Findings and Comments of Coroner Simon Cooper following the holding of an inquest under the *Coroners Act* 1995 into the death of

Andre Marc Lavoipierre

Contents

Record of Investigation into Death (With Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Simon Cooper, Coroner, having investigated the death of Andre Marc Lavoipierre with an inquest held at Hobart in Tasmania, make the following findings.

Hearing Dates

24 – 25 January 2022 at Hobart in Tasmania

Representation

V Dawkins – Counsel Assisting the Coroner

K Cuthbertson – Richmond Fellowship

T Cox – Mr S Lockwood

Introduction

1. Mr Andre Marc Lavoipierre died on 26 June 2019, age 41 years old, at his unit at the Richmond Fellowship - Unit 13, 27-29 Garfield Road, Glenorchy. Mr Lavoipierre had lived at the Richmond Fellowship since 2017. He suffered from chronic, effectively treatment resistant, paranoid schizophrenia. The Richmond Fellowship provides supported residential accommodation for vulnerable people such as Mr Lavoipierre.
2. At the time of his death Mr Lavoipierre was subject of a treatment order I made pursuant to the *Mental Health Act* 2013.[1] The order was made on 20 February 2019 and was due to expire on 26 February 2020. It was the sixth (6) renewal of the treatment order, which had originally been made on 12 March 2014.
3. Before moving to the Garfield Road property run by the Richmond Fellowship, Mr Lavoipierre had lived at the Millbrook Rise, a secure mental health facility north of Hobart.

What a coroner does

4. Before considering the circumstances of Mr Lavoipierre's death, it is necessary to say something about the role of the coroner. In Tasmania, a coroner has

[1] Exhibit C11.

jurisdiction to investigate any death that is sudden or unexpected or that of a person 'held in care'.[2] Mr Lavoipierre's death meets this definition because he was the subject of an order made under the terms of the *Mental Health Act* 2013[3] (and was therefore a person 'held in care'). An inquest was thus mandatory.[4] An inquest is a public hearing.[5]

5. 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.

6. 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.[6] 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 appropriate circumstances, recommendations to prevent similar deaths in the future.

7. 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.[7] This aspect of the role of the coroner is particularly important given the obvious vulnerability of persons in care.

8. 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

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[2] See section 3 of the *Coroners Act* 1995.
[3] See exhibit C4, in particular page 6 of 17.
[4] See section 24(1)(b) of the *Coroners Act* 1995.
[5] See section 6 of the *Coroners Act* 1995.
[6] *R v Tennent; Ex Parte Jager* [2000] TASSC 64.
[7] See section 28(5) of the *Coroners Act* 1995.

investigation. I should make it very clear that I do not consider that anyone committed any offence in relation to Mr Lavoipierre's death.

9. As was noted above, one matter that the *Coroners Act* 1995 requires, is a finding (if possible) as to how the death occurred.[8] 'How' has been determined to mean 'by what means and in what circumstances',[9] a phrase which involves the application of the ordinary concepts of legal causation.[10] 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.

10. 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.[11]

11. 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.[12] 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.

Circumstances of death

12. The case notes tendered at the inquest indicate that on the last morning of Mr Lavoipierre's life at about 6.45 am, he went to the Garfield Road office and complained of dizziness and general physical unwellness. The employee Mr Lavoipierre engaged with duly recorded that fact in his case notes.

13. Mr Lavoipierre was assigned a key worker, or perhaps Mr Lavoipierre was assigned to that key worker, Mr Alexander Brinsmead. Mr Brinsmead gave evidence at the inquest. He said that on the morning of 26 June 2019 he was at

[8] Section 28(1)(b) of the *Coroners Act* 1995.
[9] See *Atkinson v Morrow* [2005] QCA 353.
[10] See *March v E. & M.H. Stramare Pty. Limited and Another [*1990 – 1991] 171 CLR 506.
[11] (1938) 60 CLR 336 (see in particular Dixon J at page 362).
[12] See *Annetts v McCann* (1990) 170 CLR 596.

a training course (or undergoing training) and not at Garfield Road. He did not arrive at the facility until about lunchtime.

14. The two workers present were Ms Debby-Jane Daniels (formally Ms Debby-Jane Tauti) and Mr Stephen Lockwood. Mr Lockwood said in his evidence at the inquest that he arrived at work at about 9.00 am and, as a consequence, no handover occurred. Because no handover took place, he was unaware of what had occurred with Mr Lavoipierre that morning and indeed since he had last worked on the preceding Friday. In addition, Mr Lockwood told the inquest that he did not read the case notes relating to Mr Lavoipierre when he started work at all.

15. During that morning a contractor performing maintenance on the external heat pump unit of Mr Lavoipierre's unit heard a noise which sounded like someone inside the unit had had a fall. Around 12.30 pm the contractor went to the main office, and told Mr Lockwood, what he had heard.

16. Mr Lockwood said he went 'almost immediately' to Mr Lavoipierre's unit. In his affidavit tendered at the inquest he said he found Mr Lavoipierre lying on his bed apparently listening to music with headphones (something Mr Lavoipierre did frequently to quiet the voices in his head).[13] Mr Lavoipierre told Mr Lockwood that he had fallen. Mr Lockwood saw dried blood around Mr Lavoipierre's nose and described him as being 'slightly unstable' when he stood up to talk. I am satisfied that the pair discussed whether an ambulance needed to be called and that Mr Lockwood suggested to Mr Lavoipierre that no ambulance was necessary, something with which Mr Lavoipierre agreed.

17. Mr Lockwood returned to the office a short distance from the unit Mr Lavoipierre occupied. Mr Brinsmead had by now returned to the property. Mr Lockwood told Mr Brinsmead about Mr Lavoipierre's condition, who went and checked on Mr Lavoipierre.

18. A conversation took place between Mr Lockwood, Mr Brinsmead and Ms Daniels, the team leader, about the need for Mr Lavoipierre to have medical treatment. It is apparent on the evidence of Mr Lockwood, Ms Daniels and Mr Brinsmead that the possibility of calling an ambulance was canvassed. Mr Lockwood told the other two workers that Mr Lavoipierre did not want an ambulance – something Mr Lockwood had suggested to Mr Lavoipierre was

[1313] Exhibit C17, affidavit of Steven Lockwood.

unnecessary, and with which he agreed. It was decided to make an appointment for Mr Lavoipierre to see his normal treating General Practitioner, Dr Steven Hindley in Lindisfarne at 4.15 pm that day. Mr Brinsmead told Mr Lavoipierre the appointment had been made.

19. Mr Lockwood said at the inquest that he then spent the afternoon attending to the "*urgent*" task of sorting "*out some old case notes*".[14] I observe that this may have been a good opportunity for Mr Lockwood to have caught up on reading Mr Lavoipierre's case notes.

20. At about 3.45 pm, Mr Lockwood went to collect Mr Lavoipierre for this appointment. Mr Lockwood said that Mr Lavoipierre told him he did not feel well enough to go to the doctor's appointment. Mr Lockwood and Mr Lavoipierre discussed the situation and it was decided he would rest and not go to his appointment, and Mr Lockwood would organise an 'after-hours' GP.

21. Again, Mr Lockwood did not call an ambulance for Mr Lavoipierre. He offered a number of explanations during his evidence at the inquest as to why he did not. He said that he "*totally failed to appreciate that [Mr Lavoipierre] was undergoing a life-threatening process at that time and that he had 'called ambulances before and [he knew] the sorts of questions the dispatcher asks and [his] feeling was that the information that [he] could give any answer the questions [he] anticipated having put to [him] by the dispatcher would be not sufficient to merit a prompt call.*"'[15]

22. I am satisfied on the whole of the evidence at the inquest that the decision not to call an ambulance for Mr Lavoipierre at any time during the afternoon of 26 June 2019 was Mr Lockwood's and Mr Lockwood's alone. I do not accept the suggestion that the decision was Mr Lavoipierre's. The evidence does not support such a conclusion. Rather, it is quite clear on Mr Lockwood's own evidence that he suggested no ambulance was required, and Mr Lavoipierre agreed with the suggestion. Furthermore, Mr Lavoipierre was of course the subject of a treatment order under the terms of the *Mental Health Act* 2013. Before making that order, and extending it several times, the relevant tribunal had to be satisfied, *inter alia*, that Mr Lavoipierre lacked decision making

[14] Transcript, Lockwood evidence, page 9, line 40.
[15] Transcript, Lockwood evidence, page 12 generally.

capacity[16]. The evidence makes it clear that he lacked any real ability to make any appropriate decisions about his health and treatment.

23. I also note that in addition, in fact, Mr Lockwood did not organise an 'after-hours' GP either. Between 5.00 and 5.30 pm, Mr Lockwood handed over to Ms Yvonne Milton, another support worker. During that handover, Mr Lavoipierre was discussed. I am satisfied that in that handover Ms Milton queried whether an ambulance should be called, but was dissuaded from doing so by Mr Lockwood. When the after-hours Doctor's Service opened, Ms Milton arranged a doctor to attend.

24. Mr Lavoipierre did not attend the office as he normally did at around 5.30 pm to collect his medication. The significance of this is difficult to determine. Some witnesses said he was punctual (see for example Ms Yvonne Milton), others said he was less than punctual. In any event no one checked upon him, Ms Milton explaining that she was reluctant to leave her post at the front office lest she missed the call of the after-hours doctor.

25. At 8.50 pm, Dr Ken Adams from the Call the Doctor Service arrived at the Richmond Fellowship facility. He, his assistant and Ms Milton went to Mr Lavoipierre's unit. They could hear water running and, when they opened the front door, found Mr Lavoipierre lying on the kitchen floor flat on his back with the kitchen tap running. Dr Adams assessed Mr Lavoipierre and formally declared life extinct at 8.58 pm. He left a note and then left the scene.[17] Police were called and arrived at 9.23 pm. Ms Milton also contacted her superiors to notify them of Mr Lavoipierre's death.

Issues at the inquest

26. 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. The circumstances surrounding the death of Andre Marc Lavoipierre to enable findings to be made, if possible, under s 28(1) of the *Coroners Act* 1995.

[16] See section 40 (e) *Mental Health Act* 2013.
[17] Exhibit C20.

b. The care, supervision and treatment of Mr Lavoipierre whilst held in care at the Richmond Fellowship in the 12 hours prior to his death.
c. Any policies or procedures of the Richmond Fellowship relating to when residents suffer a fall or physical injury and referrals for external medical treatment.
d. The capacity, ability and training of the staff at the Richmond Fellowship working in the 12 hours prior to his death to identify and respond to physical health issues.
e. The communication between staff at the Richmond Fellowship in the 12 hours prior to his death.

Evidence at the inquest

27. After several case management conferences designed to ensure issues were identified and all evidentiary material made available to all interested parties for hearing, an inquest was held in Hobart in January 2022. 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 Alex Brinsmead;
    b. Ms Anna Weymouth;
    c. Ms Yvonne Milton;
    d. Mr Steven Lockwood;
    e. Dr Donald Ritchey, Forensic Pathologist;
    f. Dr Anthony J Bell, Medical Advisor to the Coronial Division;
    g. Ms Debby-Jane Daniels; and
    h. Ms Miriam Moreton, CEO, Richmond Fellowship.

Investigation

28. The fact of Mr Lavoipierre's death was reported in accordance with the requirements of the *Coroners Act* 1995. His body was formally identified and then taken to the mortuary at the Royal Hobart Hospital.[18]
29. At the mortuary, experienced Forensic Pathologist Dr Donald Ritchey performed an autopsy on Mr Lavoipierre's body. He swore an affidavit which

[18] Exhibit C3, affidavit of Emma-Lee Wiggins, sworn 29 June 2019.

set out his findings at autopsy and gave evidence at the inquest.[19] There was no challenge to his evidence. I consider he is well qualified to express the opinions that he did and I have no hesitation in accepting his evidence. Dr Ritchey expressed the opinion, which I accept, that the cause of Mr Lavoipierre's death was exsanguination (hypovolemic shock complicating acute blood loss) due to a fistula formation between Mr Lavoipierre's ureter and iliac artery. Dr Ritchey said that he was of the view that Mr Lavoipierre had had a syncopal episode and several falls in the hours prior to his death.

30. Samples taken at autopsy were subsequently analysed at the laboratory of Forensic Science Service Tasmania. The results of that toxicological analysis, in affidavit form, was tendered at the inquest.[20] The toxicological analysis indicates that at the time of his death Mr Lavoipierre had therapeutic levels of Fluoxetine, Lorazapem and sub-therapeutic levels of Valproic acid. Traces of Olanzapine were also detected. The presence of these drugs is completely in accordance with the treatment he was receiving for his schizophrenia and accords with his prescriptions at the time of death. Mr Lavoipierre was also prescribed Latuda (Lurasidone). That drug, an atypical antipsychotic, used in the treatment of schizophrenia, is not a target analyte for FSST and its presence could neither be confirmed nor denied by FSST. I do not consider that to be of any significance in the circumstances of this case.

31. The evidence was that Fluoxetine can increase the risk of bleeding events. However, I do not consider the drug caused the bleed which caused Mr Lavoipierre's death.

32. Fluoxetine, Olanzapine, Valproic acid and Lorazepam all can cause dizziness. However, as Dr Anthony J Bell, the Medical Advisor to the Coronial Division said in his evidence at the inquest, generally dizziness as side effect of medication is most common when the medication is commenced. I am quite satisfied that the evident dizziness Mr Lavoipierre suffered on 26 June 2019 was not due to the side effects of medication. Rather, it was a direct result of his blood loss, which lowered his blood pressure and caused him to experience dizziness.

33. Dr Bell reviewed Mr Lavoipierre's medical records and Dr Ritchey's findings at autopsy. Dr Bell expressed the view that he did not consider Mr Lavoipierre

[19] Exhibit C5, affidavit of Dr Donald Ritchey, sworn 7 November 2019.
[20] Exhibit C6, affidavit of Mr Neil McLachlan-Troup, Forensic Scientist, sworn 5 November 2019.

had developed a fistula, but said it was his opinion that he had a steady bleed into the kidney and bladder.[21]

34. It does not seem to me important or indeed necessary to determine whether a fistula was or was not involved in Mr Lavoipierre's death, given the unanimous expert opinion that the actual cause of Mr Lavoipierre's death was exsanguination from internal bleeding. But, on balance, it seems more likely that no fistula was present. I say this because both Dr Ritchey and Dr Bell said that the case was rare and unusual. Dr Ritchey did not actually see the presence of a fistula and could not establish a definitive cause for one to form between the ureter and iliac artery. Dr Bell said in his report and evidence that he doubted the presence of a fistula because he had never seen one in that location.

35. On any view of it, Mr Lavoipierre died as a result of a slow and steady internal bleed. I am also satisfied on the unchallenged evidence from Dr Bell that earlier medical intervention would nearly certainly have prevented Mr Lavoipierre's death.

Policies and procedures of the Richmond Fellowship

36. Various policies of the Richmond Fellowship were in place and designed to guide staff at the relevant time in relation to dealing with the situation Mr Lavoipierre presented on 26 June 2019. I am satisfied by the evidence of both Mr Brinsmead and Ms Weymouth's that those policies lacked sufficient specificity and left too much to the individual discretion of workers. Implicit in the evidence from the Richmond Fellowship as to the various steps taken to amend and improve the applicable policies was a recognition that this was so.

37. It is also evident that there were deficiencies in relation to communication between staff – the most glaring example being the fact that Mr Lockwood did not have a handover nor did he read Mr Lavoipierre's case notes.

38. The evidence at the inquest, and particularly that from Ms Miriam Moreton, who impressed as a careful and accurate witness, was that substantial work has been done to improve and upgrade those policies. Ms Moreton's evidence was that now if a resident presented with symptoms similar to those exhibited by

[21] Exhibit C13, Report, Dr A J Bell, 25 May 2020.

Mr Lavoipierre on 26 June 2019, Health Direct would be contacted immediately to provide clinical advice.[22]

39. In addition, a policy had been introduced which mandates the taking of vital signs including respiratory rate; oxygen saturations; resting pulse rate and temperature. All of which can be passed on to Health Direct to assist in the provision of advice and referral for appropriate treatment.

40. In addition, there was evidence that staff training had been improved in the area. Steps have been taken to address by way of policy development and training improved communication between staff.

41. All these developments are in my view appropriate responses to Mr Lavoipierre's death. They are to be commended.

Formal findings pursuant to Section 28 (1) of the *Coroners Act* 1995

42. On the basis of the evidence at the inquest I make the following findings:

    a. The identity of the deceased is Andre Marc Lavoipierre;

    b. Mr Lavoipierre died in the circumstances set out further in this finding;

    c. The cause of Mr Lavoipierre's death was exsanguination (hypovolemic shock complicating acute blood loss); and

    d. Mr Lavoipierre died on 26 June 2019 at 29 Garfield Street, Glenorchy, Tasmania.

Comments on care, supervision and treatment pursuant to Section 28 (5) of the *Coroners Act* 1995

43. The decision by Mr Lockwood not to call an ambulance at any stage during the afternoon of 26 June 2019 was wrong. I reach this conclusion fully cognisant of the need to avoid assessing actions at the time of death with the benefit of hindsight. I also have specific regard to the need to be satisfied to the *Briginshaw* standard in reaching this conclusion. Mr Lavoipierre required urgent medical attention. He had fallen and had blood on his face earlier in the day. He had complained of dizziness and generally feeling unwell, something Mr Lockwood would have known if he had read Mr Lavoipierre's case notes. There was ample indications of the need to call an ambulance. In contrast, the reasons he offered for not calling an ambulance were unpersuasive.

[22] Exhibit C21, affidavit of Miriam Moreton, sworn 20 January 2022.

44. If an ambulance had been called, it is reasonable to conclude that Mr Lavoipierre's internal bleeding would have been diagnosed and potentially successfully treated.
45. Similarly, if Mr Lavoipierre had been taken to his general practitioner then the general practitioner would most likely have identified the fact that he was suffering hypovolemic shock and arrange for the urgent treatment he needed accordingly.
46. The decision to engage the services of Call the Doctor, whilst not inappropriate, was too late. Accordingly, I **comment** that the care and supervision of Mr Lavoipierre on 26 June 2019, while subject of a treatment order pursuant to the *Mental Health Act* 2013, was not of an appropriate standard.
47. I have already mentioned that the relevant procedures at the Richmond Fellowship at the time of Mr Lavoipierre's death dealing with medical emergencies and similar seemed to me to have lacked sufficient guidance for staff. I note that the relevant policies have been the subject of substantial development and improvement since, and because of, Mr Lavoipierre's death. Accordingly I do not consider it necessary to make any comment on the policy framework as it impacted upon the care and supervision of Mr Lavoipierre.

Concluding comments

48. I express my particular thanks to Ms V Dawkins, Counsel Assisting.
49. In conclusion, I wish to express my respectful and sincere condolences to the family of Mr Lavoipierre.

Dated 29 April 2022 at Hobart in Tasmania

Simon Cooper

Coroner

Annexure A

1. Police Report of Death for the Coroner, First Class Constable E Wiggins, exhibit C1;
2. Affidavit of Life Extinct, Dr F Lam, exhibit C2, sworn 26 June 2019;
3. Affidavit of Identification, First Class Constable E Wiggins, exhibit C3, sworn 26 May 2019 (typo on the exhibit shows 26 May 2019);
4. Affidavit of Identification, A Cordwell, exhibit C4, sworn 26 June 2019;
5. Post Mortem Report, Forensic Pathologist Dr D Ritchey, exhibit C5, sworn 7 November 2019;
6. Toxicology Report, Forensic Scientist N McLachlan-Troup, exhibit C6, sworn 5 November 2019;
7. Medical Records, Mental Health Services, exhibit C7;
8. Medical Records, Richmond Fellowship, exhibit C8;
9. Medical Records, Franklin Street Clinic, exhibit C9;
10. Medical Records, Royal Hobart Hospital, exhibit C10;
11. Treatment Order, Mental Health Tribunal, exhibit C11;
12. Medical Report, Medical Advisor Dr A J Bell, exhibit C12, reported 20 November 2019;
13. Medical Report, Medical Advisor Dr A J Bell, exhibit C13, reported 25 May 2020;
14. Affidavit of Y Milton, exhibit C14, sworn 26 June 2019;
15. Affidavit of A Weymouth, exhibit C15, sworn 30 March 2020;
16. Affidavit of D Daniels; known as D Tauti at the date of making this affidavit, exhibit C16, sworn 26 June 2019;
17. Affidavit of S Lockwood, exhibit C17, sworn date unknown, before Constable J Barnard;
18. Affidavit of A Brinsmead, exhibit C18, sworn 1 April 2020;
19. Medical Imaging on disc, exhibit C19;
20. Handwritten note by Dr K Adams, made 26 June 2019;

21. Affidavit of M Moreton, exhibits C21, sworn 20 January 2022;

21A. Standard Operating Procedures, Richmond Fellowship; and

22. Statement by family, parents of Mr Lavoipierre, Noel and Joan Lavoipierre; and

23. Transcript of inquest proceedings, 24 – 25 January 2022.