fluphenazine decanoate. His dose of benzhexol had been reduced to 5mg twice daily and he was provided with 14 tablets on discharge to last him a week. The intention was that following that week he would not be provided with further benzhexol, or certainly not at a rate readily open to abuse.

A discharge letter outlining the reduction and refining of the deceased's antipsychotics was provided to Dr Wood to ensure that when he was prescribing medication related to the deceased's mental health care he was aware of the intention of the deceased's CFMHS team's management of his medications.

Also discussed between the deceased, his CFMHS team and his family prior to discharge from ASC was a plan to apply to SAT for a guardianship order for the deceased. He was already subject to the Public Trustee managing his finances, in part to limit his access to illicit drugs, but the intention was a SAT guardianship order would also allow control over his medical prescriptions. This had not been finalised prior to the deceased's death.

I note the discharge summary for the final admission provided to Dr Wood does not include the plan to apply for a guardianship order for the deceased.

Following the deceased's discharge on 14 December 2015 he attended Dr Wood on 16 December 2015 and was provided with a script for benzhexol at '5mg 2 b.d. pick up 100 every 25 days'.[89]

The deceased's discharge letter specified benzhexol was to be ceased and that the deceased had been provided 14x5mg tablets to last him a week on 14 December 2015. If the deceased needed them to control his tardive dyskinesia it would imply he had used 14 tablets in two days.

There is no indication of when the discharge letter was sent or when Dr Wood received it.

The prescription of 16 December 2015 does not take into account the deceased should still have had benzhexol tablets, nor does the prescription indicate any reduction from his pre-admission prescription by Dr Wood. The dispensing directions do imply Dr Wood was attempting to restrict the deceased to 20mg per day, but not reducing the availability of the medication overall. Dr Wood did not attempt to discuss this with the deceased's treating CFMHS team.

[89] Ex 1, tab 25C

I can only assume Dr Wood had not received or was not aware of the discharge letter from ASC on 16 December 2015 when he prescribed at the old rate of 5mg 2 b.d. 100 every 25 days. However, it does indicate that almost immediately following his discharge from ASC the deceased was again receiving a high dose of benzhexol from discharge. His exposure to benzhexol was not decreased following discharge.

Following the deceased's discharge from ASC and until his death on 28 February 2016 the deceased continued to attend ASC on most dates for his daily dispensation of olanzapine and was visited at home for his depot injection with review. Dr Pyszora continued to see the deceased on a monthly basis. Due to the CTO the deceased's case was being reviewed periodically by the Mental Health Review Board, and in Dr Pyszora's absence, he was seen by the CFMHS psychiatric registrar to ensure his continued appropriate medication with antipsychotics. His CTO was varied according to his compliance.

The deceased next saw Dr Wood on 23 February 2016 when he was again prescribed benzhexol at 5mg x 2 tablets twice daily, 100 to be picked up every 25 days. In evidence Dr Wood said this was as a result of the deceased appearing to have tardive dyskinesia in the form of a flickering tongue. Dr Wood indicated when the deceased came to see him he noticed the spasm and asked the deceased how he was going

and therefore wrote the script.[90] Dr Wood stated that at the review on 23 February 2016 the deceased had actually asked for the benzhexol.[91]

This meant the deceased likely had a new supply of 100x5mg tablets when seen by the CFMHS at his review on 24 February 2016. Dr Bennett and Mr Hindle noted the deceased presented as reasonably bright, alert and reactive, but was suspected of being intoxicated with THC.

The deceased informed them he had obtained prescriptions from Dr Wood, including benzhexol, and he advised them it was '*because it helps him with shaking from the medication*'. This supported Dr Wood's evidence he was concerned the deceased was suffering tardive dyskinesia on 23 February 2016, when he added a note to the record in April 2016, post the deceased's death. It does not account for the letter from Dr Wood advising the OSC he was prescribing in accordance with the discharge notice, which in evidence Dr Wood indicated was an error on his behalf.[92]

This would indicate that in the following days, assuming the deceased filled his prescription in accordance with his advice to CFMHS on 24 February 2016, the deceased had available a fresh quantity of benzhexol to abuse if that was his intention. Dr Wood agreed benzhexol could be used as a drug

[90] t 01.03.18, p58
[91] t 01.03.18, p55
[92] t 01.03.18, p57

of abuse, but it was part of the deceased's treatment regime from him for over six years, mostly at that level.

I appreciate Dr Wood was unaware of the contribution of benzhexol to the deceased's death until he attended court on 1 March 2018.[93] Until then he had believed illicit drug use to be responsible for the death of the deceased.

I am satisfied that on 28 February 2016 the deceased used his supply of benzhexol, prescribed and dispensed with the intention it lasted him for 25 days, to overdose as part of his abuse of prescription medications. This was a known problem with the deceased and something which his CFMHS had attempted to avoid.

Professor Joyce described how overdose with benzhexol produced results that are mildly similar to the amphetamine based drugs and, in conjunction with those drugs, can magnify the euphoric effects. The deceased had evidence at post mortem examination of the use of methylamphetamine in his system, although not at an excessive amount.

Professor Joyce was clear to point out the deceased's underlying cardiac disease increased his susceptibility to the toxic effects of drugs such as benzhexol and amphetamines. Underlying cardiac disease, especially the cardiomyopathies, increased the drug effect. Professor Joyce stated that people

[93] t 01.03.18, p62

with cardiomyopathy, without drug exposure, are more likely to suffer abnormal lethal rapid rhythm disturbances. The addition of stimulant drugs increased that likelihood. The cardiomyopathy alone or the drugs alone may have been survivable, but the two together in the deceased's case provide a very probable explanation for his death.[94]

Dr Wood confirmed he knew of the deceased's use of amphetamines, but stated he did not know how often that occurred, and the benzhexol did treat the deceased's tardive dyskinesia.[95] He understood the concern raised by Dr Pyszora over the prescribing of some other medications in a person with ischaemic heart disease, but as far as he was aware the deceased did not have ischaemic heart disease. Dr Wood was careful about which medications he prescribed at the same time, however, due to the fact the deceased was overweight and had high blood pressure.[96]

I am satisfied the combination of the drugs the deceased had in his system explained his death on 28 February 2016 in combination with his co-morbidities. I am satisfied it was an intentional abuse of both illicit drugs and prescription medications, but there is no evidence the deceased intended to take his life.

[94] t 01.03.18, p21
[95] t 01.03.18, p62
[96] t 01.03.18, p64

The evidence indicated the deceased was used to abusing both illicit drugs and prescription medication and just continued as normal despite the efforts of his CTO supervising practitioners to restrict his access to unnecessary medication. His antipsychotic medication was necessary and Professor Joyce believed the level at which it was necessary warranted the use of benzhexol for any resulting dystonia. The level prescribed by Dr Wood was high, but in Dr Wood's view was one the deceased had tolerated well over a long period. It is clear the deceased abused even that level, unknown to Dr Wood.

MANNER AND CAUSE OF DEATH

I am satisfied the deceased died as the result of his underlying pre-existing morbidities in combination with intentionally overdosing on his prescription benzhexol obtained from Dr Wood on 23 February 2016. In addition to overdosing on his antimuscarinic medication, he was also using illicit drugs in conjunction with his prescribed antipsychotics. There is no evidence he intended to die.

I find the cause of the deceased's death was the effects of benzhexol (trihexyphenidyl) overdose and amphetamines on the deceased's natural physiology which included cardiomyopathy, high blood pressure and morbid obesity.

I find death occurred by way of Accident.

SUPERVISION, TREATMENT AND CARE

The opinion of Dr Anthony Mander, an independent consultant psychiatrist, was sought by the OSC in an attempt to review the deceased's supervision, treatment and care while under a CTO supervised by Dr Pyszora and the CFMHS at the time of his death.[97]

Dr Mander pointed out there were three main issues he assessed when reviewing the care provided to the deceased. He stated it was necessary in the case of a patient such as the deceased, that his care was delivered assertively because he had no insight and was unable to appreciate the destructiveness of his own conduct.

Dr Mander was particularly careful to overview the care provided by the CFMHS on the CTO following the deceased's discharge from ASC on 14 December 2015, through to his death in February 2016. The team needed to be aware of the deceased's complicated medical history, which involved both physical problems and their appropriate treatment in conjunction with the appropriate treatment for his mental health issues, taking into account his unpredictable compliance with attempted care.[98]

In addition there is the requirement under the Mental Health Act that any treatment provided to a mental health patient is

[97] Ex 1, tab 22
[98] t 01.03.18, p5

in the least restrictive manner possible and so allow patients to live their lives as normally as possible while still attempting to manage their behaviours for their own and community safety.[99]

It was for these reasons Dr Pyszora and the deceased's CFMHS team had put in place a very strict regime with respect to the deceased's antipsychotic medication including daily dispensation of olanzapine from ASC triage, in itself a very unusual condition, and weekly reviews when providing his depot medication. In this way they had attempted to manage his mental health issues, while relying on his GPs to provide his appropriate physical medical care.[100]

Dr Wood had been the deceased's GP for eight years and was aware of his admissions to psychiatric facilities because he had been provided with discharge letters from those facilities. Dr Wood felt less aware of the deceased's CFMHS team due to the fact he had not been incorporated into the team concept until he received the letter from Dr Pyszora on 6 July 2015. He believed this was the first, and only, time they had attempted to engage him in care of the deceased.[101]

The complaint of a lack of inclusion of GPs in specialist care until critical is a known concern of many GPs appearing in this court. Access to a real time prescribing electronic data

[99] t 01.03.18, p6
[100] t 01.03.18, p7
[101] t 01.03.18, p54

system for all prescription medication would assist providers of medical care in complex cases where there can be constant tension between necessary medications for optimal management.[102]

On receipt of the letter of 6 July 2015 Dr Wood did not engage with the CFMHS, but believed he took their concerns into consideration when he was prescribing for the deceased following that letter, which did not refer to benzhexol but other medications for other conditions.

The issue specifically of the prescription of benzhexol did not directly arise until the discharge letter from ASC on 14 December 2015. By then the deceased's normal prescription from Dr Wood was for 5mg x 2 b.d., dispensed as 100 tablets every 25 days. It is not clear Dr Wood had seen that discharge letter when he prescribed at his usual rate on 16 December 2015, although he agreed he had seen the discharge letter at some time.

The deceased was not attending Dr Wood exclusively which would have made his compliance difficult to assess. The specific request for benzhexol at that level on 23 February 2016 may have seemed reasonable in view of Dr Wood's prior prescriptions and assessment the deceased was suffering tongue spasms. He had not seen the deceased since

[102] t 01.03.18, p28

16 December 2015 and did not know the deceased abused benzhexol, because he did not seem to be over prescribing.

However, the discharge letter in December 2015 had referred to the intention to cease the deceased's benzhexol and it would have been preferable Dr Wood engage with the deceased's CTO supervising CFMHS in February 2016 over the deceased's need for antimuscarinic drugs. Providing someone such as the deceased with access to a medication which could be abused, even a restricted supply, should have been done as part of a team assessment, especially as Dr Pyszora was reviewing him monthly.[103]

Nevertheless, it is clear Dr Wood had good engagement with the deceased which made it important Dr Wood contributed as far as possible to the attempts in the community to supervise the deceased. He had restricted the dispensing of benzhexol in December 2011 by providing a restricted dispensing regime.[104] However, that still had the potential for abuse, and history has indicated it clearly was abused.

I am satisfied the deceased was an extremely difficult proposition and there was little alternative to a CTO, other than continued hospitalisation. The efforts the deceased's CFMHS undertook in an attempt to protect the deceased from

[103] t 01.03.18, p30
[104] Ex 1, tab 25C

himself were as extreme as they could be without continuous undesirable admission.[105]

In hindsight more could have been done to engage his medical practitioners in the community. I am unclear as to whether this would have changed the final outcome for the deceased who had clearly taken amphetamine based drugs as well as benzhexol at the time he died.

Dr Mander was of the view the deceased's treating CFMHS provided a high standard of care, and indeed Dr Wood commented himself in evidence the deceased was difficult to care for and he thought his community CFMHS had done a very good job.[106]

I am satisfied the supervision, treatment and care the deceased received from his CFMHS while subject to a CTO in the community was of a high standard in all the circumstances with respect to the deceased.

Reference to a Disciplinary Body

With respect to Dr Wood's conduct, specifically his failure to engage with the deceased's treating CFMHS team following Dr Pyszora's letter of 6 July 2015, I decline to refer Dr Wood to his supervising disciplinary body despite the submissions of counsel.

[105] t 01.03.18, p33
[106] t 01.03.18, p64

I accept his prescription for benzhexol at 20mg per day was high, and that of 23 February 2016 probably contributed to the deceased's death on 28 February 2016. However, it was at a level Dr Wood understood the deceased had consistently required in the past to control his dystonia and Dr Wood had no evidence the deceased had been abusing that prescription.

On the day of the deceased's death it is evident the deceased had taken a variety of medication, not all prescribed by Dr Wood on 23 February 2016, and illicit amphetamine based drugs, all of which contributed to his death by lethal cardiac rapid rhythm disturbance.

E F Vicker
Deputy State Coroner
31 August 2018