**FINDINGS and RECOMMENDATIONS of Coroner Simon Cooper following the holding of an inquest under the *Coroners Act* 1995 into the death of:**

**DWAYNE EDWARD ROSENDALE**

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# Record of Investigation into Death (With Inquest)

*Coroners Act* 1995
*Coroners Rules* 2006
*Rule* 11

I, Magistrate Simon Cooper, Coroner, having investigated the death of Dwayne Edward Rosendale, with an inquest held at Hobart in Tasmania make the following findings.

## Hearing Dates

4-5 May 2021 at Hobart in Tasmania

## Representation

C Lee – Counsel Assisting the Coroner
G Chen – State of Tasmania and Tasmanian Health Service
C Mackie and J O'Farrell – Anglicare Tasmania
Mrs Moir – Mr Rosendale's mother and Senior Next of Kin, assisted by N Moir

## Introduction

1. Dwayne Edward Rosendale had a life terribly impacted by mental illness. Suffering schizophrenia, Mr Rosendale died over the night of 16 and 17 January 2019, aged just 36 years old, morbidly obese, alone in his room at Bayview Lodge, a facility run by Anglicare.[1] He had been discharged from hospital two days before. When he died, he was the subject of an order made under the *Mental Health Act* 2013.

2. Mr Rosendale was born in the Waratah Hospital in New South Wales on 1 December 1982, the son of Karyn Moir and Brian Rosendale. An athletic and talented child, Mr Rosendale began to struggle with mental health issues in his late teens when he moved from New South Wales to Tasmania to live with his father in around 1998 (there is no evidence, and I do not suggest, that the two events are in any way related). It is evident at about this time Mr Rosendale began to hallucinate and suffer from significant and damaging delusions.

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[1] Exhibit C1, Police Report of Death for the Coroner.

3. In 2000, Mr Rosendale returned to New South Wales and was admitted to the Maitland Hospital and he was formally diagnosed as suffering from schizophrenia.

4. From this time on Mr Rosendale's mental illness dominated the rest of his life. While ill and delusional, he committed assaults, including one especially brutal attack on his mother. The attack on Mrs Moir saw her seriously injured and Mr Rosendale charged, convicted and sentenced to a period of imprisonment. The assault was doubtless attributable to his diagnosis of Capgras Syndrome.[2] There followed periods of imprisonment, periods of treatment as an inpatient in secure psychiatric hospitals and homelessness. Mrs Moir was powerless to assist her son – his Capgras Syndrome meant Mr Rosendale believed his mother was an imposter, which was why he attacked her.

5. Eventually, and quite how is unclear (and irrelevant for the purpose of this finding), Mr Rosendale returned to Tasmania, in about 2008. Responsibility for his care was assumed by the Tasmanian Mental Health Services, and in 2009 Ms Tracey Withers of that service was assigned as his case worker. Ms Withers supported Mr Rosendale from then until his death.

6. Like many people suffering from mental illness, it is apparent that achieving stable accommodation was both a challenge and critical to Mr Rosendale's health. In this respect Mr Rosendale was fortunate, in the sense that although his accommodation presented challenges, he did achieve a degree of security, at least relatively speaking.

7. He first obtained a room at Bayview Lodge in March 2012, before his behaviour saw him being evicted in late 2013. Mr Rosendale spent the next few years living at another supported accommodation facility in Hobart's northern suburbs before returning to Bayview Lodge on 22 March 2017.[3] He remained at Bayview Lodge until his death. It is evident that he enjoyed living there.

8. It is very clear though that in the last year or so of his life, the staff at Bayview Lodge were struggling to cope with Mr Rosendale's challenging behaviour. Real

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[2] Capgras Syndrome is a condition categorised by an irrational belief that someone close to the patient has been replaced by an imposter.

[3] Exhibit C15A affidavit of Gary Bennett, sworn 28 April 2021.

concerns existed about his ballooning weight, and the staff at the Lodge could do nothing about his health. Mr Gary Bennett, the manager of the Lodge had already raised in conversation with Forensic Mental Health Services workers his concerns about Mr Rosendale's health, and in particular his increasing weight, as early as April 2018,[4] having first really noticed the weight gain in January of that year.

9. At the time of death, Mr Rosendale was still living at Bayview Lodge although it is doubtful that he could have remained there for much longer.

**What a coroner does**

10. A coroner in Tasmania has jurisdiction to investigate any death that is sudden or unexpected or that of a person "held in care".[5] Mr Rosendale's death meets this definition. Because he was the subject of an order made under the terms of the *Mental Health Act* 2013[6] (was a person "held in care"), an inquest was mandatory.[7] An inquest is a public hearing.[8]

11. When conducting an inquest, a coroner performs a role very different to other judicial officers. The coroner's role is inquisitorial. An inquest might be best described as a quest for the truth, rather than a contest between parties to either prove or disprove a case.

12. When conducting an inquest a coroner is required to thoroughly investigate the death and answer the questions (if possible) that section 28(1) of the *Coroners Act* 1995 asks. These questions include who the deceased was, how they died, the cause of the person's death and where and when the person died. This process requires the making of various findings, but without apportioning legal or moral blame for the death.[9] The job of the coroner is to make findings of fact about the death from which others may draw conclusions. A coroner may, if she or he thinks fit, make comments about the death or, in

[4] Exhibit C15, affidavit of Gary Bennett, sworn 17 August 2020, page 2 of 5.
[5] See section 3 of the *Coroners Act* 1995.
[6] See exhibit C4, in particular page 6 of 17.
[7] See section 24(1)(b) of the *Coroners Act* 1995.
[8] See section 6 of the *Coroners Act* 1995.
[9] *R v Tennent; Ex Parte Jager* [2000] TASSC 64.

appropriate circumstances, recommendations to prevent similar deaths in the future.

13. In addition, a coroner conducting an inquest in relation to a person who died the subject of an order pursuant to provisions of the *Mental Health Act* 2013, and thus was a "person held in care", has an obligation to report in relation to that person's care treatment and supervision.[10] This aspect of the role of the coroner is particularly important given the obvious vulnerability of persons in care.

14. It is important to recognise that a coroner does not punish or award compensation to anyone. Punishment and compensation are for other proceedings in other courts, if appropriate. Nor does a coroner charge people with crimes or offences arising out of a death that is the subject of investigation. I should make it very clear that I do not consider that anyone committed any offence in relation to Mr Rosendale's death.

15. As was noted above, one matter that the *Coroners Act* 1995 requires, is a finding (if possible) as to how the death occurred.[11] 'How' has been determined to mean "by what means and in what circumstances",[12] a phrase which involves the application of the ordinary concepts of legal causation.[13] Any coronial inquest necessarily involves a consideration of the particular circumstances surrounding the particular death so as to discharge the obligation imposed by section 28(1)(b) upon the coroner.

16. The standard of proof at an inquest is the civil standard. This means that where findings of fact are made, a coroner needs to be satisfied on the balance of probabilities as to the existence of those facts. However, if an inquest reaches a stage where findings being made may reflect adversely upon an individual, it is well-settled that the standard applicable is that expressed in *Briginshaw v Briginshaw*, that is, that the task of deciding whether a serious allegation against anyone is proved should be approached with a good deal of caution.[14]

[10] See section 28(5) of the *Coroners Act* 1995.
[11] Section 28(1)(b) of the *Coroners Act* 1995.
[12] See *Atkinson v Morrow* [2005] QCA 353.
[13] See *March v E. & M.H. Stramare Pty. Limited and Another [*1990 – 1991] 171 CLR 506.
[14] (1938) 60 CLR 336 (see in particular Dixon J at page 362).

17. The final matter that should be highlighted is the fact that the coronial process, including an inquest, is subject to the requirement to afford procedural fairness.[15] A coroner must ensure that any person (and person includes any legal entity) who might be the subject of an adverse finding or comment is made aware of that possibility and given the opportunity to fully put their side of the story forward for consideration.

**Issues at the inquest**

18. In advance of the inquest a number of issues, in addition to those mandated by the *Coroners Act* 1995, were identified as being matters to be particularly considered at the hearing. Those matters included:

    a. How Mr Rosendale's death occurred?
    b. The cause of Mr Rosendale's death.
    c. The care of Mr Rosendale's mental health by Forensic Mental Health Services ("FMHS"). Specifically,
        i. Given his prior and current mental health, was a living arrangement within Bayview Lodge ("the Lodge") appropriate?
        ii. The medication regime and the impact it was having upon his physical health.

**Evidence at the inquest**

19. After several case management conferences designed to ensure issues were identified, evidentiary material made available to all interested parties and appropriate arrangements made (having regard to the COVID 19 pandemic) for hearing, an inquest was held in Hobart in May 2021. A significant amount of documentary material was tendered and a number of witnesses called to give evidence. The details of the documentary material appear as annexure A to this finding. The witnesses called to give evidence and answer questions were:
    a. Mr Brian Green – Mr Rosendale's cousin;
    b. Mr Gregory (Greg) Fox – a resident of Bayview Lodge;
    c. First Class Constable Rhian Appleton, Investigating Officer;
    d. Dr Christopher Lawrence, Forensic Pathologist;

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[15] See *Annetts v McCann* (1990) 170 CLR 596.

e. Mr Neil McLachlan–Troup, Forensic Scientist;

f. Mr Gary Bennett – Manager, Bayview Lodge;

g. Ms Jodie Matthews – Support Worker, Bayview Lodge;

h. Ms Tracey Withers – Mr Rosendale's case manager;

i. Ms Karyn Moir – Mr Rosendale's mother;

j. Mr Colin Harris - Case worker; and

k. Dr Michael (Mike) Jordan – Forensic Psychiatrist, Tasmanian Mental Health Services.

20. All of the witnesses impressed as honest people doing their very best to assist me to properly and thoroughly investigate Mr Rosendale's death. I am grateful to each of them for their assistance. At the conclusion of the public hearing, the inquest was adjourned to allow all interested parties to make submissions in writing.

**Bayview Lodge**

21. It is perhaps best to commence with an explanation of what Bayview Lodge is and what it is not. Anglicare, a not-for-profit organisation, part of the Anglican Diocese of Tasmania, provides a number of services and facilities in the welfare sector. Bayview Lodge is one of 10 supported accommodation facilities in Tasmania. It provides accommodation for up to 26 people who, by reason of mental or physical illness, or some other cause, are at risk of homelessness.

22. The Lodge was staffed by an on-site manager (Mr Bennett), a part-time support worker (Ms Matthews) and a cook (Ms Dimitriou) (on weekends).[16] None of the staff at the Lodge were medically trained, healthcare professionals of any type or authorised to administer medication to residents. Some efforts were made to have a measure of awareness of the medication of the various residents; each resident was requested to sign a "Residential Medical Record" when they commenced living at Bayview Lodge, but that document does not appear to have been updated at any stage. Ms Matthews gave evidence that she, generally speaking, was not aware of what medication residents were taking.[17]

[16] Exhibit C15A, *supra*.
[17] Exhibit C26, paragraph 6.

23. Mr Bennett did not know either what medication Mr Rosendale was prescribed and using. There was some evidence that, in a general sense, from time to time staff would "look after" medication for residents, but on no view of it did the staff at Bayview Lodge have any role in the supervision or administration of medication to any of the residents, Mr Rosendale included.

24. There seems to have been an expectation on the part of FMHS that, perhaps on some sort of informal basis, staff at the Lodge would assist in relation to the administration of medication. Certainly, Ms Withers gave evidence at the inquest about a "recommendation" being made that Mr Rosendale's medication be kept in the office at the Lodge, sometime around November 2018. However, she was unaware as to what policy existed, if any, on the part of the Lodge in relation to the administration and supervision of medication to residents.

25. Anglicare entered into an agreement with Mr Rosendale to provide him with accommodation, electricity, a linen service and three meals a day. Each resident had a private bedroom with en-suite toilet and shower facilities, access to common areas (dining room and lounge) and the use of a laundry.

26. In return, Mr Rosendale (and every other resident) agreed to pay rent and, in effect, respect the rules of the Lodge and his fellow residents. Under the terms of his residency agreement Mr Rosendale's rent was calculated by reference to 85% of his Centrelink payment.[18]

27. It was not part of the role of Anglicare to provide Mr Rosendale with medical, psychiatric or welfare support or care. It was not any part of Anglicare's role to supervise Mr Rosendale's medication regime. As noted above the staff of the Lodge were not trained to do so, although Mr Bennett said that, in fact there were circumstances in which he would at least 'hold' medication for residents.

28. Anglicare and FMHS do not appear to have had any type of agreement or memorandum of understanding in place at any relevant time.

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[18] *Supra.*

29. Obviously too, staff were close to the Lodge residents. They saw them regularly, cared about them and were uniquely placed to see changes in the physical or mental health of a resident.[19] It is clear that Mr Rosendale benefitted from his time at the Lodge. I do not consider that he could have been looked after any better by the Lodge staff.

30. Mr Lee, counsel assisting, submitted that the staff at Bayview Lodge did their job in respect of providing meals and accommodation to Mr Rosendale, very well. I agree. I also agree that had his medical requirements been less complex, then Bayview Lodge would no doubt have continued to be a more than suitable home for Mr Rosendale. But by the time of his death, I am quite satisfied that Bayview Lodge was no longer somewhere Mr Rosendale could receive the care he needed.

**Mr Rosendale's health and treatment**

31. As identified earlier in these findings, Mr Rosendale was diagnosed in his youth as suffering from schizophrenia and Capgras Syndrome. That condition was especially severe and, in real terms, treatment resistant. It was characterised by somatic delusions and paranoia. In addition, he was morbidly obese and suffered diabetes.[20] Both conditions (one of which caused his death, were related to his mental illness). His delusional beliefs included that he suffered sickle cell anaemia (he did not), and that he suffered from a form of an undiagnosed neurological disorder which prevented him from walking. These beliefs meant he was unable to exercise, essentially because he believed he could not. This in turn impacted significantly upon his physical health. He was undoubtedly a challenging patient presenting as he did with a complex admixture of mental and physical infirmity.

32. Over the years, Mr Rosendale had been treated as an inpatient at a variety of secure mental health facilities in both Tasmania and New South Wales. He had received virtually every available medication to attempt to manage his schizophrenia. At the time of, and in the period leading to, his death Mr Rosendale was prescribed anti-psychotic medication including zuclopenthixol.

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[19] *Supra*.
[20] See exhibit C9, medical records generally.

A well-recognised side effect of this drug, and other anti-psychotic and similar medication, is significant weight gain.

33. Mr Rosendale was a long-term patient of the FMHS. He commenced with the service in 2008. He was still a patient of FMHS at the time of his death. The FMHS is part of the Tasmanian Health Service (THS). The Community 'wing' of the FMHS's charter is to provide treatment and support to psychiatric patients living in the community.[21] When Mr Rosendale was living in the community (and apart from his periods as an inpatient at the Royal Hobart Hospital this was all the time), the role of the FMHS was to, in effect, continually review him and monitor and prescribe appropriate medication.

34. Mr Rosendale presented as a complex and difficult patient. There is no doubt that Mr Rosendale's weight increased rapidly, and dangerously, in the last year or so of his life. Mr Gary Bennett said that when he saw him in about April 2017 he thought Mr Rosendale weighed approximately 100 kg. About this time, Mr Rosendale ceased his use of clozapine.

35. In about January 2018, Mr Bennett and other staff at the Bayview Lodge noticed that he was putting on weight. By June 2018 he had stopped exercising altogether (prior to this time apparently he had taken the occasional walk) and was described as spending most of his time either in bed or eating.

36. Staff observations are supported by the objective evidence provided by the FMHS case notes. Those notes show from February 2018 a steady and inexorable increase in his weight. So too does the evidence of his cousin Mr Brian Green who described Mr Rosendale as gaining extra weight in the last six months of his life.[22]

37. Backtracking slightly, in October 2017 Dr Mike Jordan took over Mr Rosendale's care, initially while Mr Rosendale's ordinary treating psychiatrist Dr Evenhuis was on leave. From July 2018, until Mr Rosendale's death, Dr Jordan was responsible for Mr Rosendale's direct psychiatric care. At around

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[21] Exhibit C21, affidavit of Dr Mike Jordan, sworn 23 December 2020, paragraph 4.
[22] Exhibit C17, affidavit of Brian Green, sworn 26 March 2020.

this time it seems that staff at Bayview Lodge first raised whether the Lodge was an appropriate facility to house Mr Rosendale.

38. In August 2018, Mr Rosendale spent a period as an inpatient at the Royal Hobart Hospital for psychiatric treatment. At about the same time, the viability of his continued accommodation at Bayview Lodge was discussed at FMHS.[23]

39. The food and drink he was consuming was also deeply problematic. Other than the food provided for him as part of his tenancy agreement he seems to have been spending the remainder of his money on junk food such as sweet fizzy drinks and ice cream. Although advised against buying and eating junk food, Mr Rosendale did not desist. The evidence was that he was also a very heavy smoker of tobacco cigarettes.

40. By October 2018, he was demonstrating paranoia. Mr Green said in his affidavit that Mr Rosendale believed "*someone was out to get him*" and had hidden money in his room in case he was killed.[24]

41. It was obvious to staff at Bayview Lodge and Mr Green that Mr Rosendale's weight gain was of real concern. He was observed to be suffering from difficulty breathing, something doubtless exacerbated by his obesity and heavy smoking.

42. Notably, he does not appear to have had a general practitioner, someone who may have been able to assist in relation to nutrition and diet as part of a holistic approach to his overall health.

43. It is evident that by the latter part of 2018 staff at Bayview Lodge were struggling to cope with both Mr Rosendale's health and behaviour. In her affidavit Ms Withers said:

> "*…towards the latter part of 2018, it was becoming apparent that [Bayview Lodge) were struggling to cope with Dwayne's health and behaviour; that he would need accommodation where he could receive more psychiatric care, starting with*

[23] Exhibit C22, affidavit of Ms Tracey Withers, sworn 24 December 2020, paragraph 27.
[24] Affidavit of Brian Green, *op cit*.

*the RHH or Millbrook Rise. I passed this information onto his inpatient treating team during admissions at the RHH*".[25]

44. Nonetheless, Mr Rosendale remained living at Bayview Lodge, eating junk food, drinking fizzy cordial and raiding the fridges while his weight increased and his health substantially declined. In September 2018, he was referred by FMHS for lap band surgery in an attempt to control his weight[26] - evidently a recognition by that service that, as Dr Jordan recognised, Mr Rosendale's physical and psychiatric health were intertwined, and that without a significant improvement in his psychiatric well-being his physical health was unlikely to ever improve. Dr Jordan said:

"*As Dwayne's treating practitioner my main aim was to bring his psychiatric symptoms derived from his schizophrenia under control; it was hoped if his psychosis was improved it would be easier to assist him in improving his physical health*".[27]

45. Dr Jordan saw Mr Rosendale on two further occasions on 14 and 26 November. On each occasion, Mr Rosendale's prescriptions were renewed and a clinical mental state examination conducted. The notes of both reviews reference Mr Rosendale's morbid obesity.[28]

46. Concerns, particularly among the staff at Bayview Lodge, continued in relation to Mr Rosendale's weight. Mr Green was also very aware of his cousin's weight gain. He spoke to Mrs Moir on Christmas Day 2018 and told her that her son could hardly breathe or walk.[29] Mr Bennett saw him falling asleep in different communal areas of the Lodge on the same day.[30]

47. Two days later, on 27 December 2018, Mr Bennett said he contacted FMHS (although there was no note of this contact in the relevant FMHS file). He described Mr Rosendale was falling asleep and plainly suffering from sleep apnoea.[31] On the same day he was seen by psychiatric registrar Dr Loh, who

[25] Affidavit of Tracey Withers, *op cit*, paragraph 28.
[26] Exhibit C10, Outpatient Notes, page 2.
[27] Exhibit C21, affidavit of Dr Mike Jordan, sworn 23 December 2020, paragraph 10.
[28] Exhibit C9, pages 1673, 1675.
[29] Exhibit C12, affidavit of Mrs Karen Moir, sworn 3 October 2019, page 4 of 5.
[30] Exhibit C15, affidavit of Gary Bennett, *op cit*, paragraph 3 of 5.
[31] Exhibit C9, page 1685.

noted Mr Rosendale's obesity, recorded his weight at 170 kg, made other observations in relation to his mental state and continued his prescription of depot zuclopenthixol deaconate 300 mg twice weekly. Curiously, the note in relation to Dr Loh's review of Mr Rosendale is recorded in the medical notes as having been performed by Dr Mike Jordan.[32] Dr Jordan's affidavit satisfies me that in fact it was Dr Loh, and not he, that saw Mr Rosendale on that date, despite the entry in the notes.[33]

48. On 31 December 2018, Mr Rosendale caught a taxi to the Royal Hobart Hospital but returned to Bayview Lodge later the same day.[34] He was returned to the Lodge by a member of FMHS staff who later the same day dropped off a Webster blister pack of Mr Rosendale's medication. The manager of the Lodge, Mr Bennett, said in his evidence that FMHS did not provide him with any 'feedback' in respect of Mr Rosendale's condition.[35] FMHS case notes tend to confirm Mr Bennett's account, in the sense that it is clear that a staff member seems to have made a decision that Mr Rosendale did not need to be admitted to hospital, and returned him to the Lodge. There is no mention in the relevant notes of any interaction with Lodge staff on that day.

**The lead up to Mr Rosendale's death**

49. On 3 January 2019, Mr Rosendale was experiencing significant problems breathing. An ambulance was called and he was taken to the Royal Hobart Hospital. He was assessed and diagnosed as suffering chronic type 2 respiratory failure secondary to chronic obstructive pulmonary disease and/or obesity. Something recognised by staff at Bayview Lodge, that is that Mr Rosendale was suffering sleep apnoea, was also suspected but formal diagnosis deferred pending sleep studies. He was admitted to the ward. He spent the next 11 days as an inpatient at the Royal Hobart Hospital.

50. At the same time, discussions were commenced about the possibility of rehousing Mr Rosendale in a facility more suited to his complex needs. The proposal was for Mr Rosendale to be transferred to a facility known as Tolosa

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[32] *Supra*.
[33] Affidavit, Dr Mike Jordan, *Op cit*, paragraph 6.
[34] Exhibit C15, affidavit, Gary Bennett, *Op cit,* page 4 of 5.
[35] *Supra*.

Park. Although there was no evidence about the nature of the Tolosa Park facility at the inquest, it seems reasonable to conclude that FMHS considered it was a facility more suited to managing Mr Rosendale's physical and psychiatric health needs, and I accept that it was. As part of these discussions, an application was made to the Mental Health Tribunal in respect of Mr Rosendale. As a consequence of that application the order under the *Mental Health Act* 2013 to which Mr Rosendale was subject was varied to include a power for him to be admitted to an appropriate facility if possible harm was suspected.

51. Mr Green visited his cousin whilst Mr Rosendale was an inpatient at the Royal Hobart Hospital. He played table tennis with him and said his cousin was "*physically struggling to stand for extended periods*."[36]

52. Whilst an inpatient a number of medical emergency team calls were made to deal with Mr Rosendale's obesity-related hypoventilation, which medical notes attributed to his heavy smoking. Consultations in relation to Mr Rosendale's breathing issues with the Department of Respiratory Medicine occurred on 8, 9 and 10 January 2019. His THS medical records include references to him smoking in his room and setting off the fire alarms on multiple occasions and falling asleep mid-sentence.[37]

53. If Mr Rosendale's medical records for his period as an inpatient 3–14 January 2019 have a theme it is that it was perceived that his psychiatric symptoms were, relatively speaking, stable. The greater concern of his treating team seems to have been in relation to his physical symptomology, in particular COPD, potential sleep apnoea and his morbid obesity, rather than the symptoms of schizophrenia.

54. There is no evidence, and indeed it seems common ground, that at no stage during his period as an inpatient at the Royal Hobart Hospital did his physical or mental health treating team make any contact with Community FMHS. Certainly, Community FMHS do not appear to have even been aware that Mr Rosendale was an inpatient.

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[36] Affidavit Brian Green, *op cit*, paragraph 8.
[37] Exhibit C9A, pages 56–59.

55. In the event, Mr Rosendale was discharged from the Department of Psychiatric Medicine on 14 January 2019. A note in his THS records on the day of his discharge, with a time recorded of 2.00 pm, states:

> "*Dwayne remains settled behaviourally on the ward. Denying psychotic symptoms, utilising leave appropriately. [Patient discharged at approximately] 1400, back to Bayview Lodge, who are aware and expecting [patient]. All relevant paperwork completed. FMHS to collect [discharge medications] and deliver to [patient], and confirmed they are aware of same.*"[38]

56. After all the evidence had been heard at the inquest, Ms Chen on behalf of the Secretary of the Department of Health, sought and was granted leave to file an additional affidavit. That affidavit was sworn by Dr Lennie Woo a psychiatrist and Clinical Director of Adult Mental Health Service South.[39] Adult Mental Health Service South includes responsibility for the Mental Health Inpatient Unit, which until recently was known as the Department of Psychiatry at the Royal Hobart Hospital. I do not consider that Dr Woo's affidavit adds anything to the evidence adduced at the inquest. In the main, the affidavit merely refers to various records in Mr Rosendale's Digital Medical Record (DMR), which were of course tendered at the inquest and speak for themselves.

57. In his affidavit, Dr Woo expresses the opinion that the DMR indicates "*appropriate discharge arrangements were made*". This is not a view that I share. Upon Mr Rosendale's discharge and return to Bayview Lodge, it is not an exaggeration to say Lodge staff were shocked and surprised to see him. Ms Matthews, who was relieving manager (Mr Bennett being on holidays) said she received no notice that Mr Rosendale had been discharged from hospital and was returning to the Lodge. In fact, Ms Matthews said she did not even know how Mr Rosendale got to the Lodge.[40] Ms Matthews was in possession of the Lodge's mobile phone, the means by which calls could be made to and from the Lodge. The evidence that she gave about this issue was compelling. Importantly, her version of events was not challenged by Ms Chen. I am satisfied that Bayview Lodge were not notified that Mr Rosendale was being discharged and was returning to the Lodge on 14 January 2019.

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[38] Exhibit C9A, page 62.
[39] Exhibit C28, affidavit Lennie Woo, sworn 1 June 2021.
[40] Exhibit C26, affidavit of Jodie Matthews, sworn 27 April 2020, paragraphs 15 and 16.

58. In any event, Ms Matthews immediately contacted FMHS and spoke to Mr Colin Harris who was performing Ms Withers' role (she also was on holiday). She told Mr Harris that Mr Rosendale had been discharged from hospital and returned to Bayview Lodge. This must have been something already known to FMHS, because a note is recorded in Mr Rosendale's case notes, that day, at 12.39 pm which indicates a phone message of some type to the effect that Mr Rosendale was being discharged from the Department of Psychiatric Medicine at the Royal Hobart Hospital. To whom the message was sent, and whether it was by voice or text is not clear on the evidence.

59. Interestingly, Mr Rosendale's Discharge Summary Form was sent to a general practitioner, Dr Ian Beltz, who last saw Mr Rosendale four years before his death. It was not sent to either Dr Jordan or Ms Withers. Neither was it sent to Bayview Lodge. The fact that the Discharge Summary was sent to a general practitioner with whom Mr Rosendale was last in a therapeutic relationship four years before his death, and not sent to anyone currently involved in his treatment or support was, to my mind, to say the least, unfortunate. It is also concerning that no one appears to have turned their mind to the need to ensure those responsible for Mr Rosendale's treatment and care in the community (remembering he was the subject of an order under the *Mental Health Act* 2013) were brought up to date with his current status.

60. However, although forming part of the circumstances of Mr Rosendale's death, I do not consider sending the Discharge Summary to Dr Beltz, and not sending it to FMHS caused or contributed to Mr Rosendale's death. It is, of course, directly relevant to the care, treatment and supervision he received whilst the subject of that order.

61. The following day, 15 January 2019, Ms Matthews and Ms Dimitriou met with Mr Harris at Bayview Lodge. The question of suitable accommodation for Mr Rosendale was, once again, discussed.[41] Mr Green also spoke to Mr Rosendale that day. Mr Green said that his cousin expressed a wish to return to New South Wales.

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[41] *Supra*, paragraph 19.

62. Later still on the same day, a registrar at the Royal Hobart Hospital emailed Dr Jordan to inform him of the fact of Mr Rosendale's discharge from the hospital and changes made to his medication.

63. The last person to have any contact with Mr Rosendale was fellow resident Mr Greg Fox. Mr Fox gave evidence at the inquest. He said that he went to Mr Rosendale's room after eating his evening meal at about 5.30 pm on 16 January 2019. He said he and Mr Rosendale drank cask wine mixed with Coca-Cola. His estimate was that they drank about a quarter of a wine cask each that is four or five drinks (he said) over a two-hour period.[42] As they shared a few drinks together Mr Rosendale and Mr Fox discussed, amongst other things, Mr Rosendale's plans for the following day.

64. Importantly, Mr Fox recognised that Mr Rosendale was not at all well. He described his friend having difficulties breathing. He said Mr Rosendale was "*sleepy and a bit tired*" and that he left his room at about 7.30 pm.

65. Mr Fox said that on previous occasions Mr Rosendale had asked him for clozapine (which was prescribed for Mr Fox) but that he Mr Fox, refused to give him any. He said he did not give Mr Rosendale any clozapine on the last night of his life.

66. No one saw Mr Rosendale alive after Mr Fox left his room.

**Discovery of body and initial investigation**

67. At approximately 1.00 pm on Thursday, 17 January 2019 Ms Jodie Matthews and Ms Judy Dimitriou, the staff on duty at Bayview Lodge noticed that neither of them had seen Mr Rosendale all day. The two women went to his room and knocked on the door. There was no answer and so they opened the door and entered the room. They found Mr Rosendale, obviously dead, lying on his back on his bed. The scene was not disturbed and emergency services were contacted.[43] Ambulance Tasmania paramedics and police officers arrived within a short time.

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[42] The type of wine was not clear on the evidence, but nothing turns on it.

[43] Exhibit C13, affidavit of Judy Dimitriou sworn 22 July 2019 (sadly Ms Dimitriou died before the inquest).

68. It was evident that nothing could be done for Mr Rosendale and so, quite appropriately, no efforts were made at resuscitation. Police commenced an investigation at the scene. Mr Rosendale's body was formally identified before an officer from Forensic Services arrived and, with the assistance of uniform officers, conducted a scene examination. Officers from the Criminal Investigation Branch also attended the scene, but departed once they had satisfied themselves that there were no suspicious circumstances associated with Mr Rosendale's death.

69. Investigating officers described Mr Rosendale's room as "*cluttered and messy*". The photographs tendered at the inquest in relation to the scene support very well this description. Nonetheless, I do not consider that the state of Mr Rosendale's room had any bearing upon his death.

70. Importantly, police found Mr Rosendale's wallet, containing cash and personal cards, his mobile phone and a large quantity of cash in his room.[44]

71. Mr Rosendale's body was transported by mortuary ambulance to the Royal Hobart Hospital. At the Royal Hobart Hospital after being formally declared life extinct, Mr Rosendale's body was taken to the hospital mortuary.

72. The following day, 18 January 2019, experienced Forensic Pathologist Dr Christopher Lawrence performed a post-mortem examination. Dr Lawrence gave evidence at the inquest and his comprehensive affidavit detailing his findings at autopsy was tendered.[45]

73. Dr Lawrence found Mr Rosendale to be morbidly obese, weighing 183.5 kg. He calculated his body mass index to be 45.3 kg/m2. There were no signs of external injury or violence. Mr Rosendale's heart weighed 625 g, and was thus significantly enlarged. Dr Lawrence did not find an anatomical cause for Mr Rosendale's death. He ultimately expressed the opinion, which I accept, that the cause of Mr Rosendale's death was the complications of morbid obesity. He also said that the mechanism of death was due to a combination of cardiac enlargement (because of his morbid obesity), the aspiration of gastric contents

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[44] Exhibit C18, affidavit of Claire White, sworn 27 March 2019, page 3 of 5.
[45] Exhibit C5, affidavit of Christopher Hamilton Lawrence, sworn 18 March 2019.

and sleep apnoea. In simple terms, to aspirate on gastric contents is to choke on one's own vomit.

74. Toxicological analysis of samples taken at autopsy revealed the presence of some alcohol and antipsychotic medications – the latter at therapeutic levels. Significantly, clozapine – 0.068 mg/L was found in Mr Rosendale's blood. Clozapine is an atypical antipsychotic, sometimes described as a drug of last resort, used to treat people with treatment-resistant schizophrenia.[46] Mr McLachlan-Troup, Forensic Scientist, gave evidence at the inquest. In addition, Mr McLachlan-Troup prepared an affidavit and a proof of evidence – both of which were tendered at the inquest. He conducted the toxicological analysis of samples taken at autopsy from Mr Rosendale's body.

75. The presence and amount of alcohol found in the samples is broadly consistent with Mr Fox's evidence of he and Mr Rosendale sharing a few drinks in the early evening of Wednesday, 16 January 2019.

76. The issue of the presence of clozapine in Mr Rosendale's body is much less easy to explain. It is also very significant because, although he had, in the past, been prescribed clozapine to treat his schizophrenia, at the time of his death Mr Rosendale was not prescribed that drug and had not been for a considerable period of time, since at least mid-2017. His digital medical record shows unequivocally he was not administered the drug during his period as an inpatient at the Royal Hobart Hospital in the immediate lead up to his death.

77. Mr McLachlan-Troup said in his evidence at the inquest that he considered that it was more likely than not that Mr Rosendale had taken clozapine within one or two days prior to his death. Given that Mr Rosendale was in the Royal Hobart Hospital until shortly before his death this seems logical. His access to drugs which had not been prescribed for him would have been, to an extent at least, made difficult whilst he was an inpatient in the hospital.

78. I will return to the issue of clozapine in due course.

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[46] Exhibit C20, Proof of Evidence, Neil McLachlan-Troup, Forensic Scientist, page 2 of 3.

## Discussion

79. I am satisfied that the cause of Mr Rosendale's death was the complications of morbid obesity. Dr Lawrence's unchallenged evidence was compelling in that regard. The objective, physical evidence in relation to Mr Rosendale and his weight makes the conclusion, to my mind, beyond argument. It will be remembered at autopsy Mr Rosendale's body weighed 183.5 kg. Dr Lawrence did not identify a pathological cause of death at autopsy. No evidence was found that suggests Mr Rosendale was the victim of violence or assault. I am quite satisfied that his death was not suspicious, and no other person was involved in it. Aside from the absence of any physical evidence to suggest he had been assaulted, there were no signs of forced entry to Mr Rosendale's room and his mobile phone, wallet and a substantial amount of cash were all located by police.

80. The most likely mechanism of death was that the alcohol and antipsychotic medication perhaps caused a level of sedation, which, given his suspected obstructive sleep apnoea led to death. Dr Jordan gave evidence, *inter alia,* about the danger of mixing alcohol with clozapine. Both substances are respiratory depressants. Dr Jordan noted that Mr Rosendale's respiratory function was obviously already compromised and considered that in those circumstances the combination of the two may well have been significant.[47]

81. Apart from the presence of clozapine the results of toxicological analysis of samples taken from Mr Rosendale's body was unremarkable, in the sense that nothing was found which could have caused or contributed to his death, and nothing was found which should not have been there, if I might put it that way.

82. The issue of the clozapine remains a mystery. As should be clear from the reasons set out earlier in this finding, I am satisfied that the period Mr Rosendale had not been prescribed that drug was something approaching 18 months before his death. His attitude to taking the drug was, on the evidence, perhaps best described as ambivalent. He referred to it as his sleeper and

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[47] Affidavit of Dr Mike Jordan, C21, *op. cit.*, par 19.

indicated to Ms Withers that clozapine helped him sleep, even though he thought it gave him brain seizures.[48]

83. Other residents at Bayview Lodge certainly were prescribed that drug. It may be that Mr Rosendale obtained clozapine from a fellow resident either by being given it or perhaps taking it without the knowledge of the resident. It is also possible that he had 'stockpiled' a quantity of clozapine from the time it was prescribed for him. Given that no clozapine was found in his room after his death, this seems the least likely explanation for the drug. I suppose it is also possible that he obtained clozapine from someone other than a fellow resident. However there is no real evidence to suggest he had the opportunity to have done so in the immediate lead up to his death.

84. Whatever the explanation, despite a comprehensive investigation, how Mr Rosendale came to be in possession of clozapine in the immediate lead up to his death is not something about which I can make a concluded finding. I can say however, because of the level of clozapine detected by toxicological analysis (0.068 mg/L, within the therapeutic range[49]) I do not consider the clozapine caused his death.

85. I am affirmatively satisfied that Mr Rosendale's death was not the result of voluntary and intentional actions undertaken by him with the express intention of ending his own life. There is no record of him expressing suicidal ideation in his extensive medical records. The evening before his body was found, Mr Fox described he and Mr Rosendale discussing plans for the future. In short, there is nothing, at all, to suggest that Mr Rosendale's death was anything other than as a result of his morbid obesity.

86. What then caused Mr Rosendale to become morbidly obese? And what, if anything, could have been recently done about it? There was a significant amount of evidence at the inquest in relation to weight gain associated with schizophrenia and the drugs used to treat it. It is quite apparent that those involved in his care were especially aware of the issue of Mr Rosendale's weight gain in the last year or so of his life. The fact that medication used to

[48] Exhibit C9G, page 1660.
[49] Exhibit C6, affidavit Neil McLachlan-Troup, page 1 of 5.

treat his schizophrenia had an unfortunate side effect of weight gain was something of which his treating team were plainly aware. Dr Jordan said in his evidence that he made various changes to Mr Rosendale's medication to attempt to minimise his weight gain.

87. In the end though Mr Rosendale presented as an almost impossible patient to treat. His psychiatric symptomology was extremely severe and in real terms his schizophrenia was treatment resistant. Dr Jordan tried to bring his psychiatric symptoms under control in the hope that if his "*psychosis improved it would be easier to assist him improving his physical health*",[50] but unfortunately no sufficient improvement in his symptoms was able to be achieved. As I have mentioned earlier in these findings some of his somatic delusions were of a nature that prevented him from exercising. In addition, some of the medication quite appropriately prescribed for Mr Rosendale had the effect of making him lethargic and causing insomnia – both outcomes which also militated against him being able to exercise.

88. His lack of engagement with a general practitioner did not assist either in relation to his ballooning weight.

89. But the most important consideration though was where Mr Rosendale was housed. Without constant supervision in relation to his food and calorific intake, it was in practical terms impossible to stop him gaining weight, let alone lose any. Bayview Lodge did not provide that environment. Bayview Lodge could not provide that environment. The staff at Bayview Lodge knew they were struggling with Mr Rosendale and had conveyed this repeatedly over a considerable period of time but Mr Rosendale remained housed where he was.

90. Discussions were occurring when he died, by which time it was plainly too late, about transferring Mr Rosendale somewhere more suitable. I think that there is considerable merit in Mr Lee's characterisation of the Lodge staff as working tirelessly and with great patience to try to look after Mr Rosendale. There is absolutely no basis to criticise the staff of, or the accommodation provided to Mr Rosendale at, Bayview Lodge – on the contrary, I consider that the

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[50] Affidavit of Dr Mike Jordan, C21 *op. cit.*, paragraph 10.

evidence makes it very clear that Mr Bennett, Ms Matthews and the late Ms Dimitriou did everything that they could to assist Mr Rosendale.

91. I am also satisfied, generally speaking, that FMHS's care for Mr Rosendale was, as Mr Lee submitted, at least adequate if not good. Dr Jordan, his predecessors, and Ms Withers all worked very hard and very professionally, to attempt to assist Mr Rosendale achieve the best possible outcome. Unfortunately, despite their best efforts, as Dr Lawrence said in his evidence at the inquest, Mr Rosendale's presentation was multifactorial and extremely complicated.

92. I also do not consider that the prescribing regime for Mr Rosendale could have been any different.

**Report pursuant to section 28 (5) of the Coroners Act 1995**

93. As I indicated earlier in this finding I am required to report "on the care, supervision or treatment" of Mr Rosendale while he was a person held in care. The relevant period in which Mr Rosendale was a "person held in care" has been traversed in this finding in some detail. It commenced on 24 August 2018 when an Interim Treatment Order was made in respect of Mr Rosendale pursuant to the provisions of the *Mental Health Act* 2013. That Interim Treatment Order remained in force until 3 September 2018 upon which date a Treatment Order was made until 28 February 2019. That order, although varied in the months leading up to Mr Rosendale's death, was in force as at 16–17 January 2019.

94. I am satisfied, on the evidence at the inquest, that from 24 August 2018 until 16–17 January 2019, subject to two qualifications (one major, one minor) articulated below, the care, supervision and treatment Mr Rosendale received both as an inpatient at the Royal Hobart Hospital and whilst in the community was of an appropriate standard. Relevantly, the evidence at the inquest satisfies me that during that time Mr Rosendale was hospitalised when he needed to be, provided with appropriate medication and reviews and referred for lap band surgery in an attempt to manage his weight.

95. The major qualification should, I think, be obvious. Bayview Lodge simply could not cope with Mr Rosendale. The fact that he was inappropriately housed was identified before 24 August 2018. A number of discussions occurred about rehousing Mr Rosendale but none of them achieved an outcome. He undoubtedly needed to have been moved to the facility at Tolosa Park or possibly Millbrook Rise. Even such a move may have not prevented his death but I consider on the evidence it would have given him at least a chance to address his morbid obesity and would have ensured greater compliance with his medication regime.

96. Earlier in this finding, I touched on the situation with respect to the administration of medication to residents at Bayview Lodge. Mr Rosendale, like so many psychiatric patients, regularly expressed reluctance and/or was resistant to the medication he was prescribed. The issue of compliance with the medication regime is frequently vexed. It was in the case of Mr Rosendale – even though I am satisfied that his medication regime neither caused nor contributed to his death. Nonetheless it is directly relevant to my duty to report pursuant to section 28(5) in relation to care, treatment and supervision. I consider that the issue of supervision of medication for residents at Bayview Lodge or similar residential facilities for FMHS patients requires attention and clarification.

97. The minor qualification relates to the circumstances of Mr Rosendale's discharge from the Royal Hobart Hospital. Sending his Discharge Summary to his former GP was pointless. Not sending it to FMHS was potentially dangerous, and at least not helpful. At the very least, the communication with Bayview Lodge was poor.

**Comments and recommendations**

98. I consider that two recommendations are appropriate in light of the evidence at the inquest and the conclusions I have reached.

99. First, I **recommend** that Forensic Mental Health Services review their policy (if one exists, and if it does not, develop and implement one) in relation to their expectations of residential accommodation providers with particular regard to any resident's medication, noting that a Memorandum of

Understanding may be required to be entered into where there is an expectation of involvement.

100. Second, I **recommend** that the Tasmanian Health Service take steps to ensure that the Royal Hobart Hospital amend its Patient Discharge Summary procedures to ensure that the discharge form is provided to any patients' treating Forensic Mental Health Service practitioner.

**Conclusion**

101. My formal findings pursuant to section 28(1) of the *Coroners Act* 1995 are:
    a. The identity of the deceased is Dwayne Edward Rosendale;
    b. Mr Rosendale died in the circumstances set out in this finding;
    c. The cause of Mr Rosendale's death was the complications of morbid obesity, including cardiac enlargement, aspiration of gastric contents and sleep apnoea; and
    d. Mr Rosendale died at Bayview Lodge, 2 Haven Court, Rosny, during the night of 16 and 17 January 2019.

102. In conclusion, I wish to express my thanks in particular to Mr Lee, counsel assisting. I also express my admiration for the work done by FMHS generally, and by Ms Tracey Withers, in particular.

103. I express my sincere and respectful condolences to Mrs Moir on the loss of a much-loved son.

**Dated** 4 November 2021 at Hobart in the State of Tasmania.

**Magistrate Simon Cooper**
**Coroner**

MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

# LIST OF EXHIBITS

**Record of investigation into the death of**
**Dwayne Edward ROSENDALE**
**As of 01.06.21**

| No. | TYPE OF EXHIBIT | NAME OF WITNESS |
|---|---|---|
| C1 | POLICE REPORT OF DEATH | Const Teagan Walkey |
| C2 | LIFE EXTINCT AFFIDAVIT | Dr G Stevens |
| C3A | AFFIDAVIT OF IDENTIFICATION | Const Rhian Appleton |
| C3B | AFFIDAVIT OF IDENTIFICATION | Mortuary Amb – Tony Cordwell |
| C4 | MENTAL HEALTH TREATMENT ORDERS | Mental Health Tribunal |
| C5 | POST-MORTEM REPORT | Dr Christopher Lawrence |
| C6 | TOXICOLOGY REPORT | Neil McLachlan-Troup |
| C7 | MEDICAL RECORDS | Glenorchy Medical Centre |
| C8 | MEDICAL RECORDS | Salamanca Medical Centre |
| C9 | MEDICAL RECORDS (A-I, electronic only) | THS |
| C10 | CLOZAPINE CLINIC RECORDS | THS |
| C11 | CLIENT NOTES | Anglicare Tasmania |
| C12 | AFFIDAVIT | Karyn Moir (SNOK) |
| C12A | ATTACHMENT 1 | Karyn Moir (SNOK) |
| C12B | ATTACHMENT 2 | Karyn Moir (SNOK) |
| C12C | ATTACHMENT 3 | Karyn Moir (SNOK) |
| C12D | ATTACHMENT 4 | Karyn Moir (SNOK) |
| C13 | AFFIDAVIT | Judy Dimitriou |
| C14 | AFFIDAVIT | Greg Fox |

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| C15 | AFFIDAVIT | Gary Bennett |
| C15A | SECOND AFFIDAVIT | Gary Bennett |
| C16 | POLICE AFFIDAVIT | I/C Const Rhian Appleton |
| C17 | AFFIDAVIT | Brian Green |
| C18 | POLICE AFFIDAVIT & PHOTOGRAPHS | Const Claire White |
| C19 | COMPLAINT LETTERS | K Moir to NSW Health |
| C20 | PROOF OF EVIDENCE – FORENSIC SCIENCE SERVICE TASMANIA | Neil McLachlan-Troup |
| C21 | AFFIDAVIT | Dr Mike Jordan, THS |
| C22 | AFFIDAVIT | Tracey Withers, FMHS |
| C23 | FINAL RCA REPORT | THS |
| C24 | POLICE CONVICTIONS | |
| C25 | AFFIDAVIT & ATTACHMENTS | Louise Bieser, Anglicare |
| C26 | AFFIDAVIT | Jodie Matthews, Anglicare |
| C27 | PHOTOGRAPHS, ARTWORK AND AWARDS | Karyn Moir |
| C28 | AFFIDAVIT | Dr Woo |