

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 001175

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

Section 67 of the Coroners Act 2008

Inquest into the death of: JASON HOSIER

Findings of: AUDREY JAMIESON, Coroner

Delivered on: 10 November 2025

Delivered at: Coroners Court of Victoria,
65 Kavanagh Street, Southbank, Victoria 3006

Hearing dates: 10 November 2025

Representation: None

Counsel assisting the Coroner: Ms Anna Pejnovic of the Coroners Court of
Victoria

I, AUDREY JAMIESON, Coroner, having investigated the death of JASON HOSIER

AND having held a Summary Inquest in relation to this death on 10 November 2025

at the Coroners Court of Victoria, 65 Kavanagh Street, Southbank, Victoria 3006

find that the identity of the deceased was JASON HOSIER

born on 24 November 1982

and the death occurred on 2 March 2022

at 94 Rees Road, Melton South, Victoria 3338

from:

1a: MIXED DRUG TOXICITY (METHADONE, BENZODIAZEPINES, OLANZAPINE, ZOPICLONE).

in the following summary of circumstances:

JASON HOSIER was 39 years old when he died at his home on 2 March 2022 following his discharge from Sunshine Hospital the previous night. At the time of his death, Jason was subject to an inpatient temporary treatment order and extant apprehension order pursuant to the *Mental Health Act 2014*, though this was not known to the clinician making the decision to discharge him.

BACKGROUND CIRCUMSTANCES

1. Jason experienced several traumatic events throughout his life and commenced using intravenous drugs at age 14. He was blind in one eye and had a history of polysubstance use, drug induced psychosis, schizophrenia, depression, generalised anxiety disorder and cluster B personality traits. He had an acquired brain injury (**ABI**) that resulted from a hypoxic episode during an overdose and had multiple previous overdoses and high lethality suicide attempts.
2. Jason had an extensive forensic history including burglary, theft, drug and driving offences and over 10 periods of incarceration.

3. Jason ceased using heroin in 2016 and was prescribed methadone by his general practitioner Dr Kenneth Bowes.
4. At the time of his death, Jason was under the care of the Mid-West Area Mental Health Service (**MWAMHS**), a clinical division of Melbourne Health, NorthWestern Mental Health. He had frequent presentations for episodes of aggression and increased psychotic symptoms that appeared to be related to the use of methamphetamine, which also impacted his compliance with the antipsychotic medication olanzapine, prescribed by the MWAMHS. There was discussion about invoking the *Mental Health Act 2014* to support his compliance.

THE CORONIAL INVESTIGATION

Jurisdiction

5. Jason's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (the Act). Reportable deaths include deaths that are unexpected or unnatural. In addition, Jason's death was reportable as he was a 'person placed in custody or care' within the meaning of the Act, as at the time of his death he was subject to an Inpatient Temporary Treatment Order and extant apprehension order pursuant to the *Mental Health Act 2014*.
6. The death of a person in care is a mandatory report to the Coroner, even if the death appears to have been from natural causes. This category of death is reportable to ensure independent scrutiny of the circumstances leading to the death, given the vulnerability of this cohort.
7. Section 52(2)(b) of the Act requires that I must hold an Inquest into the death of a person placed in custody or care, unless that death is due to natural causes.
8. Having considered the available evidence, I determined that this matter would be appropriately finalised by way of a Summary Inquest and Form 37 *Finding into Death with Inquest*. Interested parties were informed of my determination by way of a formal notice for a Summary Inquest to be held on 10 November 2025.

Purpose of a coronial investigation

9. The purpose of a coronial investigation of a reportable death is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which the death occurred.¹
10. The cause of death refers to the medical cause of death, incorporating where possible the mode or mechanism of death. The circumstances in which death occurred refer to the context or background and surrounding circumstances but are confined to those circumstances sufficiently proximate and causally relevant to the death, and not all those circumstances which might form part of a narrative culminating in death.²
11. The broader purpose of any coronial investigation is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of recommendations by coroners, generally referred to as the prevention role.³
12. Coroners are empowered to report to the Attorney-General in relation to a death; to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.⁴ These powers are effectively the vehicles by which the Coroner's prevention role can be advanced.⁵
13. The Coroners Court of Victoria is an inquisitorial jurisdiction.⁶ Coroners are not empowered to determine the civil or criminal liability arising from the investigation of a

¹ Section 67(1), of the Act.

² This is the effect of the authorities – see for example, *Harmsworth v The State Coroner* [1989] VR 989; *Clancy v West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J).

³ The “prevention” role is now explicitly articulated in the Preamble and purposes of the Act, compared with the *Coroners Act 1985* where this role was generally accepted as “implicit”.

⁴ See sections 72(1), 67(3) and 72(2) of the Act regarding reports, comments and recommendations, respectively.

⁵ See also sections 73(1) and 72(5), which requires publication of coronial findings, comments and recommendations and responses respectively; sections 72(3) and 72(4), which oblige the recipient of a coronial recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation.

⁶ Section 89(4) of the Act.

reportable death and are specifically prohibited from including in a finding or comment any statement that a person is, or may be, guilty of an offence.⁷

Sources of evidence

14. This Finding is based on the totality of the material produced by the coronial investigation into the death of Jason Hosier. That is, the Court File and Coronial Brief of evidence compiled by Senior Constable Glenn Morris.
15. The Brief will remain on the Court File, together with the Inquest transcript.⁸ In writing this Finding, I do not purport to summarise all the material and evidence but will refer to it only in such detail as is warranted by its forensic significance and in the interests of narrative clarity.

Standard of proof

16. All coronial findings must be made based on proof of relevant facts on the balance of probabilities. In determining whether a matter is proven to that standard, I should give effect to the principles enunciated in *Briginshaw v Briginshaw*⁹. These principles state that in deciding whether a matter is proven on the balance of probabilities, in considering the weight of the evidence, I should bear in mind:
 - the nature and consequence of the facts to be proved;
 - the seriousness of any allegations made;
 - the inherent unlikelihood of the occurrence alleged;

⁷ Section 69(1) of the Act. However, a Coroner may include a statement relating to a notification to the Director of Public Prosecutions if they believe an indictable offence may have been committed in connection with the death. See sections 69 (2) and 49(1) of the Act.

⁸ From the commencement of the Act, that is 1 November 2009, access to documents held by the Coroners Court of Victoria is governed by section 115 of the Act.

⁹ *Briginshaw v Briginshaw* (1938) 60 C.L.R. 336 esp. at 362-363: “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 issues had been proved to the reasonable satisfaction of the tribunal. In such matters, “reasonable satisfaction” should not be produced by inexact proofs, indefinite testimony, or indirect inferences...”.

- the gravity of the consequences flowing from an adverse finding; and
- if the allegation involves conduct of a criminal nature, weight must be given to
 - the presumption of innocence, and the court should not be satisfied by inexact proofs, indefinite testimony or indirect inferences.

SURROUNDING CIRCUMSTANCES

13. On 11 February 2022, Jason's mental health care was stepped-up from community-based case management to the Acute Community Intervention Service (**ACIS**) following a home visit by the Key Clinician (**KC**) who noted he was aggressive and irritable with paranoid delusions.
14. When Jason became aware the KC was contacting emergency services to transfer him to hospital under an Assessment Order (**AO**)¹⁰, he threatened to assault police but left the house before police arrived. He was unable to be located.
15. Following discussion with the KC, the treating psychiatrist changed the AO to an Inpatient Temporary Treatment Order (**ITTO**)¹¹ and arranged for Jason to be apprehended under the *Mental Health Act 2014*, with documentation forwarded to Melton Police Station. An alert was placed on the Victorian Client Management Interface (**CMI**) that Jason was on an ITTO with relevant paperwork held by police.¹² His mother, Marlene, was informed of the situation and agreed to contact police should Jason come home.
16. Over the next few days, ACIS were in contact with police and Marlene, but Jason was not located.

¹⁰ An assessment order is an order made by a registered medical practitioner or mental health practitioner that enables a person who is subject to the assessment order to be compulsorily (a) examined by an authorised psychiatrist to determine whether the treatment criteria apply to the person; or (b) taken to, and detained in, a designated mental health service and examined there by an authorised psychiatrist to determine whether the treatment criteria apply to the person.

¹¹ An inpatient temporary treatment order is made by an authorised psychiatrist after assessing a person on an assessment order that enables the person who is subject to the inpatient temporary treatment order to be compulsorily taken to, and detained and treated in, a designated mental health service.

¹² Statement of Dr Naveen Thomas, NorthWestern Mental Health, p.10/41.

17. On 16 February 2022, Jason's care was transferred back to the MWAMHS community team with a plan to continue to try to locate him.
18. On 19 February 2022, the KC phoned Marlene who said Jason had been in touch with her by phone but did not give his whereabouts. She agreed to attend a Mental Health Tribunal meeting on 9 March 2022 regarding the ITTO and apprehension order.
19. It is unclear when Jason returned to Marlene's house but at around 10:30am on 1 March 2022, she called an ambulance having found him at home with a reduced level of consciousness and shallow breathing. Jason was able to be roused by attending paramedics and refused transport to hospital. Marlene reported that following this episode she and Jason went shopping and she had no concerns about his wellbeing.
20. Around 8pm that evening, Marlene again found Jason unconscious and called an ambulance. Paramedics administered naloxone¹³ and Jason returned to his usual level of consciousness after about 10 minutes. Jason was transported to Sunshine Hospital Emergency Department (**SHED**) where he was treated again with naloxone.
21. Jason was reviewed by Emergency Medicine Specialist Dr Ruth Hew, who stated there was no evidence of acute mental health issues or intoxication and no psychotic symptoms, agitation or aggression. Jason denied suicidal ideation and opioid usage though he could not explain why naloxone had improved his condition.¹⁴ It had been over one hour since he received naloxone, and his level of consciousness had remained stable. As he was requesting discharge and Dr Hew was not aware of any grounds to detain him under the *Mental Health Act 2014*, he was discharged at 9:45pm. Jason arrived home between 11pm and 11:30pm.
22. At around 8am on 2 March 2022, Marlene found Jason unresponsive in the bathroom. Paramedics were unable to resuscitate him, and he was sadly declared deceased at 8:30am.

¹³ Naloxone is a drug used to counter the effects of opiate overdose, as it is an opioid antagonist. It has a short half-life of approximately one hour.

¹⁴ Statement of Sunshine Hospital, p.5/8.

INVESTIGATION PRECEDING THE INQUEST

Identification

23. On 2 March 2022, Jason Hosier, born 24 November 1982, was visually identified by his mother, Marlene Hosier, who completed a Statement of Identification.
24. Identity is not in dispute and requires no further investigation.

Medical cause of death

25. Forensic Pathologist Dr Melanie Archer from the Victorian Institute of Forensic Medicine (VIFM) conducted an external examination of the body of Jason Hosier on 4 March 2022. Dr Archer considered the Victoria Police Report of Death (Form 83), post mortem computed tomography (CT) scan, medical records, VIFM contact log and concerns submitted by Marlene Hosier and provided a written report of her findings dated 10 June 2022.
17. The external examination showed scarring on the arms with the appearance of chronic intravenous injection sites. Examination of the postmortem CT scan showed fluffy lung opacities.

Toxicology

18. Toxicological analysis of post mortem samples identified the presence of methadone and its metabolite EDPP, clonazepam and its metabolite 7-aminoclonazepam, olanzapine, zopiclone, diazepam and its metabolites nordiazepam and oxazepam, and naloxone.
19. Dr Archer considered that the combination of methadone, benzodiazepines, olanzapine, and zopiclone have led to central nervous system depression, causing death.

Forensic pathology opinion

20. Dr Acher provided an opinion that the medical cause of death was 1(a) MIXED DRUG TOXICITY (METHADONE, BENZODIAZEPINES, OLANZAPINE, ZOPICLONE).

FAMILY CONCERNS

21. Marlene wrote to the Court immediately following her son's death with concerns that he should not have been discharged from Sunshine Hospital on 1 March 2022.

FURTHER INVESTIGATION

22. Having considered the circumstances of Jason's death and in particular that he was discharged from Sunshine Hospital on 1 March 2022 despite him being on an ITTO and with an extant apprehension order pursuant to section 352 of the *Mental Health Act 2014* in place, I requested that the Coroners Prevention Unit (CPU)¹⁵ review the matter with a view to identifying any prevention opportunities.

Discharge from Sunshine Hospital

23. In her statement to the Court, Dr Hew advised that she did not have access to Jason's mental health assessments and treatment plans as at the time, mental health services were provided to patients of Western Health by NWMHS and the medical record sat within their database. She stated that after Jason's death she discovered he appeared to be under a revoked Community Treatment Order (CTO) from 11 February 2022. She explained that she was unaware of this at the time of assessing Jason because "*the revoked CTO had been filed in a part of the Western Health patient medical record but not flagged as an alert on the ED management system*".¹⁶ Ambulance Victoria were also unaware of it and thus had not informed her on transfer.
24. The CPU advised me that Dr Hew's decision to discharge Jason appeared reasonable based on the information she had to hand and her assessment of his mental state. However, had

¹⁵ The CPU was established in 2008 to strengthen the coroners' prevention role and assist in formulating recommendations following a death. The CPU is comprised of health professionals and personnel with experience in a range of areas including medicine, nursing, mental health, public health, family violence and other generalist non-clinical matters. The unit may review the medical care and treatment in cases referred by the coroner, as well as assist with research related to public health and safety.

¹⁶ Statement of Sunshine Hospital, p.6/8.

she been aware of the order requiring Jason to be detained, there may have been an opportunity to alter the course of events.

25. The inability of an ED specialist to access such important information is of concern and has implications for the wellbeing of future patients presenting to SHED, or other Emergency Departments.
26. Dr Naveen Thomas, Clinical Services Director and consultant psychiatrist at Western Health, informed the Court that the relevant information was uploaded to the CMI. The CMI is a collection of curated data from local mental health services that is accessible state-wide. One of its purposes to ensure the legal basis for providing treatment on a compulsory basis is evident to all services.
27. Dr Thomas also stated the information was placed on the MWAMHS digital health record (Bossnet) which is used by both SHED and the Emergency Mental Health Service. He stated that there may have been an opportunity for Dr Hew to become aware of the information “...if it was appropriately flagged in Bossnet... However, there was no consolidation of “alerts” and the Bossnet “alerts” did not usually flag the legal status of a consumer under the MHA”.
28. Dr Thomas further advised that the In Depth Case Review panel considered the feasibility of implementing a commonly accessed “alert” system in the digital health record to flag the legal status of a mental health patient. MWAHS’ records are being integrated into Western Health’s electronic medical record, the functionality of which will assist in addressing the concerns identified in Jason’s case.

CMI/ODS

29. Given the missed opportunity that arose due to Dr Hew not being able to access information that would have indicated Jason was on an ITTO with an apprehension order in place, I sought further information from the Office of the Chief Psychiatrist (**OCP**) about access to the CMI by non-mental health ED medical officers. The OCP reported that the CMI is under the auspice of the Department of Health (**the Department**), thus the request for information was redirected accordingly.

30. The Department explained that the CMI is the local client information management system used by each designated mental health service with the technology physically located within individual services. The Operational Data Store (**ODS**) is a statewide database that receives/sends data to/from local CMI databases in real time. Together, the CMI/ODS support continuity of mental health care but they are not a medical records management system.
31. Within a health service environment, the CMI is only accessible to staff with specific roles in designated mental health services. Currently, under section 728 of the *Mental Health and Wellbeing Act 2022*, the CMI is not accessible to staff outside such services, including non-mental health ED staff. A like-provision existed at section 347 of the *Mental Health Act 2014* at the time of Jason's death. Therefore, Dr Hew would not have had access to the CMI and had no way of knowing that Jason was subject to a compulsory treatment order.
32. In addition to the legislative barrier preventing ED clinicians accessing the CMI, the Department stated there are technical barriers to sharing the data in the CMI/ODS with information systems used by health services outside of designated mental health services. As the CMI does not 'talk' to the existing Patient Administration Systems used in health services, there was no way possible for the information about Jason's legal status to be flagged to Dr Hew through other channels.
33. In 2021, the Royal Commission into Victoria's Mental Health System recommended the Victorian government improve information sharing (Recommendation 61) and develop, fund and implement modern infrastructure for Information and Communications Technology (**ICT**) systems (Recommendation 62). Recommendation 62 included:
 - (a) *a statewide electronic Mental Health and Wellbeing Record for mental health and wellbeing services to replace the current Client Management Interface/Operational Data Store (CMI/ODS) system, and*
 - (c) *a new Mental Health Information and Data Exchange that allows interoperability between the proposed Mental Health and Wellbeing Record and other services' major*

*ICT systems to support information sharing in real-time within and across services and sectors.*¹⁷

34. Mr Matthew Tibble, Acting Executive Director, Governance & Accountability, Mental Health and Wellbeing Division of the Department of Health stated these actions will enable the secure sharing of information that is not currently possible in Victoria, and that work has commenced to develop a new system.
35. Recommendation 62 was due for implementation by the end of 2024, but the deadline was not achieved.¹⁸ In December 2024, the Department indicated they would be continuing to develop and implement new information communication technology architecture for the mental health and wellbeing system between 2024 and 2027.¹⁹

Ambulance Victoria and CMI/ODS

36. The *Mental Health and Wellbeing Act 2022* allows CMI/ODS access for emergency services staff for the purpose of providing an emergency service to whom the information relates, or in relation to a function performed by the emergency service provider under the Act. Mr Tibble stated this provision applies to Ambulance Victoria (AV).
37. However, there does not appear to be a current pathway for this to happen. Mr Tibble noted the Department and AV are currently exploring some AV Teleprompt Staff having read-only access to the ODS.

¹⁷ State of Victoria, *Royal Commission into Victoria's Mental Health System, Final Report, Summary and recommendations*, Parl Paper No. 202, Session 2018–21 (document 1 of 6), p.98/120.

¹⁸ Parliament of Victoria Public Accounts and Estimates Committee (April 2025) *2023-24 Financial and Performance Outcomes Report*. <https://www.parliament.vic.gov.au/paec>

¹⁹ Department of Health (2024) *The Next Phase of Reform: Mental Health and Wellbeing in Victoria*, p.48/55. <https://www.health.vic.gov.au/sites/default/files/2024-12/the-next-phase-of-reform-mental-health-and-wellbeing.pdf>

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

1. Dr Hew's decision to discharge Jason on 1 March 2022 appears to have been reasonable and appropriate, with the significant caveat that I make this assessment noting that she was not aware of his ITTO or apprehension order.
2. The fact that Dr Hew did not have access to that integral information was a significant opportunity lost to alter the course of events and prevent Jason's death on this occasion. Simply, had Dr Hew been aware of the ITTO in place, Jason would not have been discharged and would not have been in a position to ingest excessive quantities of his medications.
3. The need for clinicians to have access to this information has clearly been previously identified – including in the Royal Commission into Victoria's Mental Health System, the final report of which was tabled in March 2021. It is concerning that Recommendations 62a and 62c have not yet been implemented, as had they been, this situation may have been avoided. Importantly, for ED medical staff to be able to access critical mental health information, changes will also need to be made to the *Mental Health and Wellbeing Act*. I intend to make pertinent recommendations in this regard.
4. Jason had two interactions with AV paramedics on the day before the fatal incident. Had those paramedics been made aware of the information in the CMI/ODS, they would have been alerted to his legal status and could have informed ED staff and/or police. While the *Mental Health and Wellbeing Act 2022* does not present a barrier to AV staff accessing that information, in practice they are unable to do so. I consider that identifying a pathway for this to happen, while maintaining the safety of personal mental health information, has the potential to support both paramedics and ED medical officers to be more fully informed when delivering care.

RECOMMENDATIONS

Pursuant to section 72(2) of the Act, I make the following recommendations:

- (i) With the aim of promoting public health and safety and preventing like deaths, I recommend that the Victorian Government/Department of Health implement Recommendations 62a and 62c of the Royal Commission into Victoria's Mental Health System as a matter of priority.
- (ii) With the aim of promoting public health and safety and preventing like deaths, I recommend that the Victorian Government/Department of Health consider whether legislative amendment should be made to allow medical staff working in Victorian Emergency Departments to access the Client Management Interface/Operational Data Store.
- (iii) With the aim of promoting public health and safety and preventing like deaths, I recommend that the Victorian Government/Department of Health and Ambulance Victoria continue to explore ways in which Ambulance Victoria paramedics may be able to access Client Management Interface/Operational Data Store.

FINDINGS AND CONCLUSION

Having applied the applicable standard to the available evidence, I make the following Findings pursuant to section 67 of the *Coroners Act 2008* (Vic):

1. I find that Jason Hosier, born 24 November 1982, died on 2 March 2022 at 94 Rees Road, Melton South, Victoria 3338;
2. I accept and adopt the medical cause of death ascribed by Dr Melanie Archer and I find that Jason Hosier died from mixed drug toxicity;
3. AND, having considered the evidence available to me, I am satisfied that Jason Hosier's death was the unintended consequence of his intentional use and abuse of prescription drugs;

4. AND, I find that Jason Hosier would not have been discharged from Sunshine Hospital on 1 March 2022 had Emergency Department clinicians been aware that he was subject to a temporary treatment order, and accordingly I find that his death on 2 March 2022 was preventable;
5. AND FURTHER, having made a finding that Jason Hosier's death was preventable, I make no adverse findings of the clinicians involved in his care at Sunshine Hospital and in particular Dr Ruth Hew, who made the decision to discharge Jason on the information available to her.

I convey my sincere condolences to Jason's family for their loss.

PUBLICATION OF FINDING

To enable compliance with section 73(1) of the *Coroners Act 2008 (Vic)*, I direct that the Findings will be published on the internet.

DISTRIBUTION OF FINDING

I direct that a copy of this finding be provided to:

Marlene Hosier, Senior Next of Kin

Western Health

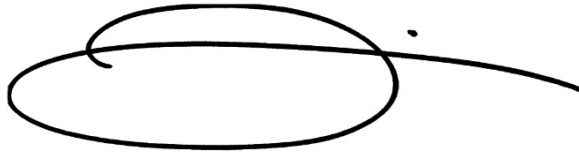
Melbourne Health

Ambulance Victoria

Ms Jenny Atta PSM, Secretary, Department of Health

Senior Constable Glenn Morris, Coronial Investigator

Signature:

A handwritten signature in black ink, consisting of a large, loopy oval shape with a horizontal line crossing it, and a long, thin tail extending to the right.

AUDREY JAMIESON
CORONER



Date: 10 November 2025

NOTE: Under section 83 of the *Coroners Act 2008* ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an inquest. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.
