CORONERS COURT OF THE AUSTRALIAN CAPITAL TERRITORY

Case Title:	**AN INQUEST INTO THE DEATH OF PAUL FENNESSY**
Citation:	**[2016] ACTCD 4**
Hearing Date(s):	30 November, 1 and 2 December 2015
Date of Findings:	16 December 2016
Before:	Coroner Hunter
Legislation Cited:	*Coroners Act 1997* (ACT) *Mental Health (Treatment and Care) Act 1994* (ACT)
Cases Cited:	*Onuma v The Coroners Court of South Australia* [2001] SASC 218 *Briginshaw v Briginshaw* (1938) 60 CLR 336 *WRB Transport v Chivell* [1998] SASC 7002 *R v Doogan* [2005] ACTSC 74 *Conway v Jerram* [2011] NSWCA 319 *Re State Coroner; ex parte Minister for Health* [2009] WASCA 165 *Matthews v Hunter* [1993] 2 NZLR 683
Appearances and Representation:	Ms Amanda Tonkin of Counsel as Counsel Assisting the Coroner. Mr Dan Crowe of Counsel for the Australian Capital Territory, instructed by the ACT Government Solicitor. Mr James Sabharwal of Counsel for Ms Finlay. Mr Robert Clynes of Counsel for Drs Robinson and Lawrence, instructed by Ms Lara Mynott of Moray and Agnew Mr Wayne Sharwood of Counsel for Mr Bailey, instructed by Mr Andrew Freer of KJB Law. Mr Mark Barrow of Ken Cush and Associates for Dr Shannon Craft.
File Number(s):	CD 11 of 2010

CORONERS ACT 1997

IN THE CORONERS COURT
AT CANBERRA IN THE
AUSTRALIAN CAPITAL TERRITORY

FINDINGS

An INQUEST having been held by me, **MARGARET ANNE HUNTER,** a Coroner for the Territory, including a hearing conducted at the Coroner's Court at Canberra in the Territory, into the death of:

PAUL FENNESSY

I find that Paul Fennessy born in September 1988, died outside and adjacent to the northern perimeter fence of 2 Zeal Place, Holder, in the Australian Capital Territory at 23:15 hours on 6 January 2010.

I further find that the cause of his death was the combined effect of a cocktail of drugs taken by him, which caused central nervous system depression and respiratory depression leading to positional asphyxia.

I further find that a matter of public safety arises in relation to Mr Fennessy's death, as further detailed in my reasons.

I make the following recommendations:

1. That the ACT Government implement DAPIS and adapt the real time monitoring system know as DORA.

2. That all medical files, including mental health records, in relation to a patient being treated at a Canberra Public Hospital be made available to all clinical staff at the hospital when required.

DATED this **16th** day of **December, 2016.**

M. A. HUNTER OAM

CORONER

CORONER HUNTER:

1. I, Coroner Margaret Hunter, find that Paul Fennessy born in September 1988, died outside and adjacent to the northern perimeter fence of 2 Zeal Place Holder in the Australian Capital Territory at 23:15 hours on 6 January 2010.

2. I further find that the cause of his death was the combined effect of a cocktail of drugs taken by him, which caused central nervous system depression and respiratory depression leading to positional asphyxia.

Jurisdiction

3. A coroner must hold an inquest into the manner and cause of death of a person who "dies violently, or unnaturally, in unknown circumstances": see section 13 (1)(a) of the *Coroners Act 1997* (ACT) ("the Act").

4. Paul Fennessy comes within my jurisdiction given that he died unnaturally on 6 January 2010.

Circumstances

5. Mr Fennessy came to the attention of health professionals after an incident where on 14 December 2007 he was picked up for what was deemed to be bizarre behaviour and which ultimately was diagnosed as drug induced psychosis. Between 2007 and 2010 when he died, Mr Fennessy had come to the attention of medical professionals from The Canberra Hospital, Calvary Hospital, the ACT Mental Health Crisis Assessment Team, and his general practitioner, as well as a number of other general practitioners.

6. The focus of the inquest is primarily on the last few days of Mr Fennessy's life, however an examination of his drug addiction issues prior to that time is important and provided a causal nexus between his addiction problems, his failure to address that addiction, and ultimately his death.

7. I have had the benefit of a chart provided by Counsel Assisting which documents the date prescriptions were given to Mr Fennessy, the date it was dispensed, the drug, the quantity, the doctor who prescribed it, and the chemist who dispensed it. The document commences on 14 December 2007 and concludes on 1 January 2010. There are 18 different prescribers between these dates. There are at least 18 dispensing chemists used by Mr Fennessy in that period. Mr Fennessy is recorded as having had at least four overdoses in 2009 despite undergoing detoxification programs and management of his drug issues. It was clear from the evidence that his detoxification was marred by his inability to accept the rules in relation to bringing drugs into the detoxification and rehabilitation facilities, with the result that he was discharged

without completing his rehabilitation. This behaviour explains his discharge from Karralika in December 2009. On that occasion he presented at the Calvary Hospital Emergency Department after overdosing on drugs.

8. In January 2010 Mr Fennessy presented on two occasions to the Emergency Department of The Canberra Hospital. The first presentation was because Mr Fennessy had ceased his medication and believed he was hallucinating and that he had had seizures. The second occasion arose as a result of a drug overdose where he was found unconscious and not breathing, whereupon he was resuscitated and admitted to The Canberra Hospital. It was later on, after he left the hospital, that he was found deceased.

9. An autopsy was performed by Dr Jain, Associate Professor of Pathology and Director of ACT Pathology. Dr Jain produced a report which was exhibited in the proceedings.[1] Dr Jain also sent samples for toxicology. The toxicology report which is attached to his autopsy report indicated at least seven different medications, a number of which were at levels in Mr Fennessy's blood with toxic effect.

10. In my view the issues for determination are those as set out in Council Assisting's submissions. They are:-

    (a) The ease with which Mr Fennessy gained access to prescription drugs;

    (b) Whether Mr Fennessy should have been discharged from the Canberra Hospital on 6th January 2010; and

    (c) Whether he was given a double dose of methadone hours before he died.

The Oral Evidence

Detective Sergeant Simon Jones Coady

11. Detective Sergeant Simon Coady gave evidence before me on 30 November 2015. Sgt Coady was the investigating officer tasked with investigating the death of Paul Fennessy. Sgt Coady provided a statement which was exhibited as Exhibit 8. As part of the investigation he collected various documentary materials which were tendered. I received documents such as identification of the deceased Paul Fennessy, a life extinct certificate, photographs of the deceased in situ, a map indicating the whereabouts of the deceased, together with an autopsy report under the hand of Dr Sanjiv Jain. I also received a letter from Ms Finlay, Mr Fennessy's mother, to Coroner Dingwall, and a police recorded conversation with Ms Finlay. I also received a statement from Dr

[1] Exhibit 5.

Robinson, three volumes of documents said to be the coronial brief exhibited as Exhibit 14, 15 and 17, a statement from Jillian Hughes and documents dated 7 September 2010 exhibited as Exhibit 18.

12. Sgt Coady gave a description of what he found at 2 Zeal Place that evening. He noted that the body was warm to the touch with rigor mortis and lividity consistent with its position. It is clear that Mr Fennessy's head was down on his chest which is consistent with Dr Jain's finding of positional asphyxia.[2]

13. Sgt Coady examined a bag found with Mr Fennessy, which contained amongst other things what appeared to be a used syringe and needle. The plunger was retracted and there was blood visible. He also noted there was a blister pack of Gabapentin and opined that it was a chronic pain reliever. Sgt Coady explained that it was the ambulance officers who attended the death scene who told him what Gabapentin was. I note Gabapentin is an anticonvulsant and is used to treat neuropathic pain as well.[3]

14. Sgt Coady examined the area where Mr Fennessy was found and opined that there was nothing found that was indicative of foul play. Dr Catherine Sansum attended and examined Mr Fennessy and noted lividity was consistent with the position of Mr Fennessy's body. Dr Sansum also noted puncture marks consistent with intravenous drug administration. Dr Sansum opined that these marks could be consistent with intravenous drug administration. I note that some few hours before his death Mr Fennessy was admitted to the Emergency Department of The Canberra Hospital and had a cannula inserted. **However I am satisfied that it is likely Mr Fennessy injected himself given the used syringe and the tourniquet found in the bag**. Dr Sansum pronounced life extinct and signed the certificate of death.

15. Sgt Coady summarised the conversation Police had with Ms Finlay. Ms Finlay said that she last saw Paul at approximately 6.30 p.m. on 6 January 2010 at her home in Holder. She told police that her son appeared to be under the influence of drugs and she asked that he leave her house. She saw him leave walking down Cardew Crescent towards De Graff Street.

16. Ms Finlay gave Police information as to her family's origins and when they arrived in Australia. Ms Finlay told Police that Paul left school in 2007 after completing his high school certificate however he was unable to hold any permanent employment since that time. Prior to his death Paul was also unable to secure and hold any residential address and he would stay with his mother or sister at various times.

17. Ms Finlay told Police that Paul had moved out of the family home and moved into the Karralika rehabilitation program, but he was discharged from the

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[2] Transcript p12.
[3] Transcript p12.

program on 23 December 2009 due to an allegation he was in possession of disallowed medications. Ms Finlay said this was not uncommon and Paul had been removed from other shelters and programs for similar reasons. Following his discharge from Karralika Paul moved into Samaritan House however again he was evicted for inappropriate behaviour. It was Ms Finlay's view that Paul suffered from a long history of mental illness, including depression and anxiety, and was at the time a patient of ACT Mental Health and ACT detox and withdrawal services.

18. Ms Finlay advised that Paul had suffered serious burns when a gas bottle ignited. He was treated in Concord Burns Unit for burns suffered as a result of the explosion.

19. In relation to Paul's use of alcohol and prescription drugs Ms Finlay described Paul as a heavy user of both alcohol and prescription drugs, and said that Paul would also use heroin and ice almost daily. Ms Finlay said that Paul commenced drug and alcohol use at the age of 14 and over the years had a history of self harm and had been admitted to The Canberra Hospital for that reason.

20. Ms Finlay also told Sgt Coady that Paul had been admitted to The Canberra Hospital on 6 January 2010 with a serious overdose and was treated with Narcan intravenously on two occasions. He was seen by medical staff and was to see the Mental Health team. She advised that Paul was to see the drug and alcohol counselling service the next day.

21. Ms Finlay advised Police that her son was a 'doctor shopper' and would attempt to acquire prescriptions from doctors in order to increase his medication. She was aware that he was on several medications for depression and sleeplessness. She was also aware that he had seen Dr John Robinson at the Phillip Medical Centre prior to his death, and that he had attended Isabella Plains Medical Centre. Ms Finlay opined that Paul had a significant drug and alcohol problem and had overdosed at least three times in the last three days prior to his death.

22. Sgt Coady gave evidence of a conversation he had with Susan Ellis, who found Mr Fennessy deceased on 6 January 2010. Ms Ellis stated that she advised the residents of 2 Zeal Place and she and the residents walked out to where Mr Fennessy was situated. Neither Ms Ellis nor the residents of 2 Zeal Place touched Mr Fennessy, but he did not respond to their calls.

23. Sgt Coady said that he walked from Zeal Place to Cardew Crescent and it was about 200 metres. Ms Finlay lives at Cardew Crescent and Sgt Coady said it took him two minutes to walk that distance. Sgt Coady offered Ms Finlay the opportunity to identify Paul's body the next day however she insisted that she identify him that evening at the place where he died. Sgt Coady delivered Ms

Finlay to that area where she identified Paul as being her son and signed the certificate identifying him.

24. Sgt Coady also indicated that he made contact with ACT Mental Health and requested the records in relation to Paul Fennessy. Several days later he received the Mental Health records, as well as the Drug & Alcohol records. Sgt Coady summarised the records as describing a significantly long history of treatment for drug and alcohol abuse, poly-substance abuse, depression and anxiety disorders related to that abuse. He also noted that Mr Fennessy had been hospitalised on numerous occasions for overdoses and that he had attended residential care over a period of time.

25. Sgt Coady advised that Mr Fennessy came to the attention of ACT Mental Health in December 2007 when he was reported missing by his mother. Mr Fennessy was later found by police wandering the streets exhibiting bizarre behaviour and appeared to be under the influence of drugs and alcohol.[4] Mr Fennessy admitted that he had used illicit drugs and it appeared that he displayed symptoms of psychosis and delirium as a result of that drug abuse. Mr Fennessy was admitted to the PSU for two nights and was discharged on 16 December 2007.

26. Mr Fennessy next came to the attention of ACT Mental Health on 23 December 2008 when he presented with symptoms of a psychotic illness. This was considered to be due to his drug and alcohol abuse. On this occasion Ms Finlay refused his admission to her home and police took him to the Emergency Department of The Canberra Hospital where he was examined by mental health workers and later released after being deemed not to be at risk.[5]

27. On 28 March 2008 Mr Fennessy was admitted to The Canberra Hospital after an overdose of Clonazepam. Mr Fennessy it is alleged told workers that he had increased his use of opiates and stated that "he would take anything". It seems Mr Fennessy was oblivious to the risk associated with this drug and was not concerned about his welfare or the consequences of his drug use. Reports show that the medical opinion was that he displayed no sign of psychosis or intention of self harm, however based on his persistent drug use he would continue to be at risk of accidental drug overdose.

28. Over this period of time there were numerous meetings held by medical professionals, Mr Fennessy and also his mother in relation to options for Mr Fennessy rehabilitation. Mr Fennessy said at the time he was keen to undertake and willing to attend rehabilitation. Mr Fennessy moved into Odyssey House and commenced treatment there, but on 7 June 2008 he and his partner were brought to The Canberra Hospital after an apparent suicide

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[4] Transcript p21.
[5] Transcript p21.

attempt. It was revealed that he had injected Seroquel and Avanza and had taken heroin orally. Mr Fennessy was admitted for further assessment and was discharged on 11 June 2008. The medical staff identified that Mr Fennessy had no suicidal ideation however again commented that he presented as an ongoing risk of misadventure due to his drug use.[6]

29. On 9 December 2008 Mr Fennessy was admitted to The Canberra Hospital for an overdose after being found unconscious outside a shopping centre in Phillip.[7] After being assessed it was considered that this was again an accidental overdose rather than self harm.

30. On 9 December 2008 Mr Fennessy was again admitted to The Canberra Hospital for suspected overdose of opiates.[8] On 25 May 2009 Mr Fennessy overdosed on heroin and required Narcan treatment.[9] On that occasion he received no other treatment but was to be monitored by the Crisis Assessment Team (CATT). Mr Fennessy continued to be treated for poly-substance abuse during that time. Mr Fennessy presented to medical practitioners with sleeplessness and depression, however Sgt Coady said there was little evidence to support Mr Fennessy's assertion.[10]

31. In September 2009 Mr Fennessy was involved in a gas bottle explosion and sustained significant burns to his arms and face. On 1 November 2009 Mr Fennessy was admitted to the PSU after a poly-substance overdose. Mr Fennessy stated to medical staff that he was homeless, he was in chronic pain after suffering the burns, and his mother did not want him and he had overdosed. Mr Fennessy was discharged on 6 November 2009 after being cleared of any further risk of self harm.

32. On 23 December 2009 Mr Fennessy discharged himself from Karralika. It was considered that Mr Fennessy may have been burning his arms so that he could access prescription drugs. On 24 December Mr Fennessy was assessed by the CAT team who identified that Mr Fennessy suffered from the effects of poly-substance abuse but there was no co-morbid psychiatric symptoms identified.[11]

33. On 2 January 2010 Mr Fennessy was evicted from Samaritan House for drug use. On 3 January Mr Fennessy attended The Canberra Hospital and requested to be admitted and return for rehabilitation. It was agreed by Hospital staff that Mr Fennessy could remain in the waiting room for the night

[6] Transcript p22.
[7] Transcript p22.
[8] Transcript p22.
[9] Transcript p22.
[10] Transcript p22.
[11] Transcript p23.

so that accommodation could be sought the next day. Mr Fennessy remained in the waiting room until the next morning.[12]

34. At approximately 2:30 pm on 6 January 2010 Mr Fennessy was bought in to The Canberra Hospital by ACT Ambulance Service following an overdose. Mr Fennessy had overdosed on methadone, benzodiazepine and heroin. The history was that Mr Fennessy was found by friends not breathing and was given CPR, and ambulance was called upon arrival the ambulance officers administered Narcan to Mr Fennessy. Mr Fennessy was stabilised and transported to The Canberra Hospital.

35. At 5:39 pm that afternoon Mr Fennessy was medically discharged and he was released. Mr Fennessy had told staff that he did not intend to overdose and had miscalculated the drugs he took.[13] Mr Fennessy told staff he wanted to go into rehabilitation and agreed to attend an appointment the next day with the Drug & Alcohol Service at 3 pm. Unfortunately Mr Fennessy died that evening.

36. Ms Finlay told Sgt Coady that in her view the overdoses were attempts at suicide. The view of the CAT team was that they were not able to identify any suicidal ideation or psychiatric problem which required intervention.[14] The medical notes from the CAT team reveal that although Mr Fennessy had a lengthy history of drug overdoses and follow-up from the team, the results of those follow-ups were consistent in that they did not identify any suicidal ideation on each of the occasions where Mr Fennessy had overdosed.

37. On the night of his death Ms Finlay described Mr Fennessy as being heavily under the influence of prescription drugs and it was for that reason that she asked him to leave that night. Mr Fennessy walked 200 metres away from his home into an area that was dark and when no persons would naturally be around or observe him and be in a position to render first aid. As a result Mr Fennessy died as a result of the overdose of prescription drugs and methadone.[15]

38. Sgt Coady advised that Mr Fennessy had some involvement with police and there were four active alerts for Mr Fennessy on the system for drug use and self harm.[16]

39. Sgt Coady gave evidence that on 5 January 2010 Mr Fennessy attended the Woden Priceline Pharmacy and presented a prescription for Rivotril. Rivotril is only prescribed by one doctor in the ACT. That doctor was alerted by the

[12] Transcript p27.
[13] Transcript p23.
[14] Transcript p23.
[15] Transcript p23.
[16] Transcript p24.

pharmacist and it was confirmed that Mr Fennessy had not been prescribed this medication and that the script was a forgery.[17]

40. Sgt Coady gave evidence from the hospital records of 6 January 2010 that Mr Fennessy was brought in by ambulance after having 2 doses of 400 mg of Narcan and was admitted at 1 pm. At 1:15 pm Mr Fennessy requested to leave the hospital however staff negotiated with him so that he remained. He was reviewed and considered not medically fit to be released and at 2:35 pm he was advised he should remain in the Emergency Department for further observation.[18]

41. Mr Fennessy remained in the Emergency Department and at 4:45 pm Mr Fennessy again requested to leave stating he felt trapped. Having been observed for some four hours and considering the context in which the medical staff operate and are bound,[19] it was Sgt Coady's conclusion that medical staff had acted professionally particularly given the two requests to leave. That conclusion was based on the fact that Mr Fennessy was kept under observation until he was medically cleared for release.[20]

42. Sgt Coady stated that in Ms Finlay's letter she asked why had staff failed to question Mr Fennessy after he indicated that he intended to pick up a another dose of methadone. Ms Finlay questioned this because Mr Fennessy had already had his dose of methadone that day. Narcan reverses the effect of opioids including methadone so therefore it would not have been unreasonable for the deceased to have a further dose due to the first being reversed.[21] Sgt Coady commented on this fact and noted that the toxicology level of methadone in Mr Fennessy's blood was within therapeutic levels.[22]

43. Ms Finlay was also concerned that ACT Mental Health did not acknowledge Mr Fennessy's drug and alcohol issues as a mental health issue. Sgt Coady commented that staff must work within the *Mental Health (Treatment and Care) Act 1994* (ACT) which in section 5(j) states that those who take drugs and alcohol should not be considered to be mentally ill.[23] [I note that for ease of reference instead of referring to the full title of the Act in these reasons I will refer to the Mental Health Act; this was also a shorthand description employed by a number of the witnesses who gave evidence before me.]

44. In Ms Finlay's letter she raised an issue in relation to her son's continued overdoses however Sgt Coady commented that under the mental health legislation he was unable to be detained by staff.

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[17] Transcript p24.
[18] Transcript p27.15.
[19] Including the *Medical Treatment (Health Directions) Act 2006* (ACT).
[20] Transcript p27.30.
[21] Transcript p28.
[22] Transcript p28.
[23] Transcript p28.

45. Sgt Coady stated that after conducting a record of conversation with Ms Finlay and investigation of the matter he considered that Mr Fennessy's use of alcohol and drugs and his extensive history of overdoses from poly-substance abuse were evident and it was likely that Mr Fennessy's death was as a result of another poly-substance overdose.

46. Sgt Coady stated that there was no suspicious circumstance involved with the position Mr Fennessy was found in and that it was clear that the deceased was highly affected by drugs, rested in the position in which he was found and that the scenario was consistent with positional asphyxia.[24]

47. Sgt Coady was cross examined by Mr Sabharwal and advised that the information in relation to the appointment on 7 January 2010 was from The Canberra Hospital and Mental Health records and that he took the records at face value.[25] When asked about the property taken from Mr Fennessy after his death, Sgt Coady said he could not recall any paper with an appointment written on it.[26] Sgt Coady indicated that there was no recording of that piece of paper and therefore he could rule out finding it because he would had recorded it. I clarified that position by asking him if the piece of paper had been in his belongings would he have recorded it and he agreed he would have.[27]

48. In relation to questions about whether he recalled a letter from Ms Finlay asking the Coroner about the vomit that was found on Mr Fennessy at the time of his death, Sgt Coady indicated that he did not recall that letter.

49. Sgt Coady identified the exercise book he found on Mr Fennessy on the night of 6 January 2010. Sgt Coady recorded the page with writing on it and gave back the book to Ms Finlay.

50. Sgt Coady was asked about the vomit found on Mr Fennessy and he indicated that he did not have it examined as that was the purview of the pathologist. He advised that he did not cause any examination of that material being the vomit.[28]

51. Sgt Coady advised that he was aware that Ms Finlay had taken exception to some of the opinions expressed in his statement. He was asked whether he recalled reading the report in the mental health notes which said *"I am concerned that Mr Fennessy will re present himself within a very short time frame, urgently needs to detox as he has no ability to manage his lifestyle or organise safety, shelter and food."* He said he recalled reading the notes but

[24] Transcript p29.
[25] Transcript p31.
[26] Transcript p31.
[27] Transcript p32.
[28] Transcript p34.

he did not recall that specific paragraph; however he accepted that that was written in the notes.[29]

52. Sgt Coady also agreed that Mr Fennessy had had three overdoses in the space of less than a week.[30] In questions in relation to residence, Sgt Coady was not aware that Mr Fennessy did not have anywhere to go when he was discharged on 6 January 2010. Sgt Coady was asked how, despite reading that note in the mental health notes, he came to the conclusion that there were no other options for the staff in treating Mr Fennessy. Sgt Coady agreed that medical staff could have perhaps rung a social worker but he referred in his statement to intervening actions in terms of keeping a person in their custody. Sgt Coady agreed that he was confining his opinion to the fact that the staff could not keep him in under the Mental Health Act.

53. Sgt Coady was also asked questions in relation to his opinion as to how, given Mr Fennessy's overdose that day and overdoses in previous days, he could speculate that if Mr Fennessy had not have been found on the morning of the 6th he could have died. He refused to speculate in that regard because it was not part of the scope of his investigation. [31]

54. It was suggested to Sgt Coady that he had gone through Mr Fennessy's history from the age of 14 and that history demonstrated that Mr Fennessy was a poly-substance abuser and had had a number of overdoses including a number of overdoses just prior to death. Sgt Coady agreed with that proposition. When asked whether that would cause him to wonder whether there was anything else that could have been done, Sgt Coady suggested that there are a number of factors that were considered and he couldn't see any other option for Mr Fennessy that night.[32]

55. In questions about other options for Mr Fennessy that night Sgt Coady suggested that Mr Fennessy could have stayed at his mother's place that evening, which is where he was just before he died. It was put to Sgt Coady that Mr Fennessy could not stay there that night and Sgt Coady could not think of any other options that were enforceable.[33]

56. In questions by me about whether Sgt Coady investigated or inquired about why medical staff didn't call a social worker for Mr Fennessy that evening, he stated it wasn't part of his investigation. He also said that on that night he had been advised that Mr Fennessy had an appointment with the Drug & Alcohol

[29] Transcript p37.
[30] Transcript p37.
[31] Transcript p39.
[32] Transcript p40.20.
[33] Transcript p41.

people the next day and that Mr Fennessy was going to stay at Ms Finlay's place. [34]

57. Despite the fact that Sgt Coady was advised that Mr Fennessy had an appointment the next day, the Sergeant could not find that appointment on a piece of paper in his belongings.[35]

Jillian Anne Hughes

58. Jillian Hughes gave evidence that she was the current Operational Director for Alcohol & Drugs Services within the Division of Mental Health, Justice Health and Alcohol and Drug Services of ACT Health.[36] Ms Hughes has held that position since May 2014. Ms Hughes provided a statement signed on 12 November 2015 which included annexures A to E, and that was exhibited as Exhibit 19 after consent of the parties. Ms Hughes provided a statement because the then Operational Director of Alcohol and Drug Services at the time of Mr Fennessy's death is no longer employed with ACT Health.[37]

59. Ms Hughes explained that in March 2011 the ACT Health Directorate underwent an extensive restructure and created the Mental Health, Justice Health and Alcohol & Drug Services Division.

60. Ms Hughes indicated in her statement that the Alcohol & Drug Service includes:

   - consultation and liaison service – which provides inpatient assessment, support and referral is for people admitted to the Canberra Hospital
   - opioid treatment service – which provides medical advice, nursing and counselling support for people with addiction issues who had been prescribed opioid maintenance treatment
   - Withdrawal inpatient unit – 24 hour medically supervised inpatient unit for people withdrawing from alcohol and other drugs
   - Medical services – providing outpatient services for people accessing opioid treatment service
   - Counselling and treatment services – providing counselling and treatment services for adults and young people in the community with alcohol and other drug issues
   - Diversion services – providing assistance in diverting people arrested and or charged with drug and alcohol related offences out of the judicial system

[34] Transcript p42.
[35] Transcript p42.20.
[36] Exhibit 19, p1.
[37] Ibid.

61. Referral to this service is by way of self referral, or referral from general practitioners or medical or allied health professionals, or family members. Treatment is by way of consent of the participant.

62. When asked about the way the system existed around 6 January 2010, Ms Hughes indicated that she was not there at that time however she has made enquiries in relation to the system as at that date. Ms Hughes indicated that the programs involved opioid treatment, withdrawal services, consultation and liaison service provided to inpatients on the wards of The Canberra Hospital, the Emergency Department and the Mental Health Units.[38] Ms Hughes indicated there was also a medical service which was part of the consultation and liaison service, the opioid withdrawal service and clients with an addiction issue. The service also provided counselling and treatment for a diversion program.[39]

63. Ms Hughes indicated that there have been significant changes since 2010. Some of those changes include medical advice, nursing and counselling support for people with addiction issues who are prescribed opioid maintenance treatment. That clinic runs from The Canberra Hospital site.[40]

64. Ms Hughes indicated that in 2010 a person requiring treatment through Accident and Emergency (ED) would have been assessed and supported by the consultation liaison team member. Ms Hughes indicated that in January 2010 the requirement would have been someone from the Emergency Department making contact with the service. Ms Hughes indicated that the person assessing someone in the Emergency Department would refer the patient to the specialised 24 hour Alcohol & Drug Service community health intake line or if appropriate refer them to the inpatient withdrawal unit.[41] Ms Hughes further explained that it would be the client who would have to make the effort to contact the unit by telephone. Ms Hughes indicated that for an inpatient referral an addiction specialist in consultation with the staff of the inpatient withdrawal unit would consider the client's need and admit if required.[42]

65. Ms Hughes further explained that the inpatient service was only for particular persons in particular situations and it was a voluntary service and therefore not suitable for all clients.[43] Ms Hughes further explained the service might take a drug affected person although it was occasional.[44]

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[38] Transcript p48.
[39] Transcript p48.
[40] Transcript p49.
[41] Transcript p50.1.
[42] Transcript p50.32.
[43] Transcript p50.35.
[44] Transcript p51.2.

66. Ms Hughes clarified that there were protocols in place in January 2010 however; there is now since January 2011 a new standard operating procedure in operation.[45] Ms Hughes stated that the reason for the shift in process was that they reviewed procedures and protocols and standard operating procedures about every three years.[46]

67. Ms Hughes identified changes to the service since 2010 as including:

   - introduction of the capital IDOSE system, which is an automated dosing system using iris scanning for accurate identification of people receiving their opioid maintenance treatment on Tier 1 at the hospital
   - The introduction of coloured prescriptions, pink scrips of methadone and blue scripts for buprenorphine, for easy identification and differentiation to reduce the risk of medication errors
   - Rapid referral process to opioid treatment service
   - Prescription extensions
   - Clients on opioid replacement treatment who are inpatients of the Canberra Hospital
   - Transfer of pharmacotherapy treatment
   - Urine drug screening
   - Follow-up for Alcohol & Drug clients who do not attend medical appointments
   - A Canberra Hospital and Health Services clinical guideline – Alcohol & Drug services – Key worker support program guideline.

68. Ms Hughes advised that in March 2011 the ACT Health Directorate underwent executive level restructure and created the service as described above, indicating that the Alcohol & Drug Service has now amalgamated in that division. The role of the ADS Consultation and Liaison Service is to assess inpatients with alcohol and other drug issues and to consult on the care and treatment provided to inpatients, which includes people receiving treatment in the Emergency Department. I note that a person discharged from The Canberra Hospital including the ED, who has not been assessed by ADS Consultation and Liaison Service may be provided with written information on the services offered and they can then arrange a follow-up appointment with the counselling and treatment service through the 24-hour intake line.

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[45] Transcript p52.
[46] Transcript p52.17.

69. The service will be operational seven days per week with an increase of hours of operation in the future. Ms Hughes indicated that this increase will focus on assessment and treatment in the ED, as well as the mental health assessment unit and the adult mental health unit at the hospital. I note that this is prospective.

70. Ms Hughes agreed that in 2010 if Mr Fennessy had had the opportunity to speak with a consultant from the Consultation and Liaison Service and that discussion had taken place, they could have decided whether he was a candidate for the withdrawal facility or not. In relation to the opioid treatment service, Ms Hughes agreed that Mr Fennessy would have been a Tier 3 patient. Ms Hughes accepted that in her statement she explained that a Tier 3 patient is a person who receives opioid maintenance therapy from a community pharmacy and is medically managed by an approved general practitioner; further that Alcohol & Drug Services are not available in the medical management of such people. She indicated that there are referral pathways which permit a general practitioner to refer that person to Tier 1 under the supervision of the Alcohol & Drug Service if that person becomes unstable.[47]

71. Essentially Ms Hughes indicated that given Mr Fennessy was a Tier 3 patient any access to the opioid treatment service would have been voluntary and something that he would have to access himself or be referred by his General practitioner.[48]

72. In relation to whether any contact with Mr Fennessy's approved general practitioner by the Alcohol & Drug Service would have occurred she said it would be either inappropriate or time restrictive and would not have permitted them to done so.[49] Ms Hughes explained the reason for this was because he Mr Fennessy was under the care of the Emergency Department and a referral would have been required for a member of the Alcohol & Drug Service to attend, and the consent of the client would have been required. [50]

73. Ms Hughes indicated that the records reflect that Mr Fennessy had a poor record of engagement with the service and given that he was quite chaotic and difficult to engage in treatment because of a chronic relapsing condition, it was difficult to prepare a comprehensive treatment plan for him. This was why there was no treatment plan in place for him, despite him being referred as early as 2009 to the Service; he failed to engage with the Service.[51]

[47] Transcript p53.5.
[48] Transcript p53.9.
[49] Transcript p53.25.
[50] Transcript p53.40.
[51] Transcript p54 and 55.

74. Ms Hughes agreed that there was a review of Mr Fennessy by the multidisciplinary team on 5 January 2010.[52] The multidisciplinary team consisted of the mental health team which included a psychiatrist, who was unavailable at the time of the assessment, a psychiatric registrar, a team leader, Mr Aloisi, and a senior clinician; however there was no one from the Alcohol & Drug Service.[53]

75. Ms Hughes indicated that the multidisciplinary team members have now changed and one could now expect a representative from the Alcohol & Drug Service in that multidisciplinary review for someone with an addiction problem and history of overdosing.[54]

76. Ms Hughes was taken through the history of 4 January 2010 in relation to whether Mr Fennessy had been seen by the Alcohol & Drug Service liaison service. There appeared in the nursing notes to be a reference to him being seen by a social worker and Drug & Alcohol liaison nurse; Mr Fennessy was to phone Karralika for an assessment with admission in possibly two days. However there was no entry by the Drug & Alcohol liaison officer to that effect. Ms Hughes indicated that this is usually documented in that situation in the emergency notes and that the usual practice is to refer patients to the 24-hour line.[55] I note that there was **no referral** to that service on the 6th: see exhibit 18.

77. Ms Hughes was referred to the mental health notes in Exhibit 16, page 374, where no date was inserted on that page. I note, however, the document is from the Emergency Department continuation sheet and the time is 15:00 hours. This note indicates that Mr Fennessy was homeless but will go to his sister's place and is waiting a bed to withdraw and then go to Karralika. Ms Hughes indicated this particular note should be in the patient hospital file rather than the patient mental health file.[56]

78. Ms Hughes was taken to the following page dated 6 January 2010: '*No referral for D/A review however Mr Fennessy admitted overnight due to overdose of medications including methadone. Advised by Fiona from CAT who is aware Mr Fennessy may have stolen prescriptions from ED when admitted on 4 January 2010*'. That note was under the hand of RN Coghlan.[57] Ms Hughes was also taken to a document under the hand of the Manager, Clinical Services, Alcohol & Drug Program, ACT Community Health, where the note records that Mr Fennessy had spoken with an ADP consultant nurse who attended Mr Fennessy in an Emergency Department on 4 January 2010 and

[52] Transcript p55.
[53] Transcript p56.1.
[54] Transcript p56.15.
[55] Transcript p59.1.
[56] Transcript p60.21.
[57] Exhibit 16, p395.

that the ADP withdrawal unit requested an admission for Mr Fennessy pending a decision by Karralika rehabilitation program. Ms Hughes agreed that it appeared that the withdrawal unit was expecting Mr Fennessy pending confirmation of a bed at Karralika.

79. Ms Hughes stated that a requirement that was not fulfilled was for Mr Fennessy to have a medical review by an addiction specialist or a multidisciplinary team if required.[58] Ms Hughes accepted it was clear from the record that despite the fact that there was a request from Mr Fennessy to attend the inpatient service, because there was no medical assessment of him by either alcohol and drugs or multidisciplinary team members, Mr Fennessy was not admitted.[59]

80. Ms Hughes in her statement provided that the current process for admission to the withdrawal unit has been updated. The process is the same as was used in 2010 except for:

    - Direct admission from the Mental Health Assessment Unit or ED can be arranged where the person has been medically cleared for discharge, triaged as suitable for admission by the withdrawal unit and there is a bed available within the unit; and

    - A person with mental health co morbidities who has been admitted to the Adult Mental Health Unit can be transferred to the withdrawal unit once assessed and found suitable by the ADS Consultation and Liaison Service when a bed becomes available.

81. In her statement Ms Hughes indicated that in 2009 the withdrawal unit closed between 24 December 2009 and 4 January 2010, but now the unit remains fully operational during the Christmas period.

82. Under cross-examination by Mr Sabharwal Ms Hughes described the process of admission into the inpatient withdrawal unit, as requiring an assessment by Consultation and Liaison Service, contacting the Alcohol & Drug Service intake line, and possible admission or admission through direct transfer from the Emergency Department after assessment by an addiction specialist; after which, having been found suitable, the patient can then be admitted.

83. Mr Sabharwal suggested a scenario where a patient - in this case Mr Fennessy - had been observed and there was a concern that he would re-present himself within a short time frame and that he had no ability to manage his lifestyle or have safety, shelter and food. Ms Hughes was then asked what service could be provided. She said that there was nothing in place after 5 pm even now as at November 2015, although she indicated the service would be expanding into the evening and that it is now seven days a week.

[58] Transcript p62.15.
[59] Transcript p62.23.

84. I note in her statement Ms Hughes said that Mr Fennessy benefited from the opioid treatment service in February 2009, however he did not attend appointments that had been made. Given Mr Fennessy received treatment and opioid maintenance by his general practitioner and receive dosing at the community pharmacy he was classified as a Tier 3 patient and was not under the supervision or management of ADS. Mr Fennessy would not have been assigned a key worker because he was not a Tier 1 or Tier 2 client.[60]

85. Ms Hughes said that in terms of drug and alcohol patients, the liaison service goes to the Emergency Department and provides advice; however they do not provide any other type of advice such as housing which is more to do with social work.

86. In her statement Ms Hughes further commented that she noted Mr Fennessy's interactions with mental health clinicians and ongoing treatment needs were reviewed at a multidisciplinary team meeting on 5 January 2010 where a decision was made that no further case management was required at that point in time.[61]

87. I note in Exhibit 19 Attachment D the criteria for any person seeking withdrawal from any substance are as follows:

   - Clients with a history of seizures during alcohol withdrawal
   - Clients withdrawing from alcohol have priority as alcohol withdrawal is potentially serious and often needs specific medication
   - Opiate dependent clients may be better managed on maintenance therapy, however if the client insists on wanting to try withdrawal initially, the case will be assessed on an individual basis
   - Pregnant opioid dependent clients are generally not suitable for admission aiming for drug withdrawal, as opioid withdrawal is dangerous to the fetus; admission for stabilisation poly drug use in pregnant clients may be very appropriate, and pregnant opioid using clients will normally be strongly encouraged to enter a maintenance program
   - Withdrawal from cannabis and amphetamines will be assessed on an individual basis
   - Interstate clients can be admitted as there are cross-border agreements with other states, however ACT clients have priority.[62]

[60] Exhibit 19, p8.
[61] Exhibit 20, p9.
[62] Exhibit 20, Attachment D.

88. I note in Attachment D, assessment for the withdrawal service either inpatient or outpatient is assessed by phone prior to admission. That assessment is based on the client's self-reported history of current symptoms, reported drug, alcohol medical, and psychosocial history as well as other information available to the assessor.[63]

89. Ms Hughes commented that Mr Fennessy's contact with ADS and mental health was sporadic and his level of engagement in the services offered were not sufficient to develop a comprehensive treatment plan. I note however that Mr Fennessy's clinical records, particularly his MHAGIC (Mental Health) records, indicate there was communication and liaison between ACT Mental Health clinicians and ADS and ED at The Canberra Hospital, as well as Mr Fennessy's general practitioner and non-government organisations in relation to the care and treatment provided to him. I also note that amongst the factors to be considered during assessment is any prior history of complicated withdrawals including seizures and/or delirium tremens, as well as the presence of significant mental health or medical issues.

90. Ms Hughes was asked questions in relation to Karralika and she replied that she knew there was a waiting list and that the person wishing to be admitted had to phone to see if there was a bed available.[64] During cross-examination by Mr Crowe, Ms Hughes was referred to Exhibit 16, page 394, which read "*Mr Fennessy homeless although will go to sisters post discharge AD, Awaiting a bed with withdrawal unit before going to Karralika. For phone assessment with Karralika rehab service, Wednesday PM, Once bed confirmed with Karralika Mr Fennessy to liaise with withdrawal unit for bed prior to rehab*".[65]

91. I asked about a situation like that which Mr Fennessy found himself in, that after discharge from an overdose he clearly had consumed more drugs or the drugs he had in his system were aggravated or potentiated. I pointed out also that there are many multidrug abusers in the system. Ms Hughes said that the Alcohol & Drug Service try to engage those patients in treatment and that the client must be willing to engage in treatment. Ms Hughes further explained the Tier system as to how that system works, in that if a person is a Tier 1 patient they get a case manager who helps them navigate the system, they also have timely medical reviews to support them and have regular appointments with addiction specialists, they are also dosed at the hospital and assessed there by team of nurses on a daily basis.[66] Tier 1 patients also have social workers available to them if they have homelessness issues.[67] Ms Hughes indicated that both Tier 1 and Tier 2 have these services available to them. She

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[63] Exhibit 20, Attachment E.
[64] Transcript p65.
[65] Transcript p66.36.
[66] Transcript p67-68.
[67] Transcript p68.

indicated that all of these patients, whether drug addicted, with mental health issues or both, must voluntarily access the programmes. Ms Hughes also noted that Tier 3 patients do not receive these services because they are prescribed their medications by their general practitioner.[68]

92. In answer to Mr Crowe's question in relation to the 24-hour intake line, Ms Hughes indicated that the line works 24 hours Monday to Friday with specialised trained staff who can assess those requesting their help. The staff will give advice and referral to an opioid treatment and counselling service. This service is also available after hours because the phone is diverted to the inpatient withdrawal services where specialist nurses can assist, advise and refer.[69]

Bruno Aloisi

93. Mr Aloisi is a psychologist who at the time of giving evidence was the Operational Director for Adult Community Mental Health Services. Mr Aloisi understood that the alcohol and drug services provided to persons such as Mr Fennessy would have been referred by not just mental health services but other services within the hospital when someone is identified as having a significant substance abuse or use issue. He understood that a medical review was required in the first instance and Mental Health can recommend patients to the opioid treatment service, however generally the pathway would be a referral from the Alcohol & Drug Service for an assessment to be made as to what is required.[70]

94. In relation to the inpatient withdrawal unit Mr Aloisi confirmed that that service was in existence in January 2010. His understanding was that it would be a phone referral and possibly face-to-face interview but would require medical review prior to admission or as part of the admission.[71]

95. Mr Aloisi stated that the Alcohol & Drug Service now sits within the Division of Mental Health, Justice Health, Alcohol & Drug Services.[72] In relation to whether ACT Mental Health could refer a client to the addiction specialists Mr Aloisi stated that that occurs now although he was unsure whether that was available in 2010. Mr Aloisi indicated that the Alcohol & Drug Service is based on a voluntary model in that the client self refers.[73] Mr Aloisi indicated that it is still the case although the relationship with the Alcohol & Drug Service has opened up new referral pathways.[74] Mr Aloisi stated that the counselling and

[68] Transcript p68.20.
[69] Transcript p69.10.
[70] Transcript p6 (1/12/15).
[71] Transcript p7 (1/12/15).
[72] Transcript p7.
[73] Transcript p7.
[74] Transcript p7.

treatment service was also available in January 2010 and again it was a voluntary self referring program.[75]

96. Mr Aloisi was taken to Exhibit 15, page 787, a document he described as a statement of actions taken. He described the document as essentially the enactment of the emergency apprehension provisions under the Mental Health Act. Mr Aloisi indicated that it was not an emergency treatment order but rather details of the emergency apprehension that was taken, he said "*it is not treatment per se but enables a person to be brought into hospital for assessment*".[76] Mr Aloisi agreed that the document on that page indicated that Mr Fennessy was brought in by Police in December 2007 after having been reported missing by his mother and police found him wandering the streets plucking at objects and the like, and Police were authorised pursuant to the *Mental Health (Treatment and Care) Act* to apprehend him and take him to the hospital for assessment.[77] Mr Aloisi indicated that on page 779 that document indicated Mr Fennessy was monitored and then discharged from the Psychiatric Services Unit (PSU) with follow-up by the Crisis, Assessment and Treatment (CAT) team initially and then for GP follow-up. Mr Aloisi indicated this is a long-term follow-up plan.[78]

97. Mr Aloisi was taken to Exhibit 16, page 38, and identified that document as a MHAGIC record. Mr Aloisi identified that acroynym stood for Mental Health Assessment Generation Information Collection, an electronic collection of material and mental health records.[79] Mr Aloisi was taken to a record with date 14 December 2007. This document outlined the general description of Mr Fennessy's appearance at the time and there was a number two circled which read priority response within 12 hours, which required the patient to be seen within that 12 hours following presentation.[80] Further down the page there were tick boxes to be marked in relation to evidence of mental illness which Mr Aloisi described as probably a suggestion from the review of the patient that some mental issue was evident.[81] Mr Aloisi was taken to the parts of the document in relation to risk of suicide and he indicated that it was an assessment to determine risks. Mr Aloisi identified a couple of risk factors in relation to Mr Fennessy which had been entered by a clinician which indicated a low to moderate risk.[82] It was Mr Aloisi's view that the risk factors identified

[75] Transcript p8.1.
[76] Transcript p8.21-37.
[77] Transcript p8.35-45.
[78] Transcript p9.29.
[79] Transcript p9.43.
[80] Transcript p10.15.
[81] Transcript p10.20.
[82] Transcript p10.40.

indicate that further assessments would be required as there is some concern about the risk, and that risk needs to be explored further.[83]

98. Mr Aloisi indicated that even though Mental Health at that time were not associated with the Drug & Alcohol assessment service, and they were not the direct service provider, co-morbid drug and alcohol use can be associated with mental health issues at times and it will be something that the Service would need to be aware of as part of the assessment which is done by a mental health clinician.[84]

99. Mr Aloisi was taken to page 114 of Exhibit 16 which is a summarised version of notes of Mr Fennessy's admission in 2007 which indicated he had been assessed in the Low Dependency Unit of the PSU. The discharge note on page 132 was an overview of his diagnosis with the CAT team to follow-up and to see GP within one week of discharge. Mr Aloisi indicated that at that point whilst in the PSU Mr Fennessy was under the care of Mental Health and also for the purposes of a review contact with Mr Fennessy, and after that assessment Mr Fennessy was under the care of his GP.[85]

100. In relation to a question about whether the discharge and follow-up with the GP meant that Mr Fennessy did not have a mental health issue, Mr Aloisi indicated that that did not mean that Mr Fennessy did not have some mental health issues, however they weren't sufficient to warrant a specialist mental health service to be involved.[86] The threshold for a mental health service to be involved was based around essentially a clinical judgement as to the severity of the symptoms and the need for voluntary treatment. Mr Aloisi said *"for example, it might be about the need for involuntary treatment so, for example, we have people who might need treatment but won't actively engage in the community so – and because of the risks associated with it might need involuntary treatment so there are a number of sort of clinical factors you would be looking at to assign clinical management service."* [87]

101. Mr Aloisi was asked about Mr Fennessy's low to moderate risk of suicide and he said *"if it was fairly persistent, for example, then you might argue – say, for example, if someone was considered – assessed as continuously at high risk of suicide, you might – there would be a strong argument for providing clinical management to provide ongoing monitoring and review."*[88]

102. Mr Aloisi was taken to Exhibit 16, page 124, and asked for his comments in relation to the meaning of the notes displayed on that page. Essentially Mr

[83] Transcript p11.5.
[84] Transcript p11.15.
[85] Transcript p12.30-40.
[86] Transcript p13.1.
[87] Transcript p13.10.
[88] Transcript p13.19.

Aloisi said that the visits were for a physical check and for further review. He also indicated in respect of page 125 that his interpretation is that the CAT team worker may be able to assist in accommodation and indeed did so. The note also indicated there was a mental state examination undertaken.[89] Mr Aloisi also agreed that Mr Fennessy was prescribed Zyprexa and was to stay in a CAT flat, which was a flat leased by city housing which could accommodate and support people who did not have accommodation but who had high needs. Mr Aloisi indicated that flat was available in January 2010 but has since been dispensed with.[90]

103. Mr Aloisi identified that the 14 March 2008 notes reflected the CAT team case closure due to resolved episodes of care and no ongoing risk issues identified after a multi-disciplinary team review was conducted. This team review did not include alcohol and drugs workers specifically as part of the review.[91] Mr Aloisi indicated that now those areas would be involved if it were required given the closer relationships between the services.

104. It was suggested that if Mr Fennessy had come along on 1 December 2015 he would have had access to alcohol and drugs staff as part of the review. Mr Aloisi indicated that there are multiple processes and within mental health services there is a co-morbidity clinician who can provide specialist assistance.[92]

105. Mr Aloisi was taken to Exhibit 16, page 133, which indicated that Mr Fennessy had been brought into The Canberra Hospital Emergency Department after taking different medications and alcohol. He was assessed by the CAT team and asked about the overdose it was reported that he said "*I do it because I like it*".[93] Mental Health then engaged with Mr Fennessy. Mr Aloisi indicated that EA meant emergency apprehension and when admitted under this indicator patients require a psychiatric review.[94]

106. In relation to the acronym HoNOS Mr Aloisi was unsure but said he thought it meant Health of the Nation Outcome Scale which was basically a way of scoring a person's functionality with certain criteria. Mr Aloisi was taken to the previous assessment where Mr Fennessy recorded a score of four. Mr Aloisi believes that it is an assessment which can vary depending on circumstances.[95]

107. Mr Aloisi was asked in relation to an admission of Mr Fennessy to the Calvary mental health facility Ward 2N on 28 March 2008 and the references in page

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[89] Transcript p14.25–35.
[90] Transcript p15.1-21.
[91] Transcript p16.1.
[92] Transcript p16.16.
[93] Transcript p16.35.
[94] Transcript p17.1.
[95] Transcript p18.5.

135 of Exhibit 16. Essentially Mr Aloisi stated that a co morbidity clinician, Steve Harnett, had reviewed Mr Fennessy specifically given his specialty. Mr Aloisi indicated that where the referral programs for rehabilitation from alcohol and drugs occurred.[96]

108. The next entry Mr Aloisi assisted with was in relation to a presentation to The Canberra Hospital on 7 June 2008. That presentation was by ambulance where Mr Fennessy was taken after being found collapsed in the toilet by security guards. Mr Fennessy had been discharged from a rehabilitation place. Staff were advised that Mr Fennessy had injected Seroquel, Avanza and had taken oral heroin, oxazepam and alcohol, and he was to be admitted to the PSU.[97] It appears Mr Fennessy was admitted to the PSU and that he was discharged from the mental health facility on 11 June 2008. Mr Aloisi agreed that the document indicated the outcome to be risk of misadventure, risk of drug use. The notes indicated that Mr Fennessy was quite irritable and anxious, and continued to drug seek. Mr Fennessy was discharged with medication for follow-up with his GP, who Mr Aloisi stated was Mr Fennessy's primary treating physician.[98]

109. Mr Aloisi was taken to page 149 of Exhibit 16 where a comprehensive history was recorded of Mr Fennessy's admission to The Canberra Hospital and the PSU on 27 June 2008. Mr Fennessy was found having taken several prescription drugs, with the possibility of cocaine and heroin being injected by him, although he denied this. It is noted Mr Fennessy's girlfriend was found with two syringes with one having liquid in it.[99] Mr Fennessy was admitted to Ward 6 of The Canberra Hospital with a diagnosis of clinical pneumonia, haematemesis and overdose of drugs.[100] Mr Aloisi was taken to page 164 where a note from Dr John Edgar was made in relation to problems with Mr Fennessy leaving the ward. It was suggested that this note appears to be the only note in relation to that admission from the mental health team. However Mr Aloisi interpreted the note to mean that Dr Edgar as part of the mental health Consultation and Liaison Service was assessing and reviewing Mr Fennessy at that time.[101]

110. Mr Aloisi was referred to the notes of the admission and it was suggested by Counsel Assisting that Mr Fennessy was seen by a psychiatric registrar on 29 June 2008.[102] That review was in relation to Mr Fennessy's past history and offered no further review required. Mr Aloisi opined that that was the only

[96] Transcript p18.1-30.
[97] Transcript p18.40.
[98] Transcript p20.15.
[99] Transcript p21.19-30.
[100] Exhibit 15, p607-611.
[101] Transcript p22.1.
[102] Refer to page 633 of Exhibit 15.

reference to the mental health involvement on that admission.[103] Mr Aloisi indicated that this was not unusual and it depended on whether the assessment required further mental health assistance or not.[104]

111. The next admission of Mr Fennessy was on 8 November 2008 to The Canberra Hospital where there was a question as to whether he had overdosed on drugs on that occasion. Mr Aloisi was taken to page 165 of Exhibit 16 where he agreed that the document was a tool for assessing suicide ideation. Mr Aloisi indicated that the rating was high risk and explained that meant that the person was deemed to be at risk and that further assessment monitoring or interventions would need to apply,[105] although Mr Aloisi indicated that it would not necessarily mean that a person would be involuntarily detained.[106] Mr Aloisi indicated that there would be a requirement to complete part B of the assessment. Mr Fennessy was assessed under part B as medium risk. Mr Aloisi identified a letter he wrote to Mr Fennessy on 13 November 2008 expressing concern they were unable to contact him. The CAT team case was closed which meant that the case was closed for that episode of care.[107]

112. Mr Aloisi indicated that it was not the seriousness of the overdose but rather the clinical assessment which guides whether follow-up is required.[108] Mr Aloisi indicated that the letter sent to Mr Fennessy's general practitioner, Dr Craft, was to alert her of the CAT referral and for her to revise further care.[109]

113. Mr Aloisi was then taken to Mr Fennessy's admission of 20 February 2009, presented to The Canberra Hospital with an overdose of drugs. Mr Fennessy was intubated and admitted to the intensive care unit for monitoring, and was discharged that same day. He was reviewed by Dr Kumar who advised that contacts for drug and alcohol and mental health were provided. That was the only psychiatric assessment he had that admission.[110]

114. Mr Aloisi indicated that given the multiple presentations of drug overdoses involving Mr Fennessy, that would be a basis for a referral to an addiction specialist in his view, saying it was a good argument for a referral and might be appropriate.[111] Mr Aloisi agreed that given the significant number of presentations of overdose by Mr Fennessy that it would have been appropriate for an Alcohol & Drug Service specialist to have an ongoing referral.[112] Mr

[103] Transcript p23.10.
[104] Transcript p23.20.
[105] Transcript p23-24.
[106] Transcript p24.5.
[107] Transcript p24.37.
[108] Transcript p24.40.
[109] Transcript p25.10.
[110] Transcript p25.27.
[111] Transcript p25.40.
[112] Transcript p26.5.

Aloisi indicated that there was a mental health suicide risk assessment Part A undertaken however there was no part B undertaken on 20 February 2009.

115. Mr Aloisi agreed that Mr Fennessy attended a multidisciplinary team review on 2 March 2009. There was a letter to Dr Singh from Calvary Emergency Department advising that Mr Fennessy had been admitted to the Calvary Emergency Department on 22 May 2009 after being brought in by ambulance from a sobering up shelter and was intoxicated with narcotics. Mr Aloisi advised that a worker from Samaritan House had called the Mental Health team to indicate that Mr Fennessy had been admitted with an overdose.[113]

116. Mr Aloisi was taken to the notes of 24 July 2009 where Mr Fennessy was offered an appointment with Dr George and saw Dr Gupta on 7 September 2009. Dr Gupta sent a letter to Dr Craft in relation to ongoing treatment and assessment for Mr Fennessy.[114]

117. Mr Aloisi was taken to the presentation by Mr Fennessy to the Calvary Hospital on 31 October 2009 after having taken an overdose of drugs. The records for this admission were located on pages 399 and 400 of Exhibit 15. There is a note from Mental Health at The Canberra Hospital indicating they had been informed by Calvary Hospital that Mr Fennessy had overdosed on medications and was now cleared. A suicide risk form and assessment was completed on 1 November 2009.

118. Mr Aloisi agreed that the notes show that Mr Fennessy was seen by Dr Rapmund at Calvary Hospital on 30 October 2009. Mr Aloisi stated that Dr Rapmund was a psychiatric registrar at the time. The notes show Mr Fennessy gave a history of taking 100 Gabapentin and 100 Serapax tablets with intent to commit suicide. Mr Fennessy reported that he had a 4-5 year history of depression and essentially wanted to end it all. Dr Rapmund decided to admit him to the Psychiatric Services Unit. Mr Aloisi agreed that that was because of the particular seriousness of this overdose and ongoing concerns.[115] Mr Aloisi was taken to page 215 of Exhibit 16 and he indicated that there was no mental health plan or follow-up for Mr Fennessy after that particular admission to PSU although he noted that there was a medical discharge summary faxed to Mr Fennessy's GP on 6 November 2009. Mr Aloisi agreed that he could infer that there was no further or specific arrangements other than to see Dr Gupta and Dr Craft.[116] Mr Aloisi was referred to Exhibit 15, pages 457 to 458, and agreed that Mr Fennessy was seen by Dr Barker, psychiatric registrar, and also the

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[113] Transcript p27.17; also Exhibit 16, p190.
[114] Transcript p28 and Exhibit 16, p194.
[115] Transcript p28.27.
[116] Transcript p29.15.

Drug & Alcohol liaison officer. Mr Aloisi agreed that there was a multidisciplinary team focused on Mr Fennessy's detoxification at this time.[117]

119. Mr Aloisi was then taken to the further presentation to The Canberra Hospital by Mr Fennessy on 29 November 2009.[118] Mr Aloisi was taken to the discharge summary from that admission. He agreed that the admission was in relation to taking tramadol and suffering seizures. Mr Aloisi agreed there was no reference to Mental Health however it would depend on whether there were any significant mental health issues evident for them to be called. Mr Aloisi agreed that Mr Fennessy had been prescribed Endone 5 mg for five days.

120. Mr Aloisi was taken to the note from Exhibit 16, page 216 onwards, which recorded that on 23 December 2009 Mr Fennessy had been discharged from Karralika. That note reflects the reasons why he was discharged particularly his drug seeking behaviour. On 24 December 2009 Mr Fennessy was admitted after overdosing on drugs. On pages 224 and 225 of the Exhibit it is clear that the multidisciplinary team discussed Mr Fennessy and considered that he was not at risk and closed contact with Mental Health, advising Mr Fennessy that contact could be made by him in relation to rehabilitation and also the CAT team.[119]

121. Mr Aloisi was taken to notes of the presentation by Mr Fennessy on 3 January 2010 at The Canberra Hospital Emergency Department where Mr Fennessy indicated that he thought he might have had a seizure and thought he was hallucinating. Mr Fennessy had indicated he had stopped his medication three days prior and wished to have a CAT review. Mr Aloisi agreed that that was consistent with Mr Fennessy requesting mental health involvement.[120] Mr Aloisi agreed that Mr Fennessy had received a comprehensive mental health assessment by Felicity Riddell. She devised a plan that Mr Fennessy was to remain in the waiting room overnight and would be reviewed by the Emergency Department for his medications. Ms Riddell indicated that Mr Fennessy also needed review by a social worker.[121] Mr Aloisi suggested that the reason Mr Fennessy was asked to remain overnight in the waiting room may have been because of his homelessness or because he may have required further review.[122]

122. Mr Aloisi was referred to notes he had made and explained that it was not he who assessed Mr Fennessy, but he had summarised the information of the prior assessment and explained that what was meant by "*episode partially*

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[117] Transcript p29.30.
[118] Exhibit 15, p325-327.
[119] Transcript p32.10.
[120] Transcript p32.20.
[121] Transcript p32.35.
[122] Transcript p32.35-40.

resolved" was that there were still residual evidence of some symptoms.[123] Mr Aloisi agreed that it stated there were no acute risks identified. Mr Aloisi however agreed with Counsel Assisting that there was a pattern of presentation to hospital over and over again with overdoses.

123. Mr Aloisi was referred to Exhibit 15, page 264, and the entry by Felicity Riddell which indicated a psychiatric admission was not indicated. On page 265 he noted a social worker referral for Mr Fennessy was received and a social worker indicated that the social workers do not have access to the MHAGIC notes in the Emergency Department and to fax the documents for his presentation to the acute fax number for inclusion on Mr Fennessy's file. Mr Aloisi indicated that "*ATOR was not in ED*" meant that the patient was not at time of review in the Emergency Department.[124]

124. Mr Aloisi agreed that there had been a referral to the Alcohol & Drug Service from the CAT requesting the Resident Medical OFficer to review Mr Fennessy and to admit him to the ED and for the ADS to review Mr Fennessy.[125] He also agreed that Ms Finlay was consulted and she indicated that Mr Fennessy had been doctor shopping and that Mr Fennessy generally got the medications he requested.[126] Mr Aloisi agreed there is no evidence in the notes to suggest Mr Fennessy had been seen by Drug & Alcohol although it is noted that the social worker advised the triage RN that Mr Fennessy had been seen by Drug & Alcohol Services.[127] Notwithstanding the number of presentations at the hospital for overdose Mr Fennessy was referred back to Dr Craft, his GP.[128]

125. Mr Aloisi was taken to a report in relation to Mr Fennessy's overdosing behaviour near ACT Directions where he had stopped breathing and was given CPR until an ambulance arrived and transported him to The Canberra Hospital.[129] ACT Directions is a community based non-government organisation for people with drug and alcohol dependence. Mr Aloisi was then taken to Exhibit 16, page 233, where an entry indicated that Mr Fennessy was medically cleared and that a Mental Health State review was conducted by Bill Bailey.[130] Mr Aloisi indicated that the note on that page could be interpreted as the time for review by Alcohol & Drugs being 7 January 2010 at 15:00 hours.

126. Under cross-examination Mr Aloisi indicated that page 231 of Exhibit 16 was his summarisation of the notes of the previous assessment. Mr Aloisi indicated that he did not actually see Mr Fennessy but summarised the assessment by

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[123] Transcript p33.15.
[124] Transcript p34.26.
[125] Transcript p35.1.
[126] Exhibit 15, p269-271.
[127] Exhibit 15, p275.
[128] Transcript p35.16.
[129] Exhibit 17, p495.
[130] Exhibit 16, p233-234.

Felicity Riddell to include in a letter sent to his GP.[131] Mr Aloisi indicated that it was written on 4 January 2010 at 10:13 am, however he did not see Mr Fennessy on that date or indeed at all on 5 January.[132] Mr Aloisi explained that he was part of a multidisciplinary team who discussed Mr Fennessy's case.[133] Mr Aloisi indicated that the multidisciplinary team meeting consisted of himself and a senior clinician he could not name because it was not identified in the notes.[134] The consultant psychiatrist was unavailable that day. Mr Aloisi agreed that the notes reflect that a decision was taken by himself and the senior clinician to close mental health contact with Mr Fennessy. Mr Aloisi indicated the decision was taken because of other referrals in place and follow-ups through the GP, and the assessment determined that there was no critical mental health acute risk.[135]

127. Mr Aloisi indicated that he would have seen the note in Exhibit 16, page 232, in relation to the comment about the phone call to Michelle, the ED social worker, who confirmed she had not seen Mr Fennessy yet but would be seeing Mr Fennessy once he had been reviewed by Drug & Alcohol liaison.[136] Mr Aloisi also indicated that he was aware prior to making the decision to close the case that a social worker review was occurring or had occurred and that there was going to be a review by Drug & Alcohol liaison as well. Mr Aloisi agreed that there was no formal plan in place despite the fact that Mr Fennessy had several presentations in close proximity, however there was to some extent plans engaged in when he presented on those occasions, but no formal management plan per se.[137]

128. Mr Aloisi acknowledged that Mr Fennessy had presented at least twice since December 2009 and that the plan as of 5 January 2010 was to refer back to the GP, and that was the primary path plan.[138]

129. Mr Aloisi indicated upon questioning that as at January 2010 there was a CAT flat available and that attempts had been made on 4 January to find a refuge or shelter for Mr Fennessy, that a social worker was available at that time, and he believed that the Alcohol & Drug liaison officer would have been in the hospital, however he noted that the service only operates during certain hours.[139]

130. In a question from me in relation to the operating hours of that service Mr Aloisi stated "*well, I suppose it's really an issue about what is the priority. So for example if the drug and alcohol issue I presume is not going to be resolved in*

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[131] Transcript p38.25.
[132] Transcript p39.1.
[133] Transcript p39.9.
[134] Transcript p39.25-40.
[135] Transcript p40.5.
[136] Transcript p41.39.
[137] Transcript p44.35.
[138] Transcript p45.1-10.
[139] Transcript p46.5.

the space of hours, so it might just be about conveying information at a later point either through the – it really would depend on the level of support they need so it really hard to answer and to say what – it would really depend on the circumstances."[140]

131. In a further question from me about what would happen when a person with a similar history to that of Mr Fennessy presented, Mr Aloisi said "*yes, so that would be – I mean, in the absence of a drug and alcohol liaison I suppose the options would be to have referral, you know, when they are available during their working hours or they have a 24/7 contact line, but that is just an information referral point."*[141] I further asked whether anybody would come and see the patient in the ED, and Mr Aloisi stated "*no not – yes, at that time no"* however he indicated that that situation is changing.[142]

Dr Shannon Craft

132. Dr Shannon Craft gave evidence before me that she was a general practitioner in a general practice at Garran and treated Mr Fennessy.

133. Dr Craft was taken to page 219 of Exhibit 14 and she identified that that was not her document and that she had not received a copy of it.[143] In relation to page 217, Dr Craft identified it as a document from The Canberra Hospital which she had received.

134. When taken to her statement Dr Craft stated that that she had first started treating Mr Fennessy in 2008 when she was working at the Gadal Chambers in Woden. Dr Craft indicated that the other practitioners in her chambers were Dr Singh, Dr Tate, Dr Colwell, Dr Wylie and Dr Kelleher.[144]

135. Dr Craft indicated that the practice of doctors at 33 Colbee Court in Phillip is Phillip Primary Health Care and she is familiar with Dr Lawrence from that practice but she does not know Dr Sanderson. She indicated that she did know Dr Robinson from the practice. Dr Craft indicated that she did not recall whether she contacted Drs Robinson or Lawrence or Sanderson in relation to Mr Fennessy.[145]

136. Dr Craft indicated that in her practice she has access to the patient's notes when seen by all of the doctors and that she would speak to them if necessary, however she cannot recall whether she did at the time discuss any concerns about Mr Fennessy with those doctors.[146]

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[140] Transcript p46.21.
[141] Transcript p46.30.
[142] Transcript p46.37.
[143] Transcript p48.14.
[144] Transcript p49.
[145] Transcript p50.5.
[146] Transcript p50.15-25.

137. Dr Craft was asked questions in relation to her prescribing of medication for Mr Fennessy and essentially what she would have to be satisfied about in relation to his history of benzodiazepine dependency. Dr Craft indicated that her recollection was her diagnosis and treatment of Mr Fennessy from the very first day she saw him, was that she continued treatments started at The Canberra Hospital.[147]

138. Dr Craft indicated that her notes confirmed that Mr Fennessy had a benzodiazepine dependency problem and needed a sort of withdrawal. Dr Craft indicated that she had Mr Fennessy's medication placed in Webster packs so that the drugs would be limited in their number.[148]

139. Dr Craft was taken through the medications Mr Fennessy received from discharge on 4 November 2009 being Seroquel 50 mg for three days and 200 mg of Seroquel for two to three days. Dr Craft indicated that once those drugs had been consumed Mr Fennessy should attend his GP for further medication. Dr Craft indicated that she prescribed Mr Fennessy that same medication; however she had changed the tablets from 100 mg tablets to 200 mg. Dr Craft indicated that the reason she prescribed Seroquel was because of sleep disturbance and agitation. In relation to the diazepam Dr Craft gave Mr Fennessy a supply and he also entered a "benzo contract" for reduction of the benzodiazepine gradually.[149]

140. Dr Craft was referred to the aide memoire prepared by Counsel Assisting which sets out the information in Exhibit 21 in relation to drugs prescribed and dispensed to Mr Fennessy, and particularly the prescription on 26 June 2008 eight days prior to her prescription for diazepam 20 tablets and Seroquel 60 tablets. Dr Craft indicated that a facility available to doctors in relation to doctor shopping is a doctor shopping line where doctors can call to see if their patients are seeking opiates or benzodiazepine medications. Dr Craft indicated that this information is through the PBS.[150] Dr Craft did not contact the doctor shopper line about Mr Fennessy however she drew up a "benzo contract" with Mr Fennessy which confines the patient to one dispensing pharmacy and that if the patient gets prescriptions filled from another pharmacy, usually the GP would be notified of people on contract. Dr Craft indicated that she receives notifications about once a month of people on benzodiazepine undertakings potentially breaching their contracts.[151] Dr Craft explained that usually the contract goes to the pharmaceutical services people and to the pharmacy as well. Dr Craft assumed that that would have occurred.[152] Dr Craft agreed that it was a benzodiazepine contract and did not relate to other types of

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[147] Exhibit 14, p211.
[148] Transcript p52.30.
[149] Transcript p53.30.
[150] Transcript p54.31-45.
[151] Transcript p55.7.
[152] Transcript p55.22.

medications. Dr Craft indicated that this has now changed and a contract in relation to opiates and other drugs can be registered. Dr Craft indicated that at the time there was no facility to enquire of other practitioners who might be treating Mr Fennessy at that time.[153]

141. Dr Craft was again referred to the aide memoire which showed there were multiple prescriptions prescribed by different doctors including Dr Singh, Dr Sarfraz and Dr Rauf Rahim. Dr Craft opined that the giving of three antidepressants could have been because the doctors were changing Mr Fennessy's medication. Dr Craft indicated that she could not recall whether she knew that Mr Fennessy was accessing medication from Dr Rahim however she said that she tried to use Webster pack to keep the medication under control.

142. Dr Craft was taken to the pink entry in the aide memoire where Dr Kam had prescribed codeine phosphate, an opiate. Dr Craft agreed that the analysis of the document revealed that Mr Fennessy was accessing hundreds of tablets at a time and that was occurring as early as 2008.[154]

143. Dr Craft agreed that she was being vigilant by prescribing only small amounts of diazepam each three days and it appears that Mr Fennessy was able to access diazepam and perhaps forge prescriptions to procure medication. In relation to the prescription Dr Craft issued on 4 July 2008, Dr Craft indicated she would not have been aware that Dr Johar had prescribed medication a matter of days previous.[155]

144. Dr Craft indicated that although the multiplicity of drugs Mr Fennessy was taking were prescribed it would be extremely sedating to take all of them together. It was suggested to Dr Craft that it was not only multiple medication prescriptions but a diversity of drugs that may even have contraindications as between each other, and when asked how a person such as Mr Fennessy could be assisted to prevent access to multiple medications, Dr Craft indicated that once a report is made to the doctor shopping line she would have no knowledge of what occurred after the report.[156]

145. Dr Craft indicated that she did not have any contact with Dr Sanderson at Phillip Medical Practice and she was aware that Ms Finlay had raised concerns about Mr Fennessy doctor shopping. Dr Craft indicated that it was difficult trying to control the medications she prescribed to Mr Fennessy however she also tried to obtain an undertaking from him to control his medications as well.[157] In response to a question from me in relation to how valid it was to get

[153] Transcript p55.35.
[154] Transcript p56.41.
[155] Transcript p58.1-5.
[156] Transcript p58.15-35.
[157] Transcript p59.30.

an undertaking from people who are affected by drugs and who cannot help themselves and only want to get the drugs, Dr Craft indicated that she did not know how one could control people's lives and that it is always difficult with medications because people can become addicted and will then seek out those medications whether it be alcohol or benzodiazepines or other medications. She said that a doctor does have to have some form of trust with such patients particularly when having regard to their appearance they appear not to be intoxicated.[158]

146. Dr Craft agrees that at page 42 of her surgery notes there is an entry on 29 August 2008 where she was advised that Mr Fennessy was getting drugs from other doctors, and that on 24 August 2008 she prescribed diazepam which was dispensed on 3 September 2008. She was not aware that Dr Robinson had also been prescribing Mr Fennessy medications being Olanzapine and Seroquel.[159]

147. Dr Craft indicated that on 22 September 2008 she did not see Mr Fennessy however she prescribed an increased dosage of Seroquel. Dr Craft indicated that a note which read 'depression prescription with no consult' meant that it must have been a notification from the pharmacy about prescription requirements.[160] In relation to the increased dose Dr Craft indicated that it was the letters from Dr George indicating an increase in his medication that she would have been following and that she would not have provided a prescription of Mr Fennessy's medication without being directed to. Dr Craft agreed that without reviewing Mr Fennessy she increased his dose of Seroquel.[161]

148. Dr Craft was taken to her notes where a prescription was given on 1 October 2008 where she did not see Mr Fennessy but she indicated that it was most likely a prescription she provided to the pharmacy to include in his Webster pack.[162]

149. Dr Craft was asked whether given Mr Fennessy was a man that she knew was doctor shopping and taking anything he could get his hands on, if she had discussed with him or investigated an addiction specialist referral. Dr Craft said she did not and essentially suggested that because Mr Fennessy was being seen by Dr George who was the Drug & Alcohol psychiatrist and because Mr Fennessy had been engaged with the drug and alcohol program at the hospital at that stage.[163]

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[158] Transcript p60.1.
[159] Transcript p60.30-40.
[160] Transcript p62.1-5.
[161] Transcript p62.11.
[162] Transcript p62.20-37.
[163] Transcript p63.

150. Dr Craft was taken to page 44 of Exhibit 14 with her note that indicated that Mr Fennessy did not keep his appointment with Dr George, and to the letter from Dr George on 4 September where it appeared that Mr Fennessy was not engaging. Dr Craft indicated that on 5 November 2008 she saw Mr Fennessy and he indicated that he was seeing Dr George but had not made an appointment.

151. Dr Craft indicated that she was aware that Mr Fennessy had presented at the hospital about 18 November having overdosed on Clonazepam and Panadine Forte and other substances. Dr Craft indicated that she did not know where he got the clonazepam from; she had not prescribed it, although she agreed that he may have got it from other doctors he was accessing. It was suggested to her that he had accessed that particular drug from Dr Johar in June 2008 and Dr Harrison in September 2008.[164]

152. Dr Craft indicated that she was aware that Mr Fennessy had overdosed on 21 February 2009 and that she saw him on 23 February, however at that time she did not make any note about a management plan for him. Dr Craft stated that she then saw him on 3 March for a urinary tract infection and that his Seroquel and Lovan were ceased and the he was on no medications.[165] Dr Craft indicated that he was actually slightly intoxicated on that particular day and that he was a concern for her however in her view his drug problem was polypharmacy rather than a mental illness.[166] Dr Craft indicated that the treatment for someone with that condition is to engage them in treatments for themselves because you cannot force them into programs unless they are willing to engage in treatment. Dr Craft stated that is the position today as well.

153. When asked questions in relation to procedures need to be taken in relation to prescription drugs Dr Craft said *"I mean, the main people that have got access to what's happening with prescriptions are the PBS, yes. So I suppose if we were a bit more aware of these sorts of drugs that people are taking, in multiple numbers, if we became aware of those, it would be a good thing – good thing I think."*[167]

154. Dr Craft was asked whether access to other medical practitioners' notes in relation to a patient that she was seeing would be of assistance and she said yes particularly if the patient is doctor shopping. Dr Craft indicated that there is a benzodiazepine register, however when it was suggested by Counsel Assisting *"so a central registry to see what chemists around Canberra, or Canberra area, are dispensing in real time, to individuals that sort of thing ?"* Dr

[164] Transcript p64.
[165] Transcript p65.
[166] Transcript p66.
[167] Transcript p66.30.

Craft considered that that would be very useful in these sorts of circumstances.[168]

155. Dr Craft was taken through her notes in relation to 2009 and confirmed basically she was treating Mr Fennessy for simple depression and had refused to prescribe Seroquel. She was aware that Mr Fennessy took an overdose in May and she referred Mr Fennessy back to Dr George and by at least August 2009 Mr Fennessy was a little on track. Despite Dr Craft refusing to give Mr Fennessy Seroquel and diazepam, it is clear that other doctors were giving him these drugs despite Dr Craft doing her best to reduce the risk of harm to him.[169]

156. In September 2009 Mr Fennessy sustained significant burns and was treated at the Concord Hospital in Sydney and his pattern of polypharmacy started again after being given significant drugs for pain relief. When Mr Fennessy returned to Canberra Dr Craft knew that he would be on a methadone daily dose from the pharmacy and she set up a methadone contract with him. Dr Craft advised that Mr Fennessy did not comply with that contract and indeed he basically ceased medication himself.[170]

157. Dr Craft was made aware that on 30 October 2009 Mr Fennessy took an overdose of Tramadol and had a fit. Dr Craft did not treat Mr Fennessy until 13 November.

158. On 27 November Dr Craft saw Mr Fennessy who said he wanted to try naltrexone and a prescription was added however, a urine screening test was to be performed prior to starting of naltrexone.[171] Dr Craft next saw Mr Fennessy on 3 December 2009 for a broken tooth and gave him 10 Endone tablets.

159. Dr Craft was aware that on 3 January Mr Fennessy presented to the hospital with seizures relating to a Tramadol overdose. She saw him on 5 January and put him on a methadone contract in order for him to get his life in order because he was in withdrawal stages, and essentially to control some of the pharmacy use he was engaged in.[172]

160. Dr Craft was advised that despite her efforts Mr Fennessy was seeking olanzapine and diazepam from Dr Robinson at the time of the methadone contract. Dr Craft opined in relation to whether there was more that could have been done to help Mr Fennessy she said there was always hope but it’s difficult to know.[173]

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[168] Transcript p57.25.
[169] Transcript p68.
[170] Transcript p68.35.
[171] Exhibit 14, p59.
[172] Transcript p72.
[173] Transcript p73.15.

161. Dr Craft received advice on 7 January 2010 that Mr Fennessy had stolen something from the pharmacy and that he would no longer be prescribed methadone there. She also believed that he had been given a double dose of methadone that day.[174]

162. Dr Craft was never aware that Mr Fennessy had forged a prescription under the hand of Dr Alison Chan.

163. Under cross-examination, Dr Craft indicated that Mr Fennessy's mother Ms Finlay had come to see her on 11 January 2010 and one of the things that concerned Ms Finlay was that Dr Craft had put Mr Fennessy on methadone on 5 January 2010 when he was already on a cocktail of drugs. Dr Craft indicated that she wasn't aware Mr Fennessy had taken a cocktail of drugs however she noted that on the 5th he was withdrawing and had been taking heroin and wanted to go on to the methadone program.[175] Dr Craft was aware Mr Fennessy had been taking Rivotril but did not have any more available to him and that he reported no other drug taking. Dr Craft did not prescribe Rivotril for Mr Fennessy and could not remember whether she asked him where he had gotten it.

164. Dr Craft was asked whether, given she was aware that Mr Fennessy was a prescription shopper, she had contacted other GPs or pharmacy in the area: she replied no.[176] When asked when looking back what would she have done differently Dr Craft said, "*I suppose, looking back I would try to get him engaged more in the drug and alcohol program that he was and try and sort of keep that going I mean, I did try and see him fairly regularly, I tried to engage with him when he did come in, I tried to sort of control of the drugs that I gave him as well, but I suppose more of that, and maybe sort of use something like the doctor shopper line or something like that to see if there's anything available*."[177]

165. Dr Craft was asked when she saw Mr Fennessy on 5 January 2010 what she meant by his being in a bad way when she saw him. She said that she meant that he had nowhere to live, was using heroin, was shaky and on edge, which indicated withdrawal symptoms. He could not sit still and needed to be in rehabilitation. However Dr Craft did not make any attempts to see if she could get him into a rehab and indicated that the rehab clinics don't take referrals from doctors - generally they are all self referral.[178]

166. I asked Dr Craft about the entry on 4 January 2010 by Dr Callaghan, who saw Mr Fennessy after he was in hospital the night before and recently discharged,

[174] Transcript p73.25.
[175] Transcript p74.20–40.
[176] Transcript p75.20.
[177] Transcript p75.30.
[178] Transcript p76.20.

and who had noted Mr Fennessy was "not at risk of self harm". I suggested that the aide memoire clearly suggested that Mr Fennessy was at serious risk of self harm, but Dr Craft distinguished what is meant by self harm in that context, saying that Mr Fennessy did not express a wish to die, rather he overdosed because of his addiction.[179]

167. Dr Craft agreed that Mr Fennessy was at a considerable risk of self harm and when I posed the question whether there was anybody who could help Mr Fennessy given the rehabilitation programs require self referral, Dr Craft answered "*not really easily at the moment no there isn't*". When I asked if there was a deficiency, Dr Craft said it is very difficult with these types of patients as they use multiple medications or drugs, they can access things from a chemist as well, and that addressing drug addiction does have to come from a self motivation perspective in relation to rehabilitation.[180]

168. I asked whether there would be some good in having a system where both the doctor and the pharmacist could be alerted if someone was doctor shopping in real time and Dr Craft agreed that that was fair.[181]

Dr Gregory Hollis

169. Dr Hollis is a specialist in emergency medicine at The Canberra Hospital. Dr Hollis was the Clinical Director of Emergency at The Canberra Hospital between September 2008 and August 2011 and was reappointed to that position on 9 November 2015. Dr Hollis does not believe that he saw Mr Fennessy during his time as the Director of Clinical Services.

170. Dr Hollis gave evidence in relation to the procedures for patients who present to the Emergency Department following a drug overdose. He agreed that the process was the patient was assessed by the Emergency Department nursing and medical staff to determine whether there is a need for further monitoring and the like. Dr Hollis agreed that there would be a medical assessment done initially of the patient and once the patient was cleared medically an assessment of whether the overdose was deliberate or accidental would be made, and if the cause was not clear mental health review was sought. Dr Hollis clarified that by stating that once the patient is stable from an overdose mental health review is then sought.[182] In order to establish whether an overdose is deliberate or not, the criteria is the taking of a history, physical examination, and any collateral history that is available from for example ambulance officers or relatives or others who have been in contact with the patient.[183] Dr Hollis indicated that generally they would err on the side of

[179] Transcript p76.38.
[180] Transcript p78.1.
[181] Transcript p78.15-27.
[182] Transcript p5 (2.12.15).
[183] Transcript p5.20.

caution and seek a mental health review if unsure. Dr Hollis further clarified the procedure by stating that if it was an elderly person confused and mistook their medications that would be deemed to be an accident.[184]

171. In the case of someone such as Mr Fennessy, Dr Hollis said the clinician will take into account all the circumstances surrounding the overdose and his past history and if there was a history of previous deliberate overdoses.[185] Dr Hollis indicated that the clinician could be a medical or mental health clinician and could consist of an emergency doctor or emergency nurse and any other physician involved in the care.

172. Dr Hollis indicated that once a person such as Mr Fennessy who has a history of overdoses is medically cleared, the first contact would be the Mental Health team which in most circumstances is a CAT, or Crisis Assessment and Treatment, team member. That contact would be initiated by the Emergency Department medical staff. Dr Hollis indicated that once the referral is made, the next steps depend on the assessment result: it may be that the person requires other medical care or other consultation referrals, and the staff from the Emergency Department still generally have some responsibility for the patient's care.[186] Dr Hollis opined that it is a collaborative approach with the CAT worker who provides the mental health input and the ED medical and nursing staff to provide input into the person's total care.[187]

173. Dr Hollis said that the person who ultimately determines whether the patient is discharged is determined by their needs, such as in the case of Mr Fennessy, the discharge decision includes whether it was appropriate from a mental health perspective to discharge the patient and whether there are any grounds to detain them against their will.[188] Dr Hollis also indicated that the medical staff from the ED will determine whether there was further treatment or monitoring required of the patient. Dr Hollis said, *"ultimately it was the medical officer who would be the final point as far as the patient leaving the Emergency Department, but in practice is a collaboration between all of those inputs."*[189]

174. Dr Hollis agreed that there have been changes to the Emergency Department medical assessment unit following May 2010: significantly, the mental health assessment unit now has a dedicated psychiatrist and a psychiatric registrar on staff and that the psychiatric registrar is on shift 8 am to midnight and then on

[184] Transcript p5.30.
[185] Transcript p5.36.
[186] Transcript p6.10-25.
[187] Transcript p6.25.
[188] Transcript p6.30.
[189] Transcript p6.35.

call overnight. Dr Hollis thought that the consultant psychiatrist was on site during the day Monday to Friday and on-call outside those hours.[190]

175. When asked about the involvement of Alcohol & Drug Services, Dr Hollis indicated that someone who had regular or intermittent use of alcohol or other illicit drugs would fit into a referral to the Alcohol & Drug Service, but someone who overdosed on their own prescription medications is unlikely to be referred to that service.[191] Dr Hollis opined that the reasoning behind that is overdose of medication is likely to be a medical or mental health issue. Dr Hollis indicated that Emergency Department doctors and nurses and mental health team staff can make referrals.[192]

176. Dr Hollis was shown on page 263 of Exhibit 15 which he identified as being the Emergency Department record which has some clerical and clinical information on it, but he indicated that it is not clear who entered the handwritten entries.[193] Dr Hollis was asked to interpret the writing on page 263 and he indicated that he was not sure how to interpret it but it appeared that it was written by nursing staff to the effect that when they looked in the waiting room they could not see the patient, and that the CAT team was aware of the patient. He was unable to assist in whether it was the case that the CAT team were rung at the time of the discovery, or that they were aware of the patient prior to that time.[194] It was suggested to Dr Hollis that the document states "*Mr Fennessy presented at 8:44 PM on 3 January 2010 presenting with hallucinations and seizure and it appears that he requested a CAT review and then at 3 AM the patient was not in the waiting room*". Dr Hollis agreed that was a reasonable interpretation.[195] In relation to page 264 Dr Hollis agreed that it appears that Mr Fennessy was assessed by the nurses and the CAT review was completed.[196]

177. Dr Hollis was taken to page 265 of Exhibit 15 and indicated that it appeared that the social worker may have only reviewed the notes rather than directly having spoken to Mr Fennessy. The reference to ATOR was not one he was aware of however he thought it might be "at time of review".[197]

178. Dr Hollis was taken to page 267 where he identified Dr Chan as being a medical practitioner from the Emergency Department and that the note stated that Ms Finlay was in attendance with Mr Fennessy, that Mr Fennessy was examined and the medical conclusion was that he did not need medication to control his seizures. Dr Hollis agreed that the note also indicated that there is

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[190] Transcript p7.5.
[191] Transcript p7.30.
[192] Transcript p33-45.
[193] Transcript p7.27-34.
[194] Transcript p9.1.
[195] Transcript p9.5-10.
[196] Transcript p9.27.
[197] Transcript p9.31-45.

no clear documentation the patient was ever supposed to be either on Prozac or Rivotril and there was a planned referral for alcohol and drugs review.[198]

179. Dr Hollis indicated that pages 272 and 270 were printouts from the electronic mental health record system. Dr Hollis agreed that there is a multidisciplinary approach in the Emergency Department when patients such as Mr Fennessy are admitted following a complaint of hallucination and seizure.

180. It was suggested to Dr Hollis that Mr Fennessy had presented to the hospital on 3 January 2010 and again re-presented on 6 January 2010 with a heroin overdose, and Dr Hollis was asked whether the Emergency Department medical practitioner would have access to the previous admission notes. Dr Hollis said that they would have access and they would be readily available with the exception of the MHAGIC notes, these would not be so accessible because it depended whether they had been printed out or not.[199]

181. It was suggested to Dr Hollis that Mr Fennessy had had 4 admissions in the recent past prior to death being 29 November 2009, 23 December 2009, 3 January 2010, and 6 January 2010. Dr Hollis indicated that any medical practitioner in emergency would have had access to the medical notes for Mr Fennessy's presentation to Emergency. Dr Hollis agreed that this would have been significant to any practitioner given the recent admissions for overdose.[200] When asked about whether that would have informed the medical practitioner receiving Mr Fennessy on 6 January 2010, Dr Hollis said that all of the collateral history including past history is of relevance in deciding what should be done on that particular occasion. He further opined that reviewing the detail of the previous assessments from those presentations would be important in deciding what treatment and management was appropriate on that occasion.[201]

182. In relation to whether access to the mental health notes was necessary Dr Hollis opined that it may be in certain circumstances important.[202] Dr Hollis also agreed that a medical practitioner assessing Mr Fennessy would have prudently considered the mental health records.[203]

183. Dr Hollis was taken to page 309 which indicated that Mr Fennessy was assessed by Dr James Falconer. In relation to page 317 Dr Hollis indicated that document was largely a nursing entry rather than medical, and said in relation to page 319 again that was a nursing note. It was suggested to Dr Hollis that there was no discharge summary on 6 January 2010 for Mr Hennessy and Counsel for the Territory agreed that that was the case. Dr

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[198] Transcript p11.1.
[199] Transcript p10-17.
[200] Transcript p12.30.
[201] Transcript p12.40.
[202] Transcript p13.1.
[203] Ibid.

Hollis indicated that he could not say what happened to Mr Fennessy and how he was released because he does not have any notes to act on, however he did say it may well be in the MHAGIC notes. I note there is no entry in the MHAGIC notes.

184. Dr Hollis explained the process of discharge and said it is expected that a discharge letter is written for all patients discharged from the Emergency Department. Dr Hollis opined that in this case either a discharge letter wasn't written or it has been lost; in his view they were the two possibilities.[204] Dr Hollis said in relation to the discharge, that the medical practitioner, the nursing staff and the mental health worker who assessed the patient should all agree that it is appropriate for the patient to be discharged. Dr Hollis said he cannot see any documentation to suggest this occurred or not.[205]

185. In a question from me in relation to whose job it was to discharge the patient, Dr Hollis said that given there are sometimes handovers throughout the day it would be the doctor who was the primary carer at the time of the discharge. Dr Hollis also indicated that collaboration with senior medical staff is not necessarily warranted in those circumstances.[206]

186. During cross-examination by Mr Crowe, Dr Hollis confirmed that page 263 was an admission of Mr Fennessy on 3 January, that page 265 included a referral to seek a review of the patient and a request for notes, and those notes were then included in the patient's ED file.[207]

187. Dr Hollis was taken to page 276 and indicated that it was not clear from the social worker notes that Mr Fennessy was seen by the social workers.[208] Dr Hollis was taken then to page 309 and confirmed that was the admission on 6 January 2010. Dr Hollis read out the document and said this*:*

> *'this admission; found unconscious on bench – besides street by friend found. Given mouth-to-mouth and ambulance called. Found to be cyanosed/ diaphoretic. Given 2 x 400 MCG – I M +2 x 400 – IV with slow response. GCS now 13/15. Patient unable to recall events of this morning other than picking up – daily methadone. Believes he may have injected heroin/BDZ.* (Which means benzodiazepine.) *Recently well. Denies fevers, sweats rigors and* (was unsure of the next word but could be cough or cold) *and shortness of breath. Has been feeling depressed and doesn't care if he dies. Homeless at present'* [209]

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[204] Transcript p15.1-20.
[205] Ibid.
[206] Transcript p15.3.
[207] Transcript p16.10-30.
[208] Transcript p16.30-40.
[209] Transcript p17-18.10.

188. Dr Hollis was asked whether the fact that Mr Fennessy had said he doesn't care if he dies would ring alarm bells within the Department. Dr Hollis indicated that there would be extra caution towards the patient. Dr Hollis agreed that in Mr Fennessy's case there had been a pattern of presentations in close proximity to each other.[210]

189. Dr Hollis explained the writing that followed summarised as Mr Fennessy would need to be monitored in acute as methadone and benzodiazepines have long "TR" (which he explained as they have a short half life) which has relevance given the administration of Narcan. The note further indicates intravenous access, that Mr Fennessy can eat and drink, and that neurological observations should be maintained. It also indicated that he should have blood tests.

190. Dr Hollis identified that nursing staff conduct the observations and those notes would be in their records and indicated at page 321 the entries at 1450 hours for the patient to be transferred to EMU, which he explained is the emergency medicine unit for patients who require observations. Dr Hollis explained that the next note suggested Mr Fennessy was drowsy but rousable.[211]

191. Dr Hollis indicated that he was not aware of Mr Fennessy's death until sometime early in 2015. In relation to whether Dr Hollis had concerns in relation to the discharge summary he indicated that there should have been a discharge summary. Dr Hollis said he was not involved in any review.[212] Dr Hollis indicated that he would have been alarmed given the words Mr Fennessy said in that he does not care if he dies and he was depressed, but Dr Hollis was unaware of any review in relation to why there was no discharge summary on file.[213] When it was suggested that I would be assisted by knowing why there wasn't a discharge summary Dr Hollis indicated that it would be more appropriate to ask the doctor who specifically looked after the patient, however, he opined that that person may not now recall given the length of time. Dr Hollis was not aware of why there was no discharge paperwork and he was not aware of any publicity about this issue. He understands there may have been a hospital review but he does not know the details at this time.

192. Dr Hollis was questioned in relation to why, given that he knew that there was no discharge summary, he did not do anything about it. Dr Hollis indicated that he was asked two specific questions to comment upon in his statement, those being procedures and practice in relation to discharge of individuals in similar circumstances to that of Mr Fennessy, and to include details of the current procedures and practice and any differences compared to those of January

[210] Transcript p18.41.
[211] Transcript p20.30.
[212] Transcript p21.17-34.
[213] Transcript p22.35.

2010. Dr Hollis could not offer any further explanation as to why there was no discharge summary and accepted that he did nothing in relation to it.[214]

193. In questions from me he indicated that he was not involved in the quality assurance process as far as he could recall. I further asked whether given the circumstances of Mr Fennessy's admission, the fact that he had been admitted previously, and that his words of not caring whether it dies or not, whether that be considered as a very great risk of harm if discharged. Dr Hollis agreed and said that would be of a significant concern but he indicated that in his view it would have been explored much more thoroughly particular given he was seen by the CAT worker. He agreed the statement did raise alarm bells and was of great concern and that a mental health assessment would have explored that. In relation to further questions about what would happen if the mental health practitioners indicated that the patient was not to be admitted, Dr Hollis indicated that a discussion would have been conducted between the medical practitioner and the CAT worker and that if the medical practitioner still had major concerns, other members of the mental health team could become involved such as the on-call psychiatry registrar or psychiatrist.[215]

194. In response to another question that I asked in relation to Mr Fennessy's attitude to remaining in the hospital, Dr Hollis stated that the staff would need to take into account all factors in relation to the patient's presentation.

195. Dr Hollis was given the information about observations such as that Mr Fennessy was rousable but drowsy at 1450 hours, his intravenous infusion was removed at 1700 hours, and that he had only overdosed a couple of days before, and I asked whether that would have made a significant difference to the doctor's assessment, and Dr Hollis agreed it would be of concern. I posed the question "*yet he was allowed to go home*" and Dr Hollis indicated that all the criteria would have to been assessed in relation to keeping him involuntarily there under the Mental Health Act. Dr Hollis indicated that given the presumption that a person generally is able to make decisions for themselves, if that person was alert and able to make the decisions and had a mental health assessment which did not indicate detention was necessary, they would be unable to be restrained under the Mental Health Act against their will.[216]

196. Dr Hollis explained in response to a question from Mr Crowe that a person who deliberately consumes harmful amount of drug to seek a high comes within the scope of a deliberate overdose.[217] Dr Hollis was shown page 263 and it was suggested that the time recorded was 2300 hours not 3 am, and Dr Hollis

[214] Transcript p24.
[215] Transcript p25.
[216] Transcript p27.1.
[217] Transcript p27.39.

agreed. Mr Crowe tended a document, Exhibit 28, which confirmed the time was 2300 hours.

197. Dr Hollis indicated that it is unusual for patients to be told to remain in the Emergency Department although it happens when there is no other social option for patients. Dr Hollis indicated it would be less likely that a decision would be made at 11:27 am that someone might be permitted to remain overnight in the waiting room. I took this to mean that the entry would be 11:27 pm when that decision was made.

198. Dr Hollis was taken to page 127 of Exhibit 15 and he confirmed that blood pathology was conducted on Mr Fennessy on 6 January which included a full blood count.[218] Mr Sabharwal asked whether the results from the urea and electrolytes and liver function tests were done. Dr Hollis indicated that it is most likely that they would have but there is no report in the notes to that effect. Dr Hollis indicated that the haemoglobin level was mildly lower than the normal range, the white cell count was mildly elevated, the platelet count was normal and that in the clinical context those results are not significant.[219]

Kenneth William ("Bill") Bailey

199. Mr Bailey gave evidence that he is a Registered Nurse and was at the date of the hearing working at the City Mental Health Unit in Moore Street. Mr Bailey provided a statement which was exhibited as Exhibit 29.

200. Mr Bailey gave evidence that he had four years' experience as a registered nurse at the time he assessed Mr Fennessy in 2010. Mr Bailey was asked whether he knew Mr Fennessy prior to 6 January 2010, and he stated that he did not recall having seen him prior to that time but he may have.[220]

201. Mr Bailey indicated that he had reviewed all of the mental health files in relation to his involvement with Mr Fennessy. Mr Bailey was taken to page 135 of Exhibit 15 and identified the document as an Emergency Department document and indicated at point 4 on that page the entry meant that the person has a mental health problem which was semi-urgent but definitely would need to be supported and addressed. Mr Bailey agreed that it would be a mental health clinician who would assess the patient.[221]

202. Mr Bailey was taken to page 135 and indicated that the document was a psychiatric triage checklist. Mr Bailey was taken to the writing on page 137 at heading "Other Relevant Notes" and identified the words as "*brought in by police, CAT requested, query family requested. Patient needs medical psych*

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[218] Transcript p30.15.
[219] Transcript p32.14.
[220] Transcript p34.
[221] Transcript p34.25.

assessment. Patient does not feel there is any reason to be in ED." Mr Bailey indicated that document is used in Emergency for the triage nurses when a patient comes in and they have a mental health presentation: the nurse assess and refer to the CAT team, who will then do an assessment.[222]

203. Mr Bailey was then taken to page 139 and he confirmed that the clinician who wrote that report was Dr Chak Wahib and that he was present and assisted Dr Wahib in the assessment and mental state examination of Mr Fennessy on 23 February 2008. [223] Mr Bailey agreed that he and the registrar knew that Mr Fennessy had been admitted previously with drug induced psychosis. Mr Bailey was referred to the document and particularly the impression drawn which stated: "*that today's presentation was most likely influenced by the use of ecstasy. There is no apparent risk issues. Situation is a bit complicated by mother refusing to accept him home tonight. Plan, discharge with Zyprexa and to stay at CAT flat tonight"*.[224] Mr Bailey indicated that the CAT flat was used by mental health services at that time as accommodation for patients who required it. Mr Bailey was then taken to the next entry which states*; "review by CAT tomorrow. If settled, able to return home. Need follow-up for the next couple of days by CAT. May need drug and alcohol service involvement".* Mr Bailey indicated that was the end of their involvement with Mr Fennessy on that occasion.[225]

204. Mr Bailey was referred to page 193 which he agreed was a statement of action for an authority for the police to convey Mr Fennessy to The Canberra Hospital. Of note it said: *"mentally dysfunctional. Psychotic. Preoccupied by internal stimuli. Increasingly confused and acting in ways which increased potential risk to well-being. Refusing voluntary assessment. Requires containment for assessment*."[226]

205. Mr Bailey was taken to page 124 of Exhibit 16, a mental health note which indicated that Mr Fennessy's parents had contacted CAT wanting to have Mr Fennessy admitted, that there had been three home visits by the CAT team and that Mr Fennessy did not know his mother had contacted CAT and was guarded and perplexed at that comment, that the CAT member examined Mr Fennessy and the impression given was that he had a psychotic illness and considerable thought disorder due to possible underlying mental illness and or apparent use of street drugs. Mr Bailey accepts that those were the notes that were taken and the assessment that was done.[227]

[222] Transcript p35.4.
[223] Transcript p35.20-40.
[224] Transcript p36.11.
[225] Transcript p36.30.
[226] Transcript p36-37.
[227] Transcript p37.

206. In relation to the entry on page 125 Mr Bailey agreed that it meant that Mr Fennessy had been transferred from the Emergency Department on that day to the CAT flat by mental health clinicians. Mr Bailey was referred to page 127 and 128 and said that he understood this to mean that the clinician from the CAT team would go to see Mr Fennessy and encourage him to ring Samaritan House, and that his mother would receive feedback with a plan.

207. Mr Bailey essentially stated that he did not know if Mr Fennessy had been referred to a case manager because he was in the care of the crisis management team which is the CAT team. Mr Bailey explained that the CAT team would take the person for a limited time and manage them and it was at the end of that period of time and if they needed ongoing support they would be referred to a community team for case management. He recalls that the CAT team at that point in time did not case manage patients.[228]

208. In relation to page 133 Mr Bailey explained that the multi-disciplinary team holds daily meetings for their own consumers to work out which cases get referred and which cases are continued or whether the care episode is completed. Mr Bailey was advised that Mr Fennessy took an overdose of clonazepam on 28 March 2008, he was medically discharged and he denies thoughts of self harm, the CAT team was involved but no case management team was ever appointed.[229]

209. Mr Bailey was again asked whether he recalled Mr Fennessy or had a memory of him, however he said that it was a long time ago and he had seen many patients in that time and could not accurately say yes or no. It was put to Mr Bailey that he had worked in the Emergency Department for a number of years and Mr Fennessy had had a number of admissions to the Emergency Department yet he has no memory of Mr Fennessy. Mr Bailey said he just cannot remember and suggested if that question had been asked in 2010 he may have given a different answer.[230]

210. Mr Bailey agreed that he would, in 2010, when assessing Mr Fennessy have had access to the MHAGIC notes and he would have reviewed those notes given it was his practice to do so. Mr Bailey stated that he did not access the admission records as he did not have access to them and Mr Fennessy wanted to leave at that time.[231] Mr Bailey accepted that he would have read in the admission record that Mr Fennessy had presented some three days earlier on 3 January 2010 and that on that occasion his problem was hallucinations and query seizures, and the presentation on 6 January was a heroin overdose.

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[228] Transcript p39.25.
[229] Transcript p40.1.
[230] Transcript p41.1.
[231] Transcript p41.10-20.

211. Mr Bailey was also taken to the notes which read: "*this admission, found unconscious on bench beside street by friend, given mouth-to-mouth and ambulance called and found to have overdose with medication. Has been feeling depressed and doesn't care if he dies. Homeless at present*". Mr Bailey indicated that he did not recall whether he was advised about that statement but if he had been advised of it he would have included it in his notes. In regard to whether he considered it as a significant fact, he said it would be significant but he would also take it into context of when Mr Fennessy said it and the time when he saw Mr Fennessy.[232]

212. Mr Bailey was again asked whether he had access to the MHAGIC notes and the multiple admissions of Mr Fennessy over the six-week period over 29 November and 23 December 2009, and 3 and 6 January 2010, and he agreed he would have had access to them and would assume that he had read them. Mr Bailey said there were times when he would not have access to the computer if he was somewhere in the Department however he could not think why he wouldn't have access to the system on any particular day.

213. Mr Bailey indicated that it was approximately 17:00 hours on 6 January 2010 when he assessed Mr Fennessy. He assumed that he would have been aware that Mr Fennessy was in the department from about 1 pm, however he was taken to page 232 and 233 which stated at 2:35 pm "*client not medically cleared at this time. Plan, CAT review when medically cleared*." Mr Bailey agreed that he was unable to do his review until Mr Fennessy had been medically cleared.[233]

214. It was suggested to Mr Bailey that the practice was that there was to be a collaborative decision by the medical and mental health teams and any other person involved in his care as to whether Mr Fennessy was fit to be discharged. Mr Bailey indicated that he thought the practice was once he had been advised by the Emergency Department the patient was ready for discharge, it was at that time that he would do his assessment.[234]

215. It was suggested to Mr Bailey that he should have informed either the ED medical registrar or some other medical person to advise them that there were no mental health issues that required Mr Fennessy to be detained. Mr Bailey indicated that it was the practice at the time that he would see the patient and if he wanted the patient to be admitted he would notify the doctors. The fact that a patient had been medically cleared was indicative that the patient had been cleared and handed over to the mental health team for either discharge or admission. Mr Bailey said that upon completion of the notes he would have

[232] Transcript p43.1-11.
[233] Transcript p45.10-46.6.
[234] Transcript p46.9.

advised the doctor that the mental health team had either discharged or admitted the patient.[235]

216. It was suggested to Mr Bailey, and he agreed, that Mr Fennessy had been admitted on 6 January 2010 to the Emergency Department. Mr Bailey also agreed that at the time he was a mental health clinician working in that department and was part of the CAT team who consulted to that Department.

217. It was suggested to Mr Bailey that the appropriate procedure was for him to convey to the medical staff that Mr Fennessy was no longer to be detained. Mr Bailey said he did not understand. Counsel Assisting suggested to Mr Bailey that there was no discharge summary for Mr Fennessy and that nobody knew how it was he left the hospital after 5 pm on 6 January 2010 without being discharged. Mr Bailey stated that it was the ED staff who wrote the discharge summaries for the ED patients and that when Mr Fennessy left he had no grounds to physically restrain him; he also said Mr Fennessy was not willing to stay.[236] Mr Bailey indicated that the information he would have conveyed to the medical staff was that Mr Fennessy was ready to be discharged although he cannot now remember, but he believed he followed the process of the day and it would have been his practice.[237]

218. Mr Bailey was asked about his assessment in relation to suicidality and the entry on page 234 of Exhibit 16 where he indicated Mr Fennessy "*does not meet any criteria to hold under the Mental Health Act*". Mr Bailey indicated that he did do a suicide risk as part of his assessment of Mr Fennessy. When asked whether there was a document that was filled out Mr Bailey indicated that at that time there was no document to fill-in.[238] Counsel Assisting suggested that there was a document in existence at the time and it was a suicide risk assessment document Parts A and B. Mr Bailey said he did not recall when that document came in. In relation to the document Mr Bailey said that he would fill it in after the event not during the process, and Mr Fennessy told him he was not suicidal.[239]

219. When it was suggested that Mr Bailey's evidence was that there was not a suicide risk assessment document in existence in January 2010, Mr Crowe objected and said that was not what Mr Bailey said, he said he couldn't recall whether the document was in use at that time. I have had the benefit of transcript and in answer to a question that I raised about whether there was a

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[235] Transcript p46.10-25.
[236] Transcript p47.4-15.
[237] Transcript p47.17.
[238] Transcript p47.27.
[239] Transcript p47.30-40.

document that he filled in Mr Bailey said, *"no, there wasn't a document to fill in at that time".*[240]

220. Mr Bailey was taken to Exhibit 16 page 164 where a reference was made at the bottom of the page to a form appearing to be a "suicide risk part A" document and which was dated 9 November 2008 and was completed by a clinician. When it was suggested to Mr Bailey that he would have been familiar with that particular document, he indicated that he did not recall having used it.[241]

221. Mr Bailey was then taken to page 169 which is a suicide risk assessment part B. It was suggested that Mr Aloisi had given evidence that they are documents used by mental health clinicians when assessing whether the clients is a suicide risk. When asked what his evidence was about completing these documents, Mr Bailey said that he had used these documents when he been working in the CAT team and working on the telephones. I indicated to Mr Bailey that was not the question that was asked: the question was in relation to the day of the assessment. Mr Bailey said he was trying to work out whether he had seen the document, and said he was trying to work out whether he had seen that particular document as they have different documents now and he was not sure when these documents changed, however he did say he did not fill in that document at the time.[242] Mr Bailey confirmed this view in a further question from me.[243]

222. Mr Bailey agreed that in his assessment he asked Mr Fennessy what time it was and at that point it was 4:45 pm which was an accurate recording of the time. Mr Bailey agreed that he did not do a suicide risk assessment form A and B on that occasion but he said that he assessed him by asking him whether he wanted to harm himself or anyone else.

223. It was suggested that Mr Bailey had said in his evidence earlier that he was not aware of the statement made to the ED medical practitioner by Mr Fennessy that he didn't care if he died. Mr Bailey said he did not recall that he was aware of it and when questioned again he said he couldn't remember and that was his answer and when pressed he indicated that he could not remember whether he was aware of it.[244] It was suggested that had Mr Bailey been aware that Mr Fennessy had expressed a statement such as that recorded in the notes that would have been significant information. Mr Bailey agreed that it would have been significant in so far as he would have had to investigate it further. When asked whether that would have changed his conclusion of no thoughts of self harm, Mr Bailey stated that when he interviewed Mr Fennessy he specifically asked him whether he was suicidal or not. Mr Fennessy said he was not.

[240] Transcript p47.33.
[241] Transcript p48.39.
[242] Transcript p49.5-21
[243] Transcript p49.31.
[244] Transcript p51.10-29.

224. Mr Bailey was asked whether his notes were an accurate representation of his assessment of Mr Fennessy at the time and he indicated that they were. In relation to his written observations "*pupils still pinpointed from overdose"* Mr Bailey indicated that when he does a mental health assessment he also does a physical observation, and he noted that people who have taken narcotics may have pinpointed pupils for some days.[245] Mr Bailey stated that in his view pinpoint pupils means that the person has taken medication and had a reaction to it. It was suggested to Mr Bailey that given he had made a note of the pinpoint pupils, it must have been significant. Mr Bailey could not explain what it meant; just that he observed it, and could add no more.

225. Mr Bailey was then asked about the notes of his assessment and his observations that Mr Fennessy's pupils were still pinpointed from the overdose and Mr Fennessy's speech was slurred but able to be understood, and having noted those observations why he did not feel it was necessary to refer Mr Fennessy back to the ED medical practitioner. Mr Bailey replied that he did not feel he needed to.[246]

226. Mr Bailey was then referred to a note on page 233: "*denied any thoughts of wanting to harm himself. Stated that he miscalculated his IV and drug cocktails which caused him to collapse earlier in the day*". He was asked whether he accepted Mr Fennessy's explanation given the earlier collapse and other occasions in the preceding weeks of overdoses and whether he took that into account in relation to the explanation given by Mr Fennessy, and he said he did.[247]

227. Mr Bailey was referred to the note on page 233: "*explained that he would like to go to rehab and wants to go to detox. He understands that detox will not take him unless he has a rehab program organised. He has been offered an appointment by drug and alcohol services tomorrow at 3 pm, which nursing staff have written down for him"*.[248] Mr Bailey was asked how he made that assertion and he indicated that Mr Fennessy told him that he had the appointment and that Mr Fennessy had a piece of paper in his hand which he assumed was from the nursing staff in the emergency medical unit. Mr Bailey also indicated that he thought the emergency staff had told him of the appointment.[249]

228. Mr Bailey indicated that he had been involved with talking to Ms Finlay but that she wasn't part of the assessment and that he had seen Mr Fennessy separately and then together with his mother.

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[245] Transcript p52.12-26.
[246] Transcript p53.5-31.
[247] Transcript p53.35.
[248] Transcript p54.1.
[249] Transcript p54.5–24.

229. Mr Bailey was referred to his note in relation to the fact that Mr Fennessy's mother did not allow Mr Fennessy to stay at home, and Mr Bailey said he was understanding of that decision and indicated that he would have discussed with Mr Fennessy the fact that he was homeless, otherwise he would not have recorded it. When asked what solution did he offer to Mr Fennessy about homelessness Mr Bailey stated that, "*he was wanting to leave. He was wanting to bring the interview to an end*" and when asked again he said "*I cannot recall*".[250] Mr Bailey was asked whether he could identify in his notes where he had written a solution, he said "*it's not in there*" and when suggested that he did not offer any solution to Mr Fennessy's homelessness Mr Bailey stated "*I don't remember the full interview*".[251] When it was suggested that had he offered Mr Fennessy a solution such as Samaritan House or a vacancy in the CAT flat he would have made a note in his notes Mr Bailey said that was possible. It was suggested by Counsel Assisting that it was more than a possibility, it was probable if he had actually offered an alternative to Mr Fennessy's homelessness he would have made a note, Mr Bailey answered, "*I can't answer that question*."[252]

230. In relation to the criteria that a clinician considers in order to decide to detain a patient under the Mental Health Act, Mr Bailey indicated that he would have to believe that the person was suffering from mental health symptomology, that the person was a risk to himself, that is, an immediate risk to himself or to others, and that he would have to believe that the person was in a deteriorating mental health state.[253] In a question from me about what he meant by "deteriorating" and how he would determine that, Mr Bailey answered that if he had identified that the person was psychotic or depressed and dysfunctional and there was no future planning, that would have been significant. Here Mr Bailey referenced the fact Mr Fennessy had talked to him earlier about going to Drug & Alcohol the next day, and said that he would not have documented the piece of paper in Mr Fennessy's hand if he hadn't seen it.[254] Mr Bailey indicated that he did not see what was written on that piece of paper.

231. Mr Bailey said that any doctor, mental health officer or police officer can decide to detain a person involuntarily under the Mental Health Act. Mr Bailey confirmed that he could have made an order on the basis that the person was mentally dysfunctional or mentally ill.[255] Mr Bailey was taken to the definition of "mental illness" in the Mental Health Act and asked to comment in respect of Mr Fennessy, and he deemed Mr Fennessy not to have a mental illness. Mr Bailey was also asked about an alternative where a person may be mentally

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[250] Transcript p55.1-12.
[251] Transcript p55.5-16.
[252] Transcript p55.20-25.
[253] Transcript p55.38-44.
[254] Transcript p56.1.
[255] Transcript p56.22.

dysfunctional, and he accepted that a person may be mentally dysfunctional under the legislation. It was put to Mr Bailey that the definition of "mental dysfunction" was a fairly broad concept which he accepted.

232. It was suggested to Mr Bailey that given the observations he made of Mr Fennessy, being slurred speech, pupils pinpoint from overdose and the fact that Mr Fennessy had been on several occasions admitted for overdoses, on those factors alone he could have made a determination to detain Mr Fennessy involuntarily. Mr Bailey did not agree with that, saying that he did not have any grounds to detain Mr Fennessy.[256]

233. Mr Bailey was taken to his note on page 234 when he said "*I am concerned that Paul will re-present again within a very short time frame*." It was suggested to Mr Bailey that in saying that he was concerned that there was a real risk to Mr Fennessy's health and safety. Mr Bailey indicated that he thought Mr Fennessy's issue was his significant drug and alcohol problems rather than it being a mental health issue. After reviewing his notes Mr Bailey indicated that it was his view that Mr Fennessy was not yet ready to go to detox and the reason he noted this comment (referred to above) was to alert people who came after him so that they could do as much as they could for Mr Fennessy.[257] When asked what he meant by this, Mr Bailey said that he did a mental health assessment not an Emergency Department assessment in that context.

234. It was suggested that what Mr Bailey meant by that note was that he was concerned that Mr Fennessy would re-present himself again within a very short time and it referred to the risk posed, that is that Mr Fennessy would re-present to The Canberra Hospital with an overdose again, not just Mr Fennessy's mental health state, and that this is exactly what happened on 6 January 2010. Mr Bailey replied no.[258]

235. Mr Bailey was referred to his note where he wrote "*urgently needs to detox as he has no ability to manage his lifestyle or organise safety, shelter and food*", and it was suggested that he was concerned that Mr Fennessy was at risk to his own health and safety. Mr Bailey stated that he was worried about Mr Fennessy and wanted Mr Fennessy to be followed up. When he was asked how that was going to happen given he was going to let Mr Fennessy go from the ED, Mr Bailey said that Mr Fennessy was agitated, wanting to leave the Department, and that he believed he had no grounds to detain Mr Fennessy for any further part of an assessment.[259]

236. It was suggested that Mr Bailey was so sceptical of Mr Fennessy attending for any appointment that he wrote in his notes "*I understand alcohol and drugs will*

[256] Transcript p57.1-14.
[257] Transcript p57.29–35.
[258] Transcript p58.4.
[259] Transcript p58.20-35.

review him tomorrow at 3 PM for detox, however he has to keep the appointment. I am not sure he will keep that appointment". Mr Bailey said in answer that many people do not keep those appointments, but that is not to say that clinicians should not follow patients through, and that people reading notes from the CAT team would be alerted to the concerns that he had.[260] It was suggested to Mr Bailey that when he wrote down this note it was his view that it was more probable than not that Mr Fennessy would not keep the appointment the following day. Mr Bailey said "*obviously yes*" and it was suggested that that was what he wanted to draw this fact to the attention of anyone subsequently treating Mr Fennessy.[261]

237. Mr Bailey agreed that his note about Mr Fennessy's mother trying passionately and valiantly to advocate on Mr Fennessy's behalf, and the fact that she was extremely frustrated that she could not assist her son into detox and treatment, was to draw the attention of the next clinician to that fact; also he wanted the fact that Ms Finlay had tried everything to protect her son to be known.[262]

238. I asked Mr Bailey some questions in relation to his observations about pinpoint pupils and the note he made that Mr Fennessy told him that he wished to get to the Weston pharmacy before 6 pm to collect his methadone. I asked whether that rang alarm bells given the circumstances of Mr Fennessy's admission, particularly the fact that he was not breathing and had to be resuscitated. Mr Bailey said that he was not focused on that because he was more focused on the fact that Mr Fennessy was not staying and that he had no grounds to hold Mr Fennessy, and it was only afterwards when he wrote his notes that he tried to put everything into them.[263]

239. I further asked Mr Bailey whether, given the circumstances, that Mr Fennessy was going to the chemist for methadone, the circumstances of Mr Fennessy's admission on the 6th, the fact that Mr Fennessy nearly died, the fact Mr Fennessy was agitated, were not grounds to consider keeping Mr Fennessy there. Mr Bailey said he did not think that at the time. When I asked why he didn't think of those things, Mr Bailey said he was too busy, there was 15 to 20 minutes of time with Mr Fennessy and that Mr Fennessy's mental state did not allow him to detain Mr Fennessy under the Mental Health Act. I asked Mr Bailey whether there were other reasons why Mr Fennessy could be detained under the Act and he said he did not think it was suitable to speak to a doctor about Mr Fennessy at the time, and he did not speak to a doctor at the time.[264]

240. I suggested to Mr Bailey that he was concerned about Mr Fennessy and that fact was reflected in his notes. Mr Bailey said that he thought when writing the

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[260] Transcript p59.1.
[261] Transcript p59.6.
[262] Transcript p59.23.
[263] Transcript p59-60.
[264] Transcript p60.9-33.

notes it was then his concern was pricked however at the time he did not have a concern.[265] (I assume Mr Bailey meant at the time he was assessing Mr Fennessy.)

241. Mr Bailey said that he felt that he had kept Mr Fennessy there longer than what happens mostly and he had done his best to engage Mr Fennessy and talk to him. Mr Bailey indicated that generally he would ask where the person had slept the night before to elicit whether they were homeless and he said he was sure he would have asked Mr Fennessy that question. Mr Bailey thought that Mr Fennessy had told him that he was staying on someone's couch but he could not remember that for a fact. Mr Bailey considered that Mr Fennessy had a drug addiction rather than a mental health issue, and identified that Mr Fennessy had been reviewed by a psychiatrist a week earlier and that the impression was that Mr Fennessy had no significant depressive components. Mr Bailey thought he had read a note which would have influenced him in his decision-making.[266] This turned out to be Dr Anna Berger's comment that Mr Fennessy did not have a significant depressive component, and Mr Bailey stated that he thought he would have had regard to her psychiatric review.[267]

242. Mr Bailey was questioned about his discussion with Mr Fennessy as to why Mr Fennessy wanted to leave and that Mr Fennessy felt trapped, as he had written in his statement. It was suggested to Mr Bailey that he added "*and thought he would be locked up again*" to his statement, which he admitted he wrote some five years after the event and was not in his notes written at the time. It was suggested that Mr Bailey made that element up, however he denied it.[268] In reference to what Mr Fennessy meant by locked up it was suggested that he meant involuntarily detained, and Mr Bailey said he imagined that would be what it was.

243. Mr Bailey was asked some further questions in relation to his understanding about what was meant by someone being monitored. Mr Bailey appeared to either misunderstand or be evasive in his answers and it was suggested to him that he knew exactly what it meant and that Mr Fennessy was in an emergency medical unit monitored by nurses. Mr Bailey agreed that Mr Fennessy voluntarily went back to Mr Bailey's office to talk with Mr Bailey after having said that he wanted to leave the ED and so wasn't locked up. Mr Bailey said that he thought Mr Fennessy was referring to previous admissions, however there was no note about that.[269]

244. Mr Bailey agreed that he did not write in his notes that he had discussed with Mr Fennessy the option of staying in the emergency medical unit overnight. He

[265] Transcript p60.35.
[266] Transcript p61.9-20.
[267] Transcript p62.35.
[268] Transcript p63-64.
[269] Transcript p64.10-40.

accepted that he also did not write in his notes any conversation in relation to accommodation options. He accepted that he did not refer him to a social worker for accommodation purposes.[270]

245. In relation to conveying to the medical practitioner in the Emergency Department that Mr Fennessy had left the hospital, Mr Bailey stated that he believed he did although there is no note in his notes about that. Mr Bailey also agreed that he could not explain why there was no Emergency Department discharge summary and said that was for the emergency medical practitioners. But Mr Bailey also could not provide an explanation as to why there was no ACT Mental Health nursing discharge summary either.[271]

246. Under cross-examination from Mr Sabharwal, Mr Bailey indicated that he did recall speaking with Ms Finlay that afternoon, however when it was suggested that he spoke to her prior to the assessment he made of Mr Fennessy, Mr Bailey indicated that it was his view that he had spoken to her between the two assessments he conducted: one at the bedside and one in his office. Mr Bailey agreed that he did not have an independent knowledge of that fact.[272]

247. It was suggested to Mr Bailey that Ms Finlay expressed strong concerns about Mr Fennessy's safety given his presentation. Mr Bailey agreed and said that he wrote something of Ms Finlay's concerns in his notes.[273] Mr Bailey agreed that Ms Finlay had mentioned also that Mr Fennessy had had three presentations at the hospital very recently. Mr Bailey also agreed that Ms Finlay discussed that she felt unable to keep her son safe any longer and that she was at her wits end. He also recalled that she said she could not have him at home any longer.[274]

248. It was suggested to Mr Bailey that Ms Finlay had asked him to look at Mr Fennessy's eyes because she said "*he can't even focus properly*", however, Mr Bailey could not recall that conversation.[275] Mr Bailey agreed that he had written down that he observed that Mr Fennessy had pinpointed pupils, and it was his view that people who have taken an overdose may have pinpointed pupils for up to 24 hours. He also opined that not all people could pick it up but agreed that Ms Finlay certainly had and he had as well.[276] Mr Bailey was asked whether the pinpoint pupils would suggest that Mr Fennessy may still be under the influence of a drug, and he indicated that not but it would suggest to him that Mr Fennessy had had a drug.[277]

[270] Transcript p66.17.
[271] Transcript p67.1–20.
[272] Transcript p67.25.
[273] Transcript p67.35.
[274] Transcript p67–68.5.
[275] Transcript p68.24.
[276] Transcript p68.30–40.
[277] Transcript p69.1.

249. Mr Bailey was asked whether Ms Finlay told him that Mr Fennessy was homeless, and he accepted that conversation probably did occur. It was suggested that Ms Finlay told him that Mr Fennessy had access to a large quantity of prescription drugs and was at risk of overdosing, and Mr Bailey stated that he did not specifically recall that conversation. It was also suggested to Mr Bailey that Ms Finlay commented about the fact she didn't know how Mr Fennessy was still alive given the amount of drugs he had taken, and Mr Bailey indicated that he did not recall that conversation in those terms specifically.[278]

250. Mr Bailey was asked what had occurred in the 5 to 10 minutes assessment of Mr Fennessy and said that he wanted to clarify whether Mr Fennessy was psychotic, and he found that Mr Fennessy wasn't; he also wanted to find out whether Mr Fennessy had thoughts of self harming, and Mr Fennessy didn't and he did not also want to harm anyone else. Mr Bailey said that part of his assessment is in relation to future plans, and Mr Fennessy was talking positively about going to the detox and that he had an appointment to go to the detox. In Mr Bailey's view that was a sign that Mr Fennessy had future planning, and Mr Bailey had no reason to disbelieve Mr Fennessy. Mr Bailey then stated that he had doubts about whether Mr Fennessy would attend and he wanted his notes to reflect that, so that people would follow through if Mr Fennessy did not attend detox.[279]

251. Mr Bailey agreed that during the time he conducted the 5 to 10 minute assessment there was only Mr Fennessy and himself in attendance. It was suggested that Ms Finlay was present prior to that interview. Mr Bailey said he could not recall that exactly, and he then went on to give an answer which was not relevant to the question. It was further suggested that the interview was the 5 to 10 minute assessment, however Mr Bailey indicated that that wasn't the case, even though it was laid out in the notes at page 234 to which he was referred. Mr Bailey said he recalled sitting beside the bed but he wasn't with Mr Fennessy's mother in the Emergency Management Unit (EMU). [280] After a direction from me, Counsel Assisting asked Mr Bailey why he was being so defensive and was not answering the question but providing answers to questions that had not been asked. Mr Bailey said that he was nervous.[281]

252. When he was asked whether the 5 to 10 minute assessment was the interview that he referred to in his notes, Mr Bailey said he couldn't answer that because his memory didn't take him specifically back that far.[282] When asked whether

[278] Transcript p69.5–12.
[279] Transcript p69.24.
[280] Transcript p70.5 and Exhibit 16, p234.
[281] Transcript p70.15.
[282] Transcript p70.28.

he could confirm that the 5 to 10 minute assessment was the interview Mr Bailey said no.[283]

253. Mr Bailey stated that he did not recall Ms Finlay asking him to admit Mr Fennessy to detox to give his mind and body some respite, but he recalled that it was the tone of the conversation that Mr Fennessy needed to be in detox. He also recalled that Ms Finlay described Mr Fennessy's situation as being chaotic and dangerous. Mr Bailey did not recall Ms Finlay telling him that detox would be a circuit breaker, but he agreed it was possible that he had told Ms Finlay there was no beds in detox.[284]

254. Mr Bailey was asked whether he recalled Ms Finlay telling him that there would be a coroner's inquest and a lot of questions would be required to be answered by everyone involved but he could not recall that conversation.[285]

255. It was suggested to Mr Bailey that Ms Finlay said something to the effect of "*how many times must the person overdose or be seen by CAT in such a short period of time before professionals believe that a person is at risk of harm*". Mr Bailey said that he did not know if those words were used but he agreed that the tenor of the conversation was about getting Mr Fennessy into treatment.[286] [I comment here that I am not entirely sure that Mr Bailey answered the question posed, so I am not sure whether Mr Bailey believed Mr Fennessy was at risk because of his overdoses of recent times, or that it was only about getting Mr Fennessy into treatment.]

256. It was suggested to Mr Bailey that he had paged Ms Finlay in relation to Mr Fennessy, but he did not know whether that had occurred. Mr Bailey also did not recall whether he spoke to her about that. It was suggested that Mr Bailey had said to Ms Finlay that Mr Fennessy was unhappy with his life and did not want to die, but Mr Bailey indicated that he could not specifically recall saying that.[287]

257. Mr Bailey stated that he could not recall whether Ms Finlay had talked to him about whether the Alcohol & Drug team had seen Mr Fennessy however he imagined she would have said that and they talked about that. Mr Bailey also agreed that it made sense that she was told by him that Mr Fennessy was to be seen by Alcohol & Drugs at 3 pm the next day, however he does not recall the conversation.[288]

258. Mr Bailey was asked in relation to why he assumed that Mr Fennessy had an appointment with Drug & Alcohol, and he said that Mr Fennessy had a piece of

[283] Transcript p70.33.
[284] Transcript p71.1.
[285] Transcript p71.35.
[286] Transcript p71.37–72.5.
[287] Transcript p72.35
[288] Transcript p73.1–14.

paper the size of a post-it note. When asked how he knew that it was an appointment on the piece of paper, Mr Bailey indicated that someone had asked Mr Fennessy about the Drug & Alcohol appointment and he recalled Mr Fennessy had a piece of paper in his hand and Mr Fennessy held the paper up indicating that it was his appointment.[289]

259. It was suggested to Mr Bailey that in his statement at paragraph 12 he made the comment, "*I now do not recall specifically discussing the option of staying at EMU overnight, however I believe I would having encouraged him to stay longer to keep him safe as I knew he had an appointment with a DS the following day"*. Mr Bailey explained that he was trying to keep Mr Fennessy safe until Mr Fennessy's appointment given his strong history of drug use, and he thought that if Mr Fennessy stayed in hospital he would possibly get to the appointment.[290] Mr Bailey was asked how it was possible to interpret the part of his statement, given what he had said about not recalling discussing the option of staying. Mr Bailey did not entirely explain it but said that was part of his assessment, he would have been trying to get Mr Fennessy to stay in the Department longer.[291]

260. Mr Bailey did not know why he did not contact Mr Fennessy's mother and say "*let's keep him here*". It was suggested to Mr Bailey that he never tried to keep Mr Fennessy at the hospital and that he was making that up. Mr Bailey denied that he had made this evidence up. He was asked again "*well what do I make of you saying I now do not recall specifically discussing the option of staying at EMU*". Mr Bailey was given the statement and asked to read it and he said "*I didn't get that opportunity to get him to stay at EMU*" when asked why he had given evidence that he was trying to persuade Mr Fennessy to stay longer. Mr Bailey indicated that he was trying to get Mr Fennessy to stay so that he could spend more time with him.[292] It was suggested to Mr Bailey by Mr Sabharwal that he did not try to persuade Mr Fennessy to stay longer. Mr Bailey indicated that he did try to get Mr Fennessy to stay in hospital, and it was then suggested that was all in that 5 to 10 minutes and Mr Bailey said yes.[293]

261. Mr Bailey was asked whether given his concern that he wrote about in his statement that Mr Fennessy would re- present within a short timeframe, which he meant as an overdose, whether he had made any arrangements for Mr Fennessy to be seen by Drug & Alcohol personnel that evening. Mr Bailey replied that given Mr Fennessy had been seen prior to his attendance he did

[289] Transcript p73.16.
[290] Transcript p74.1–40.
[291] Transcript p74.26.
[292] Transcript p75.1.
[293] Transcript p76.10.

not, particularly because Mr Fennessy had had an Drug & Alcohol appointment made for him.[294]

262. It was suggested to Mr Bailey that he knew that Mr Fennessy had no ability to manage his lifestyle, organise his safety, shelter or food, and that Mr Bailey did not do anything to assist Mr Fennessy in that regard. Mr Bailey said that he tried to get Mr Fennessy to stay in the hospital. It was suggested to Mr Bailey that he could have rung around to see if he could get Mr Fennessy somewhere to stay that evening, and Mr Bailey said he would normally do that and could not understand why he did not do that, but he also indicated that it was most likely because Mr Fennessy was insisting on leaving.[295]

263. Mr Bailey was asked questions in relation to who he had written the report for, given he had foreseen what indeed occurred in relation to Mr Fennessy's death, however Mr Bailey said that he did not know that Mr Fennessy died within hours of leaving hospital.[296] Mr Bailey was asked whether he discharged Mr Fennessy and he said, "*I didn't discharge him as such, he said "I'm going" and he left*". It was suggested to Mr Bailey that he let Mr Fennessy go, and Mr Bailey said that he could not restrain Mr Fennessy.[297]

264. It was suggested to Mr Bailey that given the benefit of hindsight he had failed Mr Fennessy. Mr Bailey replied that he could not answer that question; he did not know what to say.[298]

265. In a question from me in relation to his practice of contacting the treating physician about his assessment findings, Mr Bailey said he would have written to the registrar on call and had a discussion with him. When I asked did he do that with Mr Fennessy Mr Bailey said, "*I would have done that after he'd gone because I couldn't get him to stay for the assessment to complete the time that I would have liked to have had with him*". I then asked whether he had spoken to the registrar on duty that day and Mr Bailey said he believed he had but that he had not written it in any of his notes.[299]

<u>Ann Catherine Finlay</u>

266. Ann Finlay gave evidence that she was a social worker at The Canberra Hospital and she had worked as a social worker since 2000. Ms Finlay indicated that she was working at The Canberra Hospital in 2010 as a social worker. Ms Finlay indicated that part of her duties were to provide support for hospital outpatients and inpatients as well as their families and carers. Ms Findlay said she also provided support in bereavement cases, cases of new

[294] Transcript p76.15.
[295] Transcript p77.1.
[296] Transcript p77.20
[297] Transcript p78.1.
[298] Transcript p78.15.
[299] Transcript p78.26.

diagnoses, domestic violence, mental health, alcohol and drug issues and any other health issues, and that she was part of a multidisciplinary team.[300]

267. Ms Finlay is Mr Fennessy's mother, she has two other children, and Mr Fennessy is a middle child.

268. Ms Finlay indicated that she had written a number of letters to the Coroner in relation to her son's death. Those letters were tendered in evidence before me as Exhibit 32. In those letters Ms Finlay described the background in relation to Mr Fennessy's drug addiction as well as the difficulties she had with him as a result of his behaviour.

269. Ms Finlay gave evidence in relation to what she recalled on 6 January 2010. She said that she was called to the Emergency Department after a call from Mr Fennessy. Ms Finlay indicated that Mr Fennessy had told her that he was going to Karralika the next day. Ms Finlay knew that was not true because he had been recently discharged from that facility. Ms Finlay said that when Mr Fennessy told her at 3 pm that he would be going, she knew that would not be possible, because he was required to be detoxed before he could go back into the program after having being discharged on 23 December.

270. Ms Finlay indicated that Mr Fennessy told her that he had overdosed the night before and was left on a street in Braddon. He also told her that he had to have CPR. Ms Finlay said that he was quite loud and appeared to be affected by some substance. Ms Finlay indicated that she spoke to nursing staff about Mr Fennessy, telling them that while he said he was off to Karralika the next day, it would not be possible for him to be allowed back there, and that she did not know where he had received that information from.

271. Ms Finlay said that she rang Karralika and they told her that there was no way he would be coming back and it would be weeks if not months because he was at the bottom of the list and because he had been discharged and kicked out.[301]

272. Ms Finlay said that one of the nurses came and asked her whether she was taking Mr Fennessy home, and she told them that she could not take him home in his condition and explained why that was. Ms Finlay confirmed that the explanation she gave the nurses was the same as that contained in her letters to the coroner in Exhibit 7.[302]

273. Ms Finlay said that she was aware that Mr Bailey was to see Mr Fennessy and she was present when Mr Bailey came to see Mr Fennessy. Ms Finlay asked Mr Bailey whether he was going to assess Paul in the EMU because she

[300] Transcript p81.
[301] Transcript p83.
[302] Transcript p83–84.

indicated Mr Fennessy needs privacy and confidentiality. Ms Finlay stated that she had told Mr Bailey that she had huge concerns in relation to Mr Fennessy. She said there were massive risk factors and she pointed out that Mr Fennessy had access to huge numbers of prescription medications. Ms Finlay said that she told Mr Bailey that Mr Fennessy had overdosed twice and presented to hospital in the last week. She said that Mr Bailey told her that actually it was three presentations not two. Ms Finlay then asked Mr Bailey what more he actually needed to think that Mr Fennessy had a problem. Ms Finlay told Mr Bailey that Mr Fennessy could not come home, as his 12-year-old sister was at home and the family had been traumatised by his chaos for several weeks.[303]

274. Ms Finlay said that generally Mr Fennessy was a quite introverted person but on the 6th he appeared to be completely unaware and loud and she was trying to quieten him down. Ms Finlay also said that she pointed this out to Mr Bailey. Ms Finlay also pointed out that Mr Fennessy's eyes were unfocused. Ms Finlay said she told Mr Bailey that Mr Fennessy appeared to be obviously affected by something. Ms Finlay said that she told Mr Bailey that Mr Fennesy should be kept in hospital, that Mr Fennessy either needs to go to detox or he needs to be detained because he was not safe to be let out.[304]

275. Ms Finlay said she suggested that keeping Mr Fennessy in would be a circuit breaker for him, particularly given he had been overdosing for days if not weeks and it just seemed that he couldn't stop. Ms Finlay indicated that Mr Bailey acknowledged her concern.[305] Ms Finlay said that she told Mr Bailey that because of the high risk factors she felt in relation to Mr Fennessy's situation that Mr Bailey would be speaking to the Coroner; she said "*you will have to answer questions if you let him walk out of here*".[306]

276. Ms Finlay stated that she did not attend the assessment because it was appropriate that Mr Fennessy have privacy and confidentiality in the process; she went back to work. She received a page from Mr Bailey who told her that Mr Fennessy had left and that he couldn't keep Mr Fennessy in.[307]

277. Ms Finlay indicated that she had asked Mr Bailey whether Mr Fennessy had been seen by the Drug & Alcohol team given Mr Bailey had told her Mr Fennessy's issue wasn't a mental health one. Ms Finlay suggested that was what she been told over the last two years before Mr Fennessy had died. She said when she asked Mr Bailey why he let Mr Fennessy go, Mr Bailey told her

[303] Transcript p84.10.
[304] Transcript p84.40.
[305] Transcript p85.1
[306] Transcript p85.5-10.
[307] Transcript p85.15–21.

he could not detain Mr Fennessy as he had no way to do that.[308] She said Mr Bailey told her that he did not know where Mr Fennessy had gone.

278. Ms Finlay indicated that she stayed at work for a while because she had her 12-year-old daughter with her, and she went home around 6 or 6:30 pm. Ms Finlay said when they arrived home she saw Mr Fennessy lying on the trampoline in the backyard. He got up when they arrived and Ms Finlay asked him what was he doing there, but she cannot recall his answer, and she didn't keep note of what he had said in her records.[309]

279. Ms Finlay indicated that after Mr Fennessy had left the family home she went to the Woden police station because she was desperate, frustrated and confused because nobody could see that Mr Fennessy was at risk. Ms Finlay believed that Mr Fennessy had been seen by the social worker, CAT team, and the medical team at the hospital. She said that when she saw him that night Mr Fennessy appeared to be in the same condition he was in earlier that day because of his eyes and his slurred speech. Ms Finlay said she could not call an ambulance because he just left or been discharged from the hospital.

280. Ms Finlay indicated that Mr Fennessy had been coming to the house every day for a shower and food and he also had some clothes out on the line. She said that Mr Fennessy had asked her whether he could stay that night and she said no because of his condition, but he could come back the next day. She said she then asked him to leave. Ms Finlay stated that after Mr Fennessy left she drove with her daughter to the police station. She said that Mr Fennessy went in the opposite direction to her and that was the last time she saw him alive.[310]

281. Ms Finlay said she went to the police station and spoke with Constable Tanner and told him that Mr Fennessy had been overdosing for days and weeks, that Mr Fennessy was a huge risk to himself, that Mr Fennessy can't be at home because of his behaviour and she could not keep Mr Fennessy safe. Ms Finlay said she told the police officer that Mr Fennessy had been kicked out of the Hospital, Karralika, Samaritan House and that she did not know what to do and asked was there any way of taking him into protective custody.[311] She said that the officer told her that he would speak to his Sergeant. She then left and drove to her friend's place because she was so upset. It was there that she received a call from Police to say that Mr Fennessy was most likely far away by now and they would not send a car. Twenty minutes later she received another call from Police to inquire whether she was at home. Police asked her to return home where they then advised her that Mr Fennessy had died.[312]

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[308] Transcript p85.25–30.
[309] Transcript p86.1–15.
[310] Transcript p87.1.
[311] Transcript p87.5.
[312] Transcript p87.10–27.

282. Ms Finlay indicated that she provided Sgt Coady with items from Mr Fennessy's bag which contained prescriptions and receipts from pharmacies. Ms Finlay said she took them out of Mr Fennessy's bag on 4 or 5 January because there was Seroquel and other major drugs in his bag. Ms Finlay said she flushed the drugs down the toilet and threw the containers away. Ms Finlay said that when police returned items from Mr Fennessy's backpack she saw it contained a Blacker exercise book which contain writing and was dated 6/1/10. [313]

283. Ms Finlay advised the court that the issues that she wished to raise in the coronial inquest were as follows:

- Mr Fennessy's death could have been prevented if someone else had assessed him that day, Mr Fennessy would not have been allowed to walk out with those risk factors;
- Those risk factors were that Mr Fennessy was still affected by medication, he had exhausted all of his resources, he had access to huge amounts of prescription medication over a long period of time and that he had overdosed so many times; and
- Ms Finlay was aware that the practice in hospital was that a patient was not discharged until there was a discharge summary completed for them. She assumed that there was one on the notes in relation to Mr Fennessy however she could not find it. In her view that was important because Mr Fennessy was constantly being discharged into his GPs care after overdosing and it would have been helpful.

284. Ms Finlay indicated that she was not aware that Mr Fennessy had been placed on methadone until after she spoke to his GP Dr Craft some days after his death.[314]

285. Ms Finlay stated that in her view she had spoken to the nurses and to Mr Bailey and assumed that she had given Mr Bailey sufficient information. She considered that she had handed Mr Fennessy's care over to Mr Bailey and that Mr Bailey would do something.[315]

286. Ms Finlay stated when asked about whether she considered Mr Fennessy had a mental illness and other drug and alcohol problem or a combination of both:

"well, he was prescribed heavy psychiatric drugs for two years, the last two years of his life. On what basis? I know he was – he had started out with depression, anxiety, social phobia, and was medicated at the beginning, and somehow that morphed into just substance abuse or a misuse, and he didn't

[313] Exhibit 11.
[314] Transcript p88.35.
[315] Transcript p89.10.

have mental health issues, and I don't know what. I don't know when mental health are going to recognise that substance abuse disorder is an actual mental health issue. It is a disorder. It is in the DSM as a substance abuse disorder ... I don't see why mental health don't recognise that".[316]

287. Ms Finlay indicated that it was assumed that Mr Fennessy was a heroin addict, but that was not the case. She said that everyone assumed on the 6th that it was a heroin overdose, but they did not take into account all the heavy psychiatric drugs Mr Fennessy was on, they also assumed that Narcan (naloxone) had cancelled the effect of the overdose but Mr Fennessy still had it in his system. Ms Finlay indicated that she observed Mr Fennessy at home and in relation to his sobriety he seemed the same as it was in hospital he was not more affected or less affected.[317]

288. Ms Finlay indicated that no one had tested Mr Fennessy on the toxicological basis but doctors put Mr Fennessy on medication, benzo contracts, methadone, Seroquel, Serapax when nobody investigated all the prescription drugs and over-the-counter drugs Mr Fennessy took. Ms Finlay commented on the fact that no one seemed to have seen the problem despite the risks, despite all the reports no one saw an issue. Ms Finlay indicated that the clinical reviews were incorrect in particular in relation to the date of death. She questioned what happened after the reviews because she had not heard of any outcomes. Ms Finlay said she could not believe that no one thought there was an issue with Mr Fennessy in all that time. She could not understand how those treating Mr Fennessy had thought he could ring the Drug & Alcohol Service or anything else because he was so chaotic. She said that she had tried to ring the 24 hour line all over the Christmas period and there was no response, just message machines but no response, for every attempt she made all over Christmas after he was kicked out of Karralika and until the day he died.[318]

Tendered Reports and Statements

289. I also received the following documents which were exhibited before me and to which I have had regard in considering my finding.

    (1) Exhibit 7 - a letter to the ACT Coroner written by Ms Finlay in relation to Mr Fennessy's death

    (2) Exhibit 10 - autopsy report under the hand of Dr Jain, dated 9 April 2010

    (3) Exhibit 12 - statement of John Mark Robinson, undated

[316] Transcript p89.15–25.
[317] Transcript p90.5.
[318] Transcript p91.5.

(4) Exhibit 18 - letter from Wendy Woodman, Manager, Clinical Services, Alcohol & Drug Program, dated 7 September 2010

(5) Exhibit 20 - statement of Aidan Michael Laurence, undated

(6) Exhibit 31 - statement of Renée Beardmore, dated 30 November 2015

(7) Exhibit 22 - report from Associate Professor Vanita Parekh

290. In relation to Exhibit 18 it is clear on the face of the document that no contact was made between the Alcohol and Drug Program Consultation Liaison Team by either the Emergency Department, Mr Bailey or Mr Fennessy on 6 January 2010. It appears that Mr Fennessy left the Emergency Department without any referral to the Alcohol and Drug Program Consultation Liaison Team on 6 January 2010 or anyone else for that matter.

291. The statement from Dr Aidan Lawrence identifies that Dr Lawrence has qualifications in psychiatry, law and addiction as well as pain management and has significant experience. Dr Lawrence saw Mr Fennessy once on 2 January 2010 at the Phillip Medical and Dental Centre Philip. Dr Lawrence indicated that Mr Fennessy was not a regular patient of his and presented after hours. Dr Lawrence indicated that Mr Fennessy was seeking a replacement prescription for benzodiazepine. Dr Lawrence indicated that Mr Fennessy advised him that he had been prescribed this medication on 1 January 2010 and upon review of the clinical notes this was confirmed. Mr Fennessy advised Dr Lawrence that his prescription had been stolen from his bag. Dr Lawrence having examined the history suggested it was apparent Mr Fennessy was dependent on benzodiazepines; however he indicated that Mr Fennessy gave a cogent and lucid history, made no other demands, and clinically there was nothing to suggest cognitive dysfunction, intoxication or misuse on that occasion.[319] Dr Lawrence was disposed to believe Mr Fennessy and prescribed 55 mg tablets which in Dr Lawrence's view were reasonable until review by Mr Fennessy's GP Dr Craft.

292. Dr John Mark Robinson, a general practitioner, saw Mr Fennessy on 2 non-referral consultations - one on 26 August 2008, and one on 1 January 2010 - at the Phillip Medical and Dental Centre. Dr Robinson indicated that Mr Fennessy was not a regular patient of his. Dr Robinson stated that when he saw Mr Fennessy on 26 August 2008, Mr Fennessy advised him he had lost his previous prescription on a recent visit to Melbourne. Dr Robinson was wary given Mr Fennessy's past history of a similar complaint on July of that year. Dr Robinson discussed with Mr Fennessy compliance with his medications and prescribed him Lovan 20 mg X 28 tablets, Zyprexa 7.5 mg, 56 tablets, Seroquel 200 mg 60 tablets.

[319] Exhibit 20.

293. On 1 January 2010 Mr Fennessy demanded a provision for prescriptions for the following medications, Rivotril, Zyprexa, and Prozac. As Mr Fennessy had not been prescribed Rivotril before Dr Robinson attempted to contact Dr Craft. Dr Robinson indicated that as this drug is usually for epilepsy he refused to prescribe the medication. He noted Mr Fennessy was angry and threatened violence toward him if he did not provide that prescription. Dr Robinson discussed issues with Mr Fennessy and he gradually settled and discussed his mental health problems including post-traumatic stress disorder after an event where he had been set on fire. Dr Robinson also noted that Mr Fennessy was a heavy smoker and smelt strongly of alcohol on his breath. Mr Fennessy indicated that he had consumed a high dose of alcohol the previous evening. Dr Robinson prescribed Mr Fennessy diazepam 5 mg 50 tablets. Dr Robinson also prescribed Prozac three tablets Zyprexa 10 mg x 28 tablets. Dr Robinson advised Mr Fennessy to attend his general practitioner within the next week

294. Ms Renee Beardmore provided a statement in relation to this matter. Ms Beardmore is a registered pharmacist. Ms Beardmore was acting in the role of ACT Chief Pharmacist at the time of the proceeding.

295. Ms Beardmore was asked to provide a statement about the processes for prescribing and dispensing controlled medicines in the territory. She also provided a description of the functionalities of the database known as Drugs and Poisons Information System (DAPIS) and the DAPIS online remote access (DORA).

296. Ms Beardmore set out the legislative provisions attached to prescription of controlled drugs, explaining the prescribed medications which are subject to greater control because of the potential harms for individuals and public health. As an example she indicated that common controlled medicines include potent opioids such as oxycodone, psychostimulants such as dexamphetamine, and benzodiazepines such as alprazolam. Controlled medicines are listed in Schedule 8 of the *Poisons Standard 2015* and the Commonwealth *Therapeutic Goods Act* applies by virtue of section 157 of the *Medicines, Poisons and Therapeutic Goods Act 2008*. The *Medicines, Poisons and Therapeutic Goods Regulation 2008* outline the requirements for a prescriber to have a controlled medicines approval before prescribing controlled medicine for human use. Essentially this legislation enables a prescriber upon approval to prescribe a controlled drug. Further approval by the Chief Health Officer (CHO) is required for the dose and strength of the controlled medicine.

297. DAPIS is a database which collection reports information on the prescribing and dispensing of control medicines in the territory. The key features of DAPIS include:

- Real time and electronic reporting of controlled medicines dispensing events
- Alert functionality for identification of public health risks associated with control medicine supply
- Ability to assign risk levels to patients, prescribers and alerts to allow the CHO delegates to prioritise workloads
- Compatible with the national Electronic Reporting and Recording of Controlled Drugs (ERRCD) system (which is not yet operational)
- The DAPIS online reporting application (DORA).

298. DAPIS was first used in the ACT in September 2014. DAPIS does not collect dispensing events for prescribed medications in Schedule 4 of the *Poisons Standard*. DAPIS has an alert function which had not been phased in yet in the ACT but is being phased in. The DAPIS real-time reporting capability is active but not currently used in the ACT. This will require pharmacy dispensers to update software changes to the system to receive data in real time. The real-time reporting function would enable data from dispensing events to be automatically uploaded to DAPIS at the conclusion of each dispensing event, rather than on a weekly basis. The real-time reporting function would not enable the transmission of any data or alert from the Pharmaceutical Service Section of ACT Health back to the dispensing pharmacy.

299. DORA provides access to the DAPIS database for third parties, which are prescribers and pharmacists. DORA is accessed by logging onto an online portal which is separate to the prescribing or dispensing software used by prescribers and pharmacists. No alert function is able to be added to third-party software, such as prescribing and dispensing programs. As a result, prescribers and pharmacists would only be able to access the patient's dispensing history for control medicines via DORA should they wish to check on the prior history of a patient. Currently, ACT Health is conducting analysis to examine if DORA is a useful enhancement to the current DAPIS system.

300. Given the increased rate of medical prescribing practice of controlled medicines and the concomitant rising rate of controlled medicine abuse and misuse there is a clear case for greater oversight. The use of DAPIS has allowed for data enhancement and availability and accuracy which will provide opportunity for improvement of the current regulatory arrangements.

301. Ms Beardmore indicated that the need for ongoing improvement in control medicine regulation include factors such as:

- Ongoing complaints from prescribers, pharmacist and consumers that the current system is overly burdensome and unworkable

- Increasing national rates of pharmaceutical misuse and abuse
- The rising rate of controlled medicines being prescribed
- Community expectations of greater regulatory oversight of controlled medicines.

302. Attached to Ms Beardmore's statement were the guidelines for prescribers prescribing control medicines.

303. I note that DAPIS and DORA were not available in the ACT in 2010.

Scope of enquiry

304. The scope of my enquiry is set out in the *Coroners Act 1997*:

> **52 Coroner's findings**
> (1) A coroner holding an inquest must find, if possible—
> (a) the identity of the deceased; and
> (b) when and where the death happened; and
> (c) the manner and cause of death; and
> (d) in the case of the suspected death of a person—that the person has died.
> (2) A coroner holding an inquiry must find, if possible—
> (a) the cause and origin of the fire or disaster; and
> (b) the circumstances in which the fire or disaster happened.
> (3) At the conclusion of an inquest or inquiry, the coroner must record the coroner's findings in writing.
> (4) A coroner may comment on any matter connected with the death, fire or disaster including public health or safety or the administration of justice.

305. The scope of enquiry available to a coroner is set out helpfully in the decision of *Onuma v The Coroner's Court of South Australia* [2001] SASC 218, a case in which the Court considered the scope of the coroner's power under the *Coroners Act 2003* (SA). The court applied *WRB Transport v Chivell* [1998] SASC 7002, where the relevant phrase under consideration was "*cause and circumstances*". I note in this jurisdiction the relevant phrases are similar, namely "the manner and cause" of death.

306. In *Chivell* Lander J (with whom both Prior and Mullighan JJ agreed), said with regard to the meaning of the word "cause":

> *"Clearly enough the cause and the circumstances must be two different things if it was otherwise there would be no reason for Parliament to have included both words. The cause of a person's death may be understood as the legal cause. In determining those events which may be said to give rise to the cause of the death, the coroner is not limited by concepts such as direct cause nor is the coroner limited to a cause*

which is reasonably foreseeable. The cause of a person's death in respect of the coroner's jurisdiction is a question of fact which, like causation in the common law must be determined by applying commonsense to the facts of each particular case."

I have taken these words into account when making my findings in this matter.

307. I am also mindful that in making findings I must have regard to the principles espoused in *Briginshaw v Briginshaw* (1938) 60 CLR 336 per Dixon J:

> *"… the truth is that, when the law requires the proof of any fact, the tribunal must feel an actual persuasion of its occurrence or existence before it can be found. ... 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 issue has been proved to the reasonable satisfaction of the tribunal."*

308. In *R v Doogan* [2005] ACTSC 74 at 15 their Honours Higgins CJ, Crispin and Bennett JJ stated:

> *"The Act is generally concerned with the resolution of relatively straightforward questions such as "what was the cause of his death"? Or "what caused this fire"? It does not provide a general mechanism for an open-ended inquiry into the merits of government policy, the performance of government agencies or private institutions, or the conduct of individuals, even if apparently related in some way to the circumstances in which the death or fire occurred. Specific provisions confer jurisdiction on coroners to enquire into stipulated questions, required them to make certain findings, and empower them to make comments."*

And at [29]:

> *"A line must be drawn at some point beyond which, even if relevant, factors which come to light will be considered too remote from the event to be regarded as causative."*

Comments on the Evidence and Submissions

309. I have had regard to Submissions from all Counsel in this matter and I have carefully considered those submissions. I make the following comments in relation to the submissions of Counsel and evidence given by certain witnesses.

Submissions by Counsel Assisting

310. Counsel Assisting made submissions in relation to the findings of Dr Jain, and concluded after referring to Dr Jain's report a specific cause of death has not been identified at autopsy. It was Dr Jain's view in relation to the circumstances surrounding the death, autopsy and toxicological examination on blood obtained post-mortem, that the likely cause of death was a combined effect of a cocktail of drugs causing central nervous system and respiratory depression and most likely positional asphyxia. Dr Jain opined there were no specific causes of death identified upon examination in any of the cavities.[320]

311. After reviewing the legislative provisions and authorities in relation to an inquiry, Counsel Assisting identified issues for consideration which I agree should be considered, those issues being:

- The ease with which Mr Fennessy gained access to prescription drugs,
- Whether the hospital should have discharged Mr Fennessy on 6 January 2010; and
- Whether there was a double dose of methadone administered to Mr Fennessy on the day he died.

312. Counsel Assisting examined Mr Fennessy's and his family's background as well as his medical and mental health history. Of note Counsel Assisting identified that Mr Fennessy was seen by the Emergency Department of The Canberra Hospital on 14 December 2007 and was transferred there under the Mental Health Act for treatment for his bizarre behaviour. He was admitted to the PSU and on that day he was assessed and given antidepressant medication. On 16 December he was released and his family were advised to call the Crisis Assessment Treatment (CAT) team if they needed further assistance.

313. Mr Fennessy was referred to his GP through the Ochre Health Medical Centre. Dr Singh was aware of Mr Fennessy's admission to PSU for this drug induced episode and noted that Mr Fennessy felt it was his depression which was the underlying problem. Dr Singh conducted an assessment noting Mr Fennessy had not taken illicit drugs since December. Dr Singh recorded that Mr Fennessy was not keen on counselling for his drug problem.

314. On 23 February 2008 Mr Fennessy was transported to the Emergency Department at The Canberra Hospital by police because there were concerns as to his confusion. Mr Bailey examined and interviewed Mr Fennessy and determined that he had no psychotic symptoms and was most likely under the influence of ecstasy. Mr Bailey opined that there was no need for Mr Fennessy

[320] Paragraph 5, Counsel Assisting submissions.

to be in the Emergency Department as he was not at risk of self harm. Mr Bailey referred him to the CAT team for appointment the following day for review. Mr Fennessy was reviewed by the CAT team and accommodated in one of their flats. A multidisciplinary team reviewed Mr Fennessy. It is noted that at the time there was no Alcohol & Drug Service representative as part of the multidisciplinary team.

315. On 7 April 2008 Mr Fennessy was extensively assessed by the mental health team whilst admitted to Ward 2N. He was also seen by a co-morbidity clinician in relation to his mental health and alcohol and drug abuse.

316. Counsel Assisting extensively referred to the history of the dispensed medications prescribed by various doctors as well as the numerous presentations by Mr Fennessy to the Emergency Departments of both Canberra hospitals for overdoses of medications which had been prescribed for his use. I accept that information is factual in relation to the dispensing history.

317. Counsel Assisting referred also to Dr Craft taking over management of Mr Fennessy's treatment and care. I have carefully reviewed those submissions and accept them as being factual.

318. It is clear from those submissions that Mr Fennessy was doctor shopping and prescription hunting at various pharmacies and medical practices. It appears he was able to get as many prescription drugs as he sought from a variety of doctors and pharmacists. It is clear from Counsel Assisting's submissions and indeed on any view of the evidence that Mr Fennessy was able to access multiple prescriptions for multiple medications and was misusing these medications which subsequently caused his admission to hospital for overdoses. As a result of those overdoses he was admitted to Emergency Departments and was reviewed by mental health professionals on many of those occasions. It is noted that in 2008 he was initially classified as a high risk of suicide and after further assessment considered medium risk.

319. Counsel Assisting further identified that Mr Fennessy suffered psychotic episodes most likely caused by the drugs he had abused. Counsel Assisting also noted that in his evidence Mr Aloisi said that the multiple presentations to hospital with drug overdoses could possibly be a basis for referring Mr Fennessy to an addiction specialist, and in his view this should have been a concern for the Alcohol & Drug Service.[321] I am unable to ascertain from the evidence whether Mr Fennessy ever saw an addiction specialist, other than Dr George on one occasion.

320. Counsel Assisting also referred to the October 2009 admission where it was determined that Mr Fennessy was at risk of suicide and was admitted to the

[321] Paragraph 105, Counsel Assisting's submissions.

PSU. He was discharged on 4 November after being seen by Drug & Alcohol Services.

321. Counsel Assisting also reviewed the hospital and MHAGIC notes particularly in relation to 2-6 January 2010 when Mr Fennessy sought admission following requests by him after suffering seizures and hallucinations from cessation of his medication. Counsel Assisting referred to the comprehensive history taken upon admission on 3 January by the CAT team member. Counsel carefully reviewed the notes of 6 January 2010, which is the day that Mr Fennessy was admitted to the ED of The Canberra Hospital arriving by ambulance after being found unconscious from a drug overdose. I have adopted those submissions as accurately reflecting the evidence before me from the medical notes.

322. Counsel Assisting reviewed the MHAGIC notes particularly those written by Mr Bailey from the CAT team. In those notes Mr Bailey wrote a review of the assessment he performed upon Mr Fennessy after he was medically cleared by the Emergency Department doctors. Mr Bailey noted that Mr Fennessy had pinpoint pupils and slurred speech but was easily understood. Counsel Assisting referred to a note written by nursing staff that Mr Fennessy was to be seen the next day at 3 pm by Drug & Alcohol Services. Mr Bailey's evidence was that he was told by Mr Fennessy that he had such an appointment. Counsel Assisting notes there was no discharge summary located in The Canberra Hospital records nor was there any note on the Alcohol & Drug Services file for a scheduled appointment for Mr Fennessy for the next day.

323. Counsel Assisting usefully reviewed the evidence from the witnesses who gave evidence and in particular Dr Craft who was the treating general practitioner for Mr Fennessy. Counsel Assisting noted that Dr Craft undertook to restrict the drugs dispensed to Mr Fennessy, and particularly the quantity, however despite this restriction Mr Fennessy received the full script rather than the restricted version intended by Dr Craft. Dr Craft, it would appear, was fully aware of Mr Fennessy's 'doctor shopping' disposition and Counsel Assisting opined that little appears to have been done to address that concern. Importantly Dr Craft advised that it would have been very useful to have access to other practitioner's files in relation to Mr Fennessy's medication history. Dr Craft also agreed it would be useful to have a central registry when doctors could observe what chemists were dispensing for patients.[322] Dr Craft agreed that a real time pharmacist's alert system is needed.

324. Counsel Assisting also referred to questions that I posed in relation to the issue of self harm and the risk to Mr Fennessy. Dr Craft clearly indicated that Mr Fennessy was at considerable risk of self harm. It was her view that

[322] Paragraph 225, Counsel Assisting's submissions.

rehabilitation programs required self referral and that nobody could assist Mr Fennessy in that regard because it was up to him to self refer.[323]

325. Counsel Assisting reviewed the evidence from Dr Gregory Hollis who was the Specialist Emergency Staff Physician and Clinical Director of the Department. She outlined his evidence as to the procedure for patients presenting to the Emergency Department with overdoses and in particular what type of overdoses, that is whether accidental or not and if unsure to err on the side of caution and seek a review by Mental Health. Counsel Assisting referred to his evidence about the collaborative approach between the medical and mental health staff and it was his view that it would be the medical officer who is the final point as far as discharge is concerned. Dr Hollis confirmed that there was no discharge documents produced on 6 January 2010 in relation to Mr Fennessy leaving hospital. There is no note on the file about Mr Fennessy being discharged either.

326. Counsel Assisting submitted that it appears that Mr Fennessy ricocheted from one treating practitioner to another and from one section of the system to another over an 18 month period despite there being a warning by his mother that there was no coordinated response to his care and that he was at continuing risk of self harm. There were warning signs available to practitioners involved in his care during this time and these were not addressed adequately.[324]

327. Counsel Assisting submitted essentially that it is clear on the evidence that Mr Fennessy was able to access a range of powerful prescription drugs from multiple medical practitioners and multiple pharmacists. Given that Mr Fennessy was clearly doctor shopping, and given concerns had been raised by Ms Finlay, no action seems to have been taken as a result of his doctor shopping. It appears there is a lack of knowledge or understanding on the part of medical practitioners as to what should happen when reports of information that a patient has been doctor shopping.[325] Further, in relation to the methadone program Mr Fennessy was prescribed, proper procedure was clearly not followed in Mr Fennessy's case. This was clearly demonstrated after perusing the methadone guidelines provided by Ms Trickett in her letter to the Coroner.

328. Counsel Assisting concluded her submissions and suggested some recommendations. I will refer to those conclusions in due course.

[323] Paragraph 232, Counsel Assisting's submissions.
[324] Paragraph 265, Counsel Assisting's submissions.
[325] Ibid.

Submissions by the ACT

329. I now turn to the submissions on behalf of the Australian Capital Territory. Mr Crowe of Counsel referred me to several authorities including *Re State Coroner; ex parte Minister for Health* [2009] WASCA 165, which referred again to *R v Doogan*. I certainly agree with those comments particularly in relation to the principle that the Coroners Act "*does not authorise a Coroner to undertake a roving royal commission for the purpose of inquiring into any possible causal connection no matter how tenuous, between an act, of omission or circumstance on the one hand and the death of the deceased on the other*" (at [46]).

330. However in my view the direct causal connection between the admissions, particularly those closest to Mr Fennessy's death on 6 January 2010, are directly causal to his death. Further, the history of admissions from overdoses in similar circumstances over the prior two years is informative about and is useful in relation to gauging the similarity between the history and the events which ultimately caused the death.

331. Having said that I have very carefully considered the reference to *Conway v Jerram* [2011] NSWCA 319 and I have followed the warning in that decision where Young JA said:

> *"Just what is the scope of an inquest, is a matter for a coroner; a matter to be exercised using proper discretion and common sense ... In the usual cases of deaths, a line must be drawn at some point beyond which, even if relevant, factors which come to light will be considered too remote."*

332. In relation to considering whether to make any adverse comments I have also considered the decision in *Matthews v Hunter* [1993] 2 NZLR 683 where Heron J said "*in going about his function the coroner must recognise the damage to reputations and the aggravation of personal suffering such comments may bring."*

333. I have also had regard to the very helpful Manual written by Coroner Hugh Dillon for Australasian Coroners (The Federation Press: 2015). I agree with his assessment in relation to the care that one must take when considering making adverse comments. I am mindful of his comment about hindsight in relation to medical staff who are required to make decisions in often difficult situation and on the run as it were. I have personal experience in this regard and except that it is an important consideration and I have considered the evidence from the medical practitioners very carefully in that regard.

334. Further I have reviewed the legislation referred to by Council being the *Human Rights Act*, the *Mental Health (Treatment and Care) Act* and the *Health*

Records (Privacy and Access) Act, in considering the protection of drug dependent persons, particularly Mr Fennessy who was clearly struggling to take adequate care of himself.

335. I accept that there are specific criteria for determining whether a person has a mental illness and can be detained against their will because of it. I note the classification of a mentally dysfunctional person described as requiring them to be disabled by a disturbance or defect in perceptual interpretation, comprehension, reasoning, learning judgement, memory, motivation or emotion. In my view Mr Fennessy comes within those criteria insofar as he was clearly lacking in reasoning and judgement by continuing to take significant amounts of drugs whether they were prescribed or otherwise knowing they could have significant consequences for his health. However, I also accept that was not the view taken by the treating team at the time. In their view he did not have a mental illness and therefore could not be detained under the provisions of the *Mental Health (Treatment and Care) Act*.

336. Having said that I also note Mr Fennessy had presented to hospital on a number of occasions having overdosed on illicit and prescribed drugs. I also note he had been assessed on a number of those occasions as being at risk of self harm. The mere fact that Mr Fennessy was overdosing to the extent that he was is of itself an indication that he was self harming. It is difficult to say whether he intended to overdose or that he just didn't care if he did. There is some evidence to suggest both.

337. On the day of Mr Fennessy's death he was found unconscious and not breathing. He required Narcan to revive him. He was admitted to The Canberra Hospital for treatment. It was not clear at the time whether the overdose was deliberate or not. It may have just been recklessness on his part.

338. In terms of deciding whether someone comes within the mental health criteria, I accept that it is a difficult determination to make because at times there is no clear delineation as to whether a person is or is not mentally ill, and I accept that medical staff working at the coalface do not always have the big picture at their fingertips and rely on what they observe and what medical records they have available to them at the time when making these types of decisions. It is often a judgement call.

339. Mr Fennessy said he was depressed and did not care whether he lived or died, which in my view suggests he was at least mentally dysfunctional when he took the overdose. That is evident from his responses that he did not care whether he lived or died. Those details should have been made available to the CAT team clinician.

340. Having considered the evidence and submissions by Counsel on this issue, I accept that it is a difficult matter to determine, the judgement is made on a case-by-case basis and given the constraints upon medical practitioners by the legislation it may have been reasonable for them to conclude that Mr Fennessy did not come within the criteria for detaining him. I am satisfied that Mr Bailey believed he had no basis upon which to detain him.

341. In terms of co-ordination between the agencies It does appear to me that as at January 2010 there was a lack of coordination between the Divisions and I note that the various agencies have become more coordinated and have become a part of an umbrella Division. This clearly has improved access in relation to communication, coordination and referrals between what had been separate agencies.

342. In relation to the submissions by the ACT at paragraph 24, the evidence is quite clear that the only pathway for referral was self referral by Mr Fennessy. In fact Dr Craft was of the belief that she was unable to refer him to programs such as those covered for Tier 1 patients.

343. In relation to the submissions at paragraph 26 it is quite clear that Mr Fennessy struggled for many years with drug dependency and was treated by the various organisations including Mental Health and Drug & Alcohol Services. The view of these professionals was consistent to some extent with the civil rights of Mr Fennessy in that it was up to him to make the decision to rehabilitate himself. However, in my view having considered the evidence, Mr Fennessy appeared to be in a situation which he could not ultimately control himself despite attempts at rehabilitation. He was clearly unable to stop abusing prescription drugs and clearly unable to stop attending various medical practices seeking prescription drugs for that purpose.

344. Mr Fennessy presented as a difficult case with a multifaceted problem. In my view he would have benefited from the coordinated approach now available under the new umbrella Department particularly given the multidisciplinary approach to treatment of persons suffering from polysubstance abuse and possibly mental health issues. Given that there is this new approach, this highly suggests that there was a lack of coordination prior to the implementation of the coordinated group approach. This is also borne out in the evidence before me.

345. In relation to the submission that the evidence strongly suggests an appointment was made for Mr Fennessy for 7 January 2010, I reject that submission given the letter of 7 September 2010 authored by Wendy Woodman.[326] There is evidence of a notation in the medical notes about an appointment having been made, however the Community Health Drug and

[326] Exhibit 18.

Alcohol Program have no record that one was made for 6 January. There was information that an appointment and referral was made on 4 January. Clearly the agency did not receive any information about a referral to it on 6 January 2010. The police did not find any note on Mr Fennessy about an appointment. Mr Bailey did not see any note about an appointment. Mr Bailey relied on what Mr Fennessy told him and observed a piece of paper in his hand but did not see what was on it.

346. In relation to the submissions at paragraph 30, I accept to some degree that Mr Fennessy had been medically cleared and was awaiting Mr Bailey to conduct an assessment. I also accept that Mr Bailey was satisfied that Mr Fennessy could be discharged from his point of view. However no discharge summary was written and no letters were written to his GP, the very person who should have been advised of his overdose and discharge from hospital as Mr Fennessy was her Tier 3 client. In my view this was a gross oversight in protocol, however there is no evidence it had a direct causal effect on Mr Fennessy's death.

347. In relation to paragraph 34, whilst it is clear that Mr Fennessy had episodic and sporadic admissions with polysubstance abuse over the years, in my view there should have been at least better consultation between the agencies (ED, CAT and D&A) and his GP in relation to whether he could be managed appropriately in the community as a Tier 3 client. I accept that there had been a number of occasions where Mr Fennessy was referred to and attended rehabilitation programs only to be discharged because of abuse of the strict rules that apply to clients.

348. It is unfortunate that something further could not have been done in terms of managing his care. It appears that there is now better communication and referrals between the agencies under the new umbrella Department.

349. In my view having considered all the evidence as a whole it was open to those who had the care of Mr Fennessy to consider reviewing whether his treatment in the community as a Tier 3 client was appropriate, particularly given his numerous admissions with prescription polysubstance drug abuse and overdose and his ability to obtain prescription drugs from various practitioners. I make no criticism of the medical teams when I say this because it is not clear that the medical staff treating him at the relevant times knew of his doctor shopping or had a global picture which we now have of the obvious consistent ability to get prescription drugs in quantities clearly not contemplated by any one particular prescriber.

350. I note the submission in relation to Mr Bailey as to his unreliability as a witness and I will deal with Mr Bailey's evidence separately.

Submissions from the Family

351. Mr Fennessy's family wish to clarify certain matters suggested by others in their submissions. One of those issues was the easy access to hundreds of prescription drugs and the lack of monitoring by the prescribers placed him at huge risk. The family concluded that no health professional took responsibility for Mr Fennessy's increasing and lethal addiction to the medications when he did not have the capacity to take responsibility himself.

352. The family expressed the view that Mr Fennessy was removed from the Emergency Department by The Canberra Hospital staff prior to his death. The family suggested that Mr Fennessy was not officially discharged according to the Emergency Department procedures. They also suggested that no summary of discharge was ever actioned which I accept was clearly the case.

353. They also criticised Mr Bailey for not adequately assessing Mr Fennessy's mental health state despite warnings from the family. They also suggested that Mr Bailey did nothing to ensure his safety from harm that day. In my view I think that is a rather harsh criticism, given that Mr Bailey it appears had assessed Mr Fennessy on the usual criteria and was satisfied that he was not a risk to himself or others and therefore he was unable to hold him under the legislative provisions for doing so.

354. The family also were concerned that Mr Fennessy was given a double dose of methadone on the day he died. Clearly this is an accurate assessment and indeed he was given two doses that day.[327] The family consider that this double dose had a toxic effect on him given his post-mortem toxicology results. I am unsure as to what evidence there is to suggest this submission.

355. The family also considered that the failure of the GP to vigorously investigate the number of opiate medication Mr Fennessy was prescribed was a significant issue. In relation to the chronology showing the prescribed medication and the easy availability and access Mr Fennessy had to them in the years leading to his death has given great concern to the family and they are disturbed by it.

356. In my view it is very disturbing that Mr Fennessy was able to access so many prescription medications from a wide variety of GP practices and pharmacies. This is clearly evident from the chronology provided by and referred to by Counsel Assisting.

357. The family took the view that Mr Fennessy was prescribed a significant number of medications over the years. Ms Finlay said she warned the various medical and pharmacy practitioners about the powerful and dangerous medications he was given and in her view, no one took her seriously and no one cared enough

[327] Submissions by Coolamon Court Pharmacy.

to do anything about it. Something could have been done which would have made a huge difference to his survival.

358. Ms Finlay advised that she had seen Mr Fennessy have access to prescription pads and witnessed him being left alone in an ED room on 4 January 2010 where prescription pads were easily accessed by anyone. Indeed she saw Mr Fennessy with a prescription pad in his hand when she visited him in the ED.

359. Ms Finlay explained the context of why Mr Fennessy was refused access or asked to leave home. Ms Finlay explained that over the years she had become burnt out try to keep him safe and alive. Significantly the attempts at getting him support were mostly futile.

360. Ms Finlay was of the view that a collaborative approach including family members or carers, as well multidisciplinary health teams, should be involved in the management of clients with dual diagnoses.

361. The family criticised Mr Bailey for not reviewing the ED medical notes where it was documented that Mr Fennessy said '*he did not care if he died or not'*. It was Ms Finlay's view that Mr Bailey should have read those notes and that he had ample time to do so given he knew of Mr Fennessy's admission at 13:00 hours and did not see him until 17:00 hours.

362. In my view it is unfortunate that Mr Bailey did not review the ED medical notes, particularly given the notation, however in his evidence he suggested that they were not available to him and the only notes he had were the MHAGIC notes. I also note that after assessing Mr Fennessy Mr Bailey formed the view that he was not mentally ill or dysfunctional. Whether or not these comments by Mr Fennessy would have made a difference is unknown and I cannot speculate. I note there was no evidence before me as to why the medical notes were not available for the CAT assessment done by Mr Bailey.

363. Ms Finlay made the comment that it was a complete dereliction of responsibility to give just one person responsibility for a complex mental health and addiction case. Ms Finlay asked why Mr Fennessy was not referred to an addiction specialist. I understand that Mr Fennessy was seen by Dr Gupta, an addiction specialist on one occasion.[328] There is no evidence before me as to whether Mr Fennessy made or kept another appointment.

364. In my view, given the circumstances surrounding Mr Fennessy's situation, particularly in regard to Mr Fennessy's drug addiction to both illicit and prescription medication, consideration should have been given as to whether being a Tier 3 client was an appropriate level of support.

[328] Exhibit 14, p165.

365. Ms Finlay criticised the failure of early intervention for Mr Fennessy and she also criticised the GPs who prescribed benzodiazepine and other medication which she suggested was contraindicated with codeine use. Ms Finlay suggested these practitioners did so often increasing doses without even seeing Mr Fennessy and without him ever receiving any real meaningful substance abuse treatment. She also criticised Dr Craft when she stated that there was nothing essentially available for Mr Fennessy and therefore no meaningful treatment for his addiction was offered. That criticism may be well founded given Dr Craft did not know she could refer Mr Fennessy back to the Alcohol & Drugs Unit for an assessment to upgrade his status.

366. Further in submissions Ms Finlay refutes the assertion that she did not seek assistance from the police until 8 pm. She asserts that she went directly to the Police Station after speaking with Mr Fennessy at 6:30 pm on 6 January. Ms Finlay rejects the assertion that she delayed seeking assistance.

367. Ms Finlay also referred to the evidence of Mr Fennessy identifying his underlying problem of substance abuse as being depression. Ms Finlay indicated that in her view Mr Fennessy was treated for his psychotic episodes by a short inpatient stay and then released with case file closed. I note that Dr Gupta suggested that Mr Fennessy did not suffer from depression.[329]

368. Ms Finlay indicated that it was her view Mr Finlay was able to access medications from GPs and was able to request and be supplied with a prescription for any medication he mentioned. Ms Finlay suggested there was little investigation to ensure Mr Fennessy was taking the medication as prescribed.

369. Ms Finlay criticised the Coolamon Court Pharmacy for taking so long to admit they had administered mistakenly a second dose of methadone to Mr Fennessy just hours before he died. Ms Fennessy also criticised the failure of the Pharmacy in relation to the investigation conducted by Coroner Dingwall to provide the documents that she now knows exist in relation to the second dose of methadone on 6 January. In my view this is well founded as Mr Fennessy was prescribed and given a dose of methadone that evening: his second dose.

370. Ms Fennessy opined that Mr Fennessy self medicated to relieve his mental health symptoms and tried to do so to manage his anxiety and depression over the years. Ms Finlay opined that Mr Fennessy was given a distinct lack of care or authentic response from very dangerous situations by those who were there to treat him. Ms Finlay believed there was more that could have been done for him.

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[329] Exhibit 14, p165.

Submissions from Dr Craft

371. Dr Craft wanted to reassure the family that she did the best she could to understand Mr Fennessy's condition and circumstances and attended to his health care. As she said in her evidence, she always had hope for him although it was difficult to know what to do.

372. In relation to the doctor shopping issue raised by Ms Finlay, Dr Craft indicated that she was very careful in the way she prescribed and monitored Mr Fennessy's medication. She also engaged in getting Mr Fennessy to undertake not to attend other practices, and she ensured that his prescriptions were sent directly to the Coolamon Court Pharmacy so that only they could dispense his medications. There were Webster packs implemented and Dr Craft was never made aware of any issues surrounding their use.

373. Dr Craft submitted she always assessed Mr Fennessy for intoxication and referred him to specialists when required, particularly in relation to his mental health and drug management. Dr Craft also instituted a benzodiazepine contract which would allow her to be notified if Mr Fennessy had been given prescription for that medication by other practitioners. Dr Craft never received any notifications of this. Dr Craft notes that since 2012 voluntary undertakings for other medicines are now available.

374. Dr Craft was well aware of Mr Fennessy's difficult circumstances particularly in relation to failure at residential rehabilitation. Dr Craft indicated that in her view an opioid treatment program was appropriate as an immediate response to his situation in early January 2010.

Statement from Australian Pharmacy Group (trading as Coolamon Court Pharmacy)

375. I caused a section 55 notice to be sent to the Australian Pharmacy Group, trading as Coolamon Court Pharmacy, in relation to comments that I had considered I may make in relation to this inquest.

376. In responding, Simon Blacker on behalf of the Australian Pharmacy Group admitted that Mr Fennessy was given a double dose of methadone on 6 January 2010. Mr Blacker stated that Mr Fennessy was given the correct dose in the morning, however he attended again in the evening seeking a dose. The evening pharmacist after confirming the prescription confirmed the dose of 25 mg and dispensed it, and Mr Fennessy consumed the dose. The pharmacist only realised her mistake when she prepared to write up the evening dose. The Pharmacy accepted the dose was not administered as per protocol. Had the protocol been followed Mr Fennessy would not have received a double dose.

377. The pharmacist in question advised her superiors that because Mr Fennessy appeared relieved that the pharmacy was still open and he appeared calm, communicative and did not appear intoxicated, as well as denying having an earlier dose, she administered the dose. It appears that the pharmacist immediately upon completing the paperwork realised the error and contacted the pharmacist who had worked earlier in the day. Mr Fennessy was still in the pharmacy at the time and she asked him to remain. Whilst Mr Fennessy remained in the pharmacy he attempted to take some benzodiazepine from the pharmacy. Mr Blacker opined that in his 20 years of experience it is a very rare occurrence for someone to blatantly steal from behind the counter. Mr Fennessy then left the Pharmacy. After confirming the double dose with the morning pharmacist, the evening pharmacist tried to contact Dr Craft.

378. Mr Blacker considered a system of real time reporting (like DORA) would better assist in the monitoring of customers with addiction issues, with the monitoring of who prescribed, what was prescribed and who dispensed medications. In his view it would be ideal for such a system to be in place.

379. Mr Blacker criticised the fact that it was clear at The Canberra Hospital that Mr Fennessy had been brought in because of an overdose of benzodiazepine and heroin. He also considered that the fact Mr Fennessy had told staff that he had to get himself to the Westin Pharmacy to get his methadone was significant. Mr Blacker indicated that the Hospital should have rung to see whether Mr Fennessy had been dosed already that day. Mr Blacker advised that generally in his experience if a client presented to The Canberra Hospital and medication is mentioned the ED pharmacist would normally call the Pharmacy to confirm the prescribed medications. In his opinion if such a call was made the ED would have a greater insight into whether Mr Fennessy was given his morning dose of methadone and what particular medications he had taken.

380. In relation to doctor shopping Mr Blacker opined that it is a challenge for both doctors and pharmacists, who are as vigilant as they can be given the lack of real time data shared between pharmacies.

381. Mr Blacker opined that integrated healthcare is a worthy objective and his Pharmacy endeavours to contribute to this with all patients they assist and they did so in the case of Mr Fennessy.

<u>Comments in relation to Dr Craft</u>

382. I found Dr Craft to be an honest witness who appeared to genuinely care for Mr Fennessy. Dr Craft was concerned about Mr Fennessy's persistent drug abuse. I accept that she found Mr Fennessy's condition difficult to treat given the circumstances Mr Fennessy found himself in. It would appear Mr Fennessy was hopelessly addicted to prescription and other medications. It seems to me that it would also been obvious to Dr Craft that nothing had worked so far in

relation to Mr Fennessy's addiction. This is self-evident given the numerous occasions Mr Fennessy was admitted to hospital for drug overdoses, particularly November and December 2009 and January 2010.

383. It is unfortunate that Dr Craft did not understand she could have referred Mr Fennessy for reassessment as to his Tier status. In my view that was necessary in order to have given him better support.

384. Dr Craft took the view, as did a number of other medical witnesses, that Mr Fennessy was the person to make the decision to rehabilitate himself. I find that concept difficult to accept given it was clearly evident that Mr Fennessy appeared to be incapable of making that decision for himself. It appears from the evidence that if a person has a drug addiction they must make the effort themselves to deal with it regardless of whether they are capable of doing so or keeping themselves safe.

385. Dr Craft appeared to, in order to build a therapy relationship with Mr Fennessy, accept his assertion that he would keep his contract when clearly he was incapable of abiding by it. The evidence supports the conclusion that Mr Fennessy had attempted residential rehabilitation on a couple of occasions and was unsuccessful in completing the program, usually lasting only a few days and being discharged because he had drugs on him or he broke the rules of the organisation.

386. I accept Dr Craft referred Mr Fennessy to Dr George, a psychiatrist and addiction specialist. Dr George was aware of Mr Fennessy doctor shopping and made a request of Mr Fennessy to not attend other practices for medication. The evidence suggests that there was no further inquiry made to ensure that Mr Fennessy was compliant with that request and no referral was made to the Doctor Shopping Line.

387. Dr Craft was aware that there was a doctor shopping line, but there is no evidence to suggest she referred Mr Fennessy to that facility either. In my view there was opportunity to refer Mr Fennessy to the Doctor Shopping Line, but unfortunately that opportunity was not taken by his treating medical practitioners.

<u>Comments in relation to Bill Bailey</u>

388. I note Mr Bailey was asked to provide a statement some six years after he had seen Mr Fennessy in January 2010. He was also asked to give evidence and asked to recall incidents that took place over six years ago with little notice.

389. In relation to how he gave his evidence, I have carefully reviewed the transcript and my notes. My notes indicate that it appeared to me at the time that Mr

Bailey was not as forthright as he should have been, appeared distracted whilst giving evidence and had difficulty recalling the events he was asked to recall.

390. At first blush I was concerned about the way he gave his evidence; it appeared that he was being obfuscatious. However, when I considered the fact that he was asked to recall an event from six years ago on an occasion when he interviewed a patient for between 15 and 20 minutes, this view changed. This was so particularly after considering that he was only recently, prior to him giving evidence in the inquest, asked for a statement. I also considered his response to a question from Counsel for the family about why he was lying to the court: I recall he said that he was nervous. I also note submissions from counsel for Mr Bailey.

391. I am satisfied on a balance of probabilities that Mr Bailey was not lying when giving evidence about his dealings with Mr Fennessy on 6 January 2010. I am satisfied that what he was saying in his evidence was not what he did at the time because he had no recall of it, but what his practice was at the time. There appears to be some confusion in the way he gave his evidence but in my view it would appear that was what he was trying to convey.

392. It appears Mr Bailey also relied on his notes which give reasons as to why he made the assessment that Mr Fennessy was not at risk and that he could not hold him under the Mental Health Act. Whether those reasons were sufficient is another matter and one which I will consider in due course.

393. Mr Bailey indicated that he was not aware that Mr Fennessy had made a comment about not caring whether he lived or died to medical staff in the ED, however he opined that it would have made no difference to him in his assessment that he was not at risk. I find that comment, that it would have made no difference to his assessment, quite remarkable given Mr Fennessy's past history for admission of overdose of drugs and asserting that some of the overdoses were potentially suicidal ideation. Those admissions resulted in Mr Fennessy's admission to a mental health facility. Some of those admissions where he was admitted to a mental health facility occurred in the past three years prior to his death.

394. I note that the assessment conclusion drawn by Mr Bailey on 6 January 2010 was not dissimilar to those drawn by other psychiatric professionals attending Mr Fennessy in the past.

395. Mr Bailey made his decision based on an assessment of Mr Fennessy, without any reference to the current ED medical notes. Mr Bailey had access to a recent psychiatric assessment on the MHAGIC system which indicated the psychiatrist had diagnosed Mr Fennessy with a drug addiction and not a mental health issue. This may have coloured Mr Bailey's judgement. I say that because the assessment took somewhere between 10 and 20 minutes, which

seems to be a short time to assess someone in relation to their mental health given the circumstances of the presentation on that day.

396. However it appears that the mental health teams who assessed Mr Fennessy in December 2009 and January 2010 considered him not to be at risk of self harm despite his persistent misuse of drugs and despite some recognition that he would be at risk of accidental overdose. That risk was clearly open on the evidence of his multiple overdoses over a period of three years.[330]

397. I note that on 1 November 2009 Mr Fennessy was admitted to the PSU of The Canberra Hospital following an overdose of prescription drugs with suicidal intentions. I note that Mr Fennessy was found to be in crisis due to loss of family support and accommodation. On that occasion he was seen by the Drug & Alcohol team and reviewed by a psychiatrist, Dr Siew and Dr Rapmund.[331] I note Mr Fennessy was found to have no psychosis or major affective disorder. The discharge plan was for Mr Fennessy to contact a methadone rehab in Lilyfield and an occupational therapist.[332]

398. I note that on 24 December 2009 Dr Anna Berger reviewed Mr Fennessy after he was admitted to the Emergency Department of Calvary Hospital with an overdose of prescription medication. He had been discharged from Karralika after using illicit substances. Dr Berger considered Mr Fennessy had no sustained depressive symptoms and no psychotic symptoms, and her view was that his presentation was one of substance abuse with no psychiatric symptomology.[333]

399. Mr Fennessy was admitted again on 3 January 2010 after experiencing hallucinations and seizures after withdrawal of his medications. After being seen by the social worker, a plan was developed for the social work team, the CAT team and the Alcohol & Drugs Service to review Mr Fennessy. There is evidence to suggest that the Drug & Alcohol liaison nurse saw Mr Fennessy on that presentation.[334] There is also an entry under the hand of Felicity Riddell who conducted a mental state examination and a summary of risk on 4 January 2010.[335]

400. In relation to the admission of 6 January 2010 I note in the medical notes the ED registrar's plan in relation to Mr Fennessy included that Karralika had called and will call patient back, for the CAT team to review, to have IV access, for Mr Fennessy to eat and drink, for Mr Fennessy to have neurological observations, for a chest x-ray and some blood tests. There was nothing in the plan in

[330] See Exhibit 15 p251-327.
[331] Exhibit 14, p148.
[332] Ibid.
[333] Exhibit 14, p133-141.
[334] Exhibit 15, p271.
[335] Exhibit 15, p271–275.

relation to a Drug & Alcohol Service review. I note the observation nursing notes include the transfer to the EMU, that Mr Fennessy was seen by CAT team, and was to be seen by the Drug & Alcohol Service on 7 January at 15:00 hours.[336]

401. In relation to the discharge of Mr Fennessy on 6 January 2010, clearly there was no formal discharge from either the medical practitioner or Mr Bailey. The evidence is clear that there were no notes on file as to the discharge and no discharge document. There is no evidence that a discharge letter was sent to Dr Craft. In my view this is concerning particularly given the consequences which followed. I note there was no case management plan devised for Mr Fennessy on his discharge that day despite the concerns articulated by Ms Finlay. There was a tenuous reference to Mr Fennessy having an appointment to see someone from the Drug & Alcohol program. It appears that there was an appointment made on 4 January which could have been what Mr Fennessy had referred to, although that is speculative.

402. In any event there was no entry in the notes of Mr Fennessy's discharge. There is no evidence that Mr Fennessy was sent away with a treatment plan or care plan.

403. There was knowledge by at least Mr Bailey that Mr Fennessy was off to the pharmacy to get his dose of methadone in a situation where he had been brought in by ambulance, unconscious, requiring CPR and Narcan to reverse the effects of the drugs he had consumed.[337] It was clearly evident from the MHAGIC note written by Mr Bailey on 6 January that he had significant concerns that Mr Fennessy would present in a very short time frame and that he had no ability to manage his lifestyle or organise safety, food, or shelter. I interpret that to mean Mr Fennessy would present to emergency with an overdose within a short period of time. Mr Bailey was also concerned that Mr Fennessy would not keep his Alcohol & Drug review appointment the next day.[338]

404. Given those concerns, there does not appear to be any evidence that a plan to thwart that situation was devised by any of the medical staff.

<u>Adverse comment – the ACT</u>

405. I caused a notice to be sent to the ACT Government Solicitor on behalf of the Australian Capital Territory in relation to comments that I had considered I may make in relation to this inquest.

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[336] Exhibit 15, p321.
[337] Exhibit 16, p232–233.
[338] Exhibit 16, p234.

406. As I have already said supra I have taken considerable cognition of the authorities and the legislation referred to me by Counsel for the ACT. I also considered very carefully the submissions of Counsel. Having considered those matters I make the following comments.

407. In relation to communications between agencies, at the time of Mr Fennessy's death there appeared to be at least from the evidence before me, a lack of communication, coordination and referrals between agencies for Mr Fennessy, who clearly had some mental health and drug and alcohol issues, in particular, Mr Fennessy's clear addiction to both prescription and illicit substances. These two factors caused him to have multiple hospital admissions over the years, some culminating from suicidal ideation and some from his hopeless addiction to medication.

408. As an example of this I refer to the evidence of Ms Hughes. Ms Hughes was taken to the 4 January 2010 admission and I note she agreed that an assessment was conducted by the A&D consultant nurse and that a request was made for admission to the A&D withdrawal unit pending a bed being available at Karralika. Mr Fennessy was expected to be admitted, but no medical review by an addiction specialist was conducted as required and so he could not be admitted.[339]

409. At other times it was left to Mr Fennessy to make his own arrangements and was merely given a phone number, discharged and told to ring the relevant agency.

410. It appears to me that Mr Fennessy was a person who was clearly unable to look after himself or make any considered decisions about himself in relation to his addiction. Yet he was required to self refer for appointments to Alcohol & Drug Services and/or rehabilitation clinics on numerous occasions. I was told by Dr Craft that was a requirement for persons seeking rehabilitation.

411. It appears that Mr Fennessy was unable to get his life organised sufficiently to keep appointments and to assist in his own rehabilitation. When he did attend rehabilitation Mr Fennessy spent very little time there as he broke the rules because of his significant addiction to medication and illicit drugs.

412. The evidence shows that Mr Fennessy was admitted on multiple occasions to a health facility in the ACT. In my view it was clear from the evidence before me that Mr Fennessy was hopelessly addicted to prescription drugs and to some extent illicit substances. It is also my view that Mr Fennessy was unable to help himself.

413. I note that the Territory in its submissions in reply referred to Mr Fennessy's opioid addiction being managed by his GP. Clearly Mr Fennessy's problem

[339] Transcript 30/11/15.

was more than opioid addiction: in fact he was a chronic doctor shopper who consumed a multitude of various drugs in various quantities over a period of time. In that regard having considered the very helpful evidence of Ms Hughes in respect of the three tier system, it is my view that consideration should have been given to whether Mr Fennessy's tier level was the appropriate level for him given his presentations for overdosing of prescription medications on multiple occasions.

414. There was no evidence before me indicating that upon review by the multidisciplinary team consideration was given to whether the level of support should be increased to a level of Tier 1. That in my view was unfortunate because it seems to me given the evidence, Mr Fennessy would have benefited from that increased level of support. It may even have precluded him from the ability to doctor shop.

415. It appears from the evidence as a whole that Mr Fennessy just fell through the cracks despite the efforts of treating clinicians. In my view, it is the system at the time that allowed this to occur not a particular person or agency. This was a failing of the system in place at the time. Clearly this was recognised by the relevant departments because now improvements have been made. As I have indicated supra there is a division known as ACT Mental Health, Justice Health and Alcohol and Drug Services. Following on from the implementation of that umbrella division, the new system would facilitate someone like Mr Fennessy who has varying degrees of symptomology for mental health issues and a significant drug and alcohol addiction. It appears that if Mr Fennessy were to present today the multidisciplinary team which now includes Alcohol & Drug Services could review the situation. I anticipate that would also include an addiction specialist. I cannot say whether that would have saved Mr Fennessy's life but at least it would have been a better option for him as he may have been elevated to a more supportive environment as seen in Tier 1 clients.

<u>Possible adverse comment – Bill Bailey</u>

416. I caused a notice to be sent to the ACT Government Solicitor on behalf of Mr Bailey in relation to comments that I had considered I may make in relation to this inquest. I do not propose to make any adverse comments as set out in the notice. I will comment on the following matters.

417. I accept that Mr Bailey gave his evidence in a manner which did cause me some concern at first blush, however I accept that Mr Bailey was asked to recall an incident that occurred six years previously, was asked to recall events for a statement to be prepared for an event that occurred six years previously. Mr Bailey was asked to recall whether he knew Mr Fennessy after having only seen him once prior to 6 January 2010.

418. In giving evidence I noted that Mr Bailey was distracted and had difficulty recalling matters. It was suggested to him that he was lying, however I accept Mr Bailey was nervous and had difficulty recounting events because of the passage of time. In my view that is understandable given that Mr Bailey was only recently required to recall the events.

419. I note Mr Bailey relied on the notes he took on 6 January 2010 where he said that he had conducted a risk assessment, had considered the previous MHAGIC notes and in his view there was no risk of self harm and he was happy to discharge Mr Fennessy because Mr Fennessy was keen to leave and felt trapped. I also note that it was a very limited assessment however Mr Bailey explained why that was so given Mr Fennessy's behaviour.

420. I am satisfied that despite the fact that Mr Bailey knew Mr Fennessy would most likely not attend his appointment and would most likely represent again in a short period of time, he took the view that he could not hold Mr Fennessy because of the restriction placed upon him. Mr Bailey noted in the MHAGIC notes that he did not have any grounds to hold Mr Fennessy under the Mental Health Act because he formed the view Mr Fennessy was not mentally ill.

421. Mr Bailey accepted that he had failed to discharge Mr Fennessy properly in so far as he did not prepare a discharge summary for him.

<u>Possible adverse comment – Dr Shannon Craft</u>

422. I caused a notice to be sent to Dr Craft in relation to comments that I had considered I may make in relation to this inquest. I do not propose to make any adverse comments as set out in the notice. I will comment on the following matters.

423. As I have noted supra I found Dr Craft to be an honest witness who appeared to genuinely care for Mr Fennessy. There are things that Dr Craft could have done better in caring for Mr Fennessy but I accept that she did as much as she thought she could and was open to her.

<u>Adverse comment – Australian Pharmacy Group (trading as Coolamon Court Pharmacy)</u>

424. I caused a notice to be directed to the Coolamon Court pharmacy trading as the Australian Pharmacy Group in relation to the care provided to Mr Fennessy on 6 January 2010. The notice was given in relation to whether Mr Fennessy received a double dose of methadone that day.

425. I received submissions under the hand of Simon Blacker who accepted that Mr Fennessy did receive a second dose contrary to the prescription. Mr Blacker described how the medication came to be given twice as an error by his

pharmacist who did not follow protocol. The morning dose had been noted and I have dealt with that issue supra. Mr Blacker also indicated that because of Mr Fennessy's behaviour in attempting to steal some medications somehow that was an explanation as to why he was given his methadone incorrectly.

426. I do not accept this explanation. It is clear that the pharmacist for whatever reason gave Mr Fennessy the dose and then went to examine the record and it was only upon examination of the record after the dose had been administered that it was discovered he had an earlier dose that day. That was a failure in protocol.

Conclusion

427. I find that it was not unreasonable, on the balance of probabilities, for medical staff to have discharged Mr Fennessy on 6 January 2010, given they believed they had no mechanism available to detain him.

428. I further find that Mr Fennessy was given a double dose of Methadone on 6 January 2010 where he was only prescribed one dose.

429. I further find Mr Fennessy was able to access prescriptions from multiple prescribers and have the prescriptions dispensed by multiple pharmacies. It was clearly evident that Mr Fennessy successfully doctor shopped his prescriptions enabling him to consume significantly more quantities of drugs than proposed by the treating medical practitioners, to the point he overdosed on numerous occasions.

430. It appears that neither the doctors nor the pharmacists were aware of just how many prescriptions Mr Fennessy had available to him. If there had been a real time mechanism for detecting overprescription and overdispensing such as that described by Ms Hughes in her evidence (DAPIS and DORA) the pharmacists would have been able to detect the misuse of the prescriptions in real time thus avoiding over supply of prescription drugs. This would have prevented Mr Fennessy from having access to the multitude of drugs he did have access to, thus preventing him from overdosing at least on prescription drugs and at least in the ACT. It would have also shown just what drugs were being prescribed and which doctors were prescribing them.

431. I note that the ACT has available a data base (DAPIS) which could if utilised in the Territory, be adapted to provide a real time monitoring system (DORA). I am also aware that Coroners across Australia have called for such a system to be available nationwide.[340]

[340] Coroners Conference 2015 Tasmania.

Findings confirming Interim Findings

I find that Paul Fennessy born in September 1988, died outside and adjacent to the northern perimeter fence of 2 Zeal Place Holder in the Australian Capital Territory at 23:15 hours on 6 January 2010.

I further find that the cause of his death was the combined effect of a cocktail of drugs taken by him, which caused central nervous system depression and respiratory depression leading to positional asphyxia.

Recommendations

1. That the ACT Government implement DAPIS and adapt the real time monitoring system know as DORA.
2. That all medical files, including mental health records, in relation to a patient being treated at a Canberra Public Hospital be made available to all clinical staff at the hospital when required.

<end of findings>