

CORONER'S COURT OF THE AUSTRALIAN CAPITAL TERRITORY

Case Title: Inquest into death of DEAN CHRISTOPHER BRICE (No. 2)

Citation: [2022] ACTCD 4

Findings Date: 30 June 2022

Before: Coroner Morrison

Decision: See [20], [24], [27]-[28].

Catchwords: **CORONIAL LAW** – death in care – no issues of quality of care, treatment and supervision – no matters of public safety – recommendations made in relation to mental health scheme

Legislation Cited: *Coroners Act 1977* (ACT)

Cases Cited: *Inquest into the death of Dean Christopher Brice* [2022] ACTCD 1
Inquest into the death of Kaitlin McGill [2020] ACTCD 7
Inquest into the death of Paul Fennessy [2016] ACTCD 4

Texts Cited: *Productivity Commission Inquiry Report into Mental Health in Australia*, Report no. 95 (2020)

Representation: Counsel Assisting – Ms Baker-Goldsmith
Mr and Mrs Brice – Self-represented

File Number(s): CD 96 of 2020

CORONER MORRISON:

1. I refer to the deceased as Dean without intending any disrespect.
2. An argument took place before me about the scope of the Coronial Inquest into Dean's death. I handed down my decision on that issue on 24 February 2022: see *Inquest into death of Dean Christopher Brice* [2002] ACTCD 1.
3. I am now in a position to make the formal findings under the *Coroners Act 1997* in relation to Dean's death.
4. At the time of his death Dean was subject to a Psychiatric Treatment Order (PTO) and accordingly his death is classified under the *Coroners Act 1997* as a death in care: see [2] of my earlier decision.
5. There are a number of consequences that follow for a death in care. They include:
 - a. A public hearing must be held for the purposes of my inquest.

- b. I must appoint Counsel Assisting.
 - c. In addition to the standard findings I must make, I must include in the record of proceedings findings about the quality of care, treatment and supervision of Dean that in my opinion contributed to the cause of his death.
 - d. I must report my findings to the Attorney-General, the Ministers for Mental Health and Canberra Health Services, and the Australian Institute of Criminology.
6. A brief of evidence has been tendered in the proceedings. It includes a post mortem report of Professor Johan Duflou. In Professor Duflou's opinion, the direct cause of Dean's death was:
 - a. Multiple drug toxicity (gamma hydroxybutyrate and methamphetamine).
 - b. Cardiorespiratory arrest with:
 - Aspiration pneumonia
 - Hypoxic ischaemic encephalopathy.
7. Professor Duflou's opinion is not in dispute and I accept it.
8. At around 2-3pm on 23 March 2020, and at his request, Dean was dropped off at a friend's house. Dean and his friend obtained and used Ice (methamphetamine). The friend told Police later that Dean appeared to have no adverse side effects after using the Ice.
9. Later that night, Dean was called by another friend and invited to visit her. Dean took a taxi to her home. While there, at an unknown time, Dean voluntarily consumed GHB (gamma hydroxybutyrate) in liquid form.
10. At about 3:45am the following day, 24 March 2020, Dean began to exhibit adverse effects and lapsed into unconsciousness. Persons at the residence called 000, and conducted cardiopulmonary resuscitation (CPR). There is no evidence of any delay in calling 000 or providing CPR.
11. Paramedics arrived approximately 10 minutes after the call was made and treated Dean on site, before moving him to Calvary Hospital. There is no evidence of any delay in paramedic arrival or treatment.
12. While in hospital Dean again went into cardiac arrest, but was successfully resuscitated. Tests showed that he had suffered a hypoxic brain injury and a decision was made (with input from his parents Michael and Caterina Brice) that Dean be palliated. He died at about 1:47pm on 28 March 2020.
13. The evidence points to the drugs found in Dean's system having been obtained by him illicitly and consumed voluntarily. As I understand the matter such a conclusion is not in dispute and I find accordingly.
14. There is no evidence to suggest that Dean intended to end his life. Accordingly, I find that Dean's death was an accident.
15. As recorded in my earlier decision, Dean had a long history of mental health and substance abuse problems. The submissions of Mr and Mrs Brice set out in summary what was the long and painful experiences of the family in trying to deal with Dean's problems and obtain assistance for him.

16. For the reasons discussed in my earlier decision, it is beyond the scope of this inquest to examine the decision to discharge Dean from the Adult Mental Health Unit (AMHU) some seven months prior to his death.
17. Accordingly, in considering the care, treatment and supervision of Dean under his PTO, I look only to those aspects of his care, treatment and supervision by ACT Mental Health services in the community in the period immediately before his death.
18. The cause of Dean's death was an accidental, illicit drug overdose. It was not a condition directly related to his mental health, and Dean did not (and ACT Mental Health say, could not) receive mandatory treatment for his drug addiction under his PTO. The medical records show that multiple attempts were made to interest Dean in rehabilitation, but he did not engage with them. It is not in contest that Dean did not engage with drug rehabilitation suggestions and recommendations. The records also show that Dean was counselled on multiple occasions about risks arising from his illicit drug addiction, and particularly the possibility for adverse reactions between illicit drugs and his mental health medication.
19. In the circumstances I am not persuaded that the quality of care, treatment and supervision of Dean in the community under his PTO contributed to the cause of his death, and I so find.
20. The findings I formally make are as follows:

Dean Christopher Brice died at about 1:47pm on 28 March 2020 at Calvary Public Hospital, Mary Potter Circuit, Bruce in the Australian Capital Territory.

The manner and cause of Dean's death was cardiorespiratory arrest due to aspiration pneumonia and hypoxic-ischaemic encephalopathy, caused by accidental multiple drug toxicity.

No matter of public safety arises in connection with the inquest.

There are no matters relating to the quality of care, treatment and supervision of Dean in the community under his PTO that contributed to his death.
21. In my earlier decision I foreshadowed that notwithstanding my decision on the scope of the inquest, I could still make general recommendations in respect of the ACT mental health scheme. That course is urged upon me by both Counsel Assisting and Mr and Mrs Brice.
22. I concluded in my earlier decision that under ACT law as it stood at the time (and as it presently stands), it was not possible for any order to be made imposing mandatory drug rehabilitation treatment for Dean.
23. In my earlier decision I referred to the *Productivity Commission Inquiry Report into Mental Health in Australia*, Report no. 95 (2020). It is apparent that there is no simple or straightforward answer to the problems which are the subject of that report and its recommendations, and which were a feature of Dean's case. The complexity of and difficulty in treating persons with mental health and substance abuse co-morbidities is well recognised in this Court: see *Inquest into the death of Paul Fennessy* (Coroner Hunter) [2016] ACTCD 4.

24. That the problems are complex is a basis for the dedication of more not lesser resources to them. I urge the ACT Government to pursue the recommendations of the *Productivity Commission Inquiry Report into Mental Health in Australia*.
25. I am aware that NSW has an Involuntary Drug and Alcohol Treatment (IDAT) Program, not limited to persons with a co-morbid mental health condition. That program is based on legislation providing for involuntary assessment, detention, stabilisation and treatment as an option of last resort to people with severe substance dependence. Care is provided by a multidisciplinary team including medical practitioners, nurses, social workers, psychologists and occupational therapists.
26. The case for considering a program such as the NSW IDAT is more compelling in circumstances where intended patients suffer both drug dependence and a mental health condition. It seems to me that the 'holistic' model of care in the NSW IDAT Program is precisely what Mr and Mrs Brice submitted should be available in the ACT for persons such as Dean and the need for which is clearly demonstrated in this case.
27. I recommend that ACT Government review the NSW IDAT Program in the context of its pursuit of the Productivity Commission recommendations.
28. I also reiterate the observations in my decision in the *Inquest into the death of Kaitlin McGill* [2020] ACTCD 7 about circumstances where giving primacy to the personal choices made by mental health patients may not be in their best interests. This is likely to be the case for many consumers of mental health services who also have co-existing substance abuse issues, such as Dean.
29. At the request of Mr and Mrs Brice I annex to these reasons a copy of each of the written submissions they made to me. For the sake of completeness I also annex a copy of a letter dated 7 June 2022 sent to Mr and Mrs Brice jointly by the ACT Minister for Health and the ACT Minister for Mental Health in response to issues raised with them.
30. I direct that a copy of these reasons and recommendations be sent to the Attorney-General, the Ministers for Mental Health and Canberra Health Services, and the Australian Institute of Criminology.
31. I express my condolences to Caterina and Michael, and their family, on the loss of Dean. They have been staunch advocates in his memory.

I certify that the preceding thirty-one [31] numbered paragraphs are a true copy of the Reasons for Decision of his Honour Magistrate Morrison.

Associate: Xiao Lin King

Date: 30 June 2022