IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2010 3218

FINDING INTO DEATH WITH INQUEST[1]

Form 37 Rule 60(1)
Section 67 of the ***Coroners Act 2008***

Inquest into the Death of: GEOFFREY FARROW

Hearing Dates:	4 November 2011
Representation:	Mr Robert McCloskey of Counsel on behalf of Dr R. Karoly (North Western Mental Health Services)
Police Coronial Support Unit	Senior Constable Kelly Ramsey
Findings of:	AUDREY JAMIESON, CORONER
Delivered On:	11 February 2013
Delivered At:	Level 11 222 Exhibition Street Melbourne 3000

[1] The finding does not purport to refer to all aspects of the evidence obtained in the course of my investigation. The material relied upon included statements and documents tendered in evidence together with the transcript of proceedings and submissions of legal representatives/counsel/counsel assisting. The absence of reference to any particular aspect of the evidence, either obtained through a witness or tendered in evidence does not infer that it has not been considered.

I, AUDREY JAMIESON, Coroner having investigated the death of GEOFFREY FARROW

AND having held an inquest in relation to this death on 4 November 2011
at Melbourne
find that the identity of the deceased was GEOFFREY EDWARD FARROW
born on 11 January 1943
and the death occurred on 17 August 2010
at John Cade Unit, Royal Melbourne Hospital, 34-54 Poplar Road Parkville 3052
from:

1 (a) HYPERTENSIVE CARDIOMEGALY AND ISCHAEMIC HEART DISEASE

in the following summary of circumstances:

1. At the time of his death Geoffrey Edward Farrow was an involuntary patient subject to an involuntary treatment order under the *Mental Health Act 1986*.

BACKGROUND CIRCUMSTANCES

2. Mr Geoffrey Farrow was 67 years of age at the time of his death. He lived alone at 14/109 Manningham Street Parkville. He was retired and was made a bankrupt in or about 1989.

3. Mr Farrow had a history of mental ill health dating back to 1987 when he was diagnosed with Delusional Disorder/Paranoid Schizophrenia. He required many admissions to hospital over the following years for treatment of his mental ill health which was characterised by severe episodes of violence, persecutory delusions and lack of insight. He had been treated on a Community Treatment Order for a number of years but was discharged from the order in 2007. He also had an extensive forensic history including assaults and imprisonment. He also had long-standing untreated hypertension.

SURROUNDING CIRCUMSTANCES

4. On 15 August 2010, police and the Inner West Community Assessment and Treatment (CAT) team attended Mr Farrow's home at the request of Federal Police Officer, Joanne Taylor. Ms Taylor reported grave concerns for Mr Farrow's mental health after he had attended the Federal Police offices making threats against the Prime Minister and Federal Police. Mr Farrow was alleging a conspiracy and his behaviour was threatening and intimidating.

5. Mr Farrow was arrested under section 10 of the *Mental Health Act 1986* and transported to the John Cade Psychiatric Unit at the Royal Melbourne Hospital.

6. Mr Farrow was admitted to the hospital and assessed by psychiatry registrar, Dr Andrew Cheong at 1.00pm. Dr Cheong found Mr Farrow to *be psychotic and completely preoccupied with persecutory delusions about a longstanding conspiracy against him.*[2] Mr Farrow did not believe that he was unwell, was refusing to stay in hospital and was verbally threatening. Dr Cheong certified Mr Farrow under section 12AA of the *Mental Health Act 1986* and he was placed in the locked High Dependence Unit (HDU).

7. On 16 August 2010 at approximately 1.15pm, Mr Farrow was reviewed by Dr Robert Karoly, Consultant-In-Charge Inner West Community Assessment and Treatment Team, NorthWestern Mental Health. Dr Karoly upheld the certification as an involuntary patient under section 12AC of the *Mental Health Act 1986* because he found Mr Farrow continuing to refuse treatment and persistent in his denial that he was suffering from mental illness. In addition, Mr Farrow was continuing to express persecutory delusions about the Federal Police and members of parliament and in combination with Mr Farrow's history of extreme violence, Dr Karoly formed the opinion that Mr Farrow was an immediate threat to others because of his untreated schizophrenia. Dr Karoly ordered the administration of Olanzapine 10mg orally and the anti psychotic medication Zuclopenthixol Acetate 100mg intramuscularly (IMI) to be given as a one off dose to help settle Mr Farrow's *agitation, physical restlessness and verbal aggression*[3]. At 2.20pm, security staff was requested to assist in the administration of these medications[4] as Mr Farrow had refused to consent to their administration and was preparing to leave the hospital as he was under the misapprehension that he could only be held by the hospital for 24 hours.

8. On 17 August 2010 at 9.50am, Mr Farrow was reviewed by medical registrar Dr Altaleb and medical resident Dr Gray. He was noted to have ongoing persecutory delusions but was engaging more easily in conversation. It was decided to continue to monitor Mr Farrow within the HDU.

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[2] Exhibit 1 – Statement of Dr Robert Karoly dated 26 October 2010

[3] *Op cit*

[4] Referred to as a "planned Code Grey" – Exhibit 2 – Statement of Dr Karoly dated 30 August 2011, T @ p 10

9. On 17 August 2008 at 4.45pm, Mr Farrow was found collapsed by Registered Psychiatric Nurse (RPN) George Doward. A Code Blue was called. Mr Farrow was found to be in cardiac arrest. The hospital resuscitation team attended the HDU to co-ordinate cardio-pulmonary resuscitation attempts. Active resuscitation attempts continued for approximately 14 minutes, however, Mr Farrow failed to respond. He was pronounced deceased at 4.59pm.

JURISDICTION

10. The ***Coroners Act 2008*** (the Act) came into operation on 1 November 2009. In the preamble to the Act, the role of the coronial system in Victoria is stated to involve the independent investigation of deaths for the purpose of finding the causes of those deaths and to contribute to the reduction of the number of preventable deaths and the promotion of public health and safety and the administration of justice. Reference to preventable deaths and public health and safety are referred to in other sections of the new Act.[5]

11. Section 67 of the Act describes the ambit of the coroners' findings in relation to a death investigation. A Coroner is required to find, if possible, the identity of the deceased, the cause of death and, in some cases, the circumstances in which the death occurred.[6] The 'cause of death' generally relates to the *medical cause of death* and the 'circumstances' relates to the *context* in which the death occurred.

12. A Coroner may also comment on any matter connected with the death, including matters relating to public health and safety and the administration of justice.[7] A Coroner may also report to the Attorney-General and may make recommendations to any Minister, public statutory authority or entity, on any matter connected with a death which the Coroner has investigated including recommendations relating to public health and safety or the administration of justice.[8]

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[5] See for example, sections 67(3) & 72 (1) & (2)

[6] Section 67(1)

[7] Section 67(3)

[8] Section 72(1) & (2)

INVESTIGATION

Medical investigation

13. Dr Melissa Baker, Forensic Pathologist at the Victorian Institute of Forensic Medicine performed an autopsy on the body of Mr Farrow. The post mortem examination revealed significant natural disease affecting the cardiovascular system with cardiomegaly and severe single vessel coronary artery atherosclerosis. No other significant natural disease was identified and Dr Baker found no evidence of any injuries which may have caused or contributed to death. Toxicological analysis of an antemortem blood sample collected on 16 August 2010 revealed the presence of a trace of Olanzapine only. Zuclopenthixol was not detected. Post mortem toxicological analysis revealed the presence of Olanzipine at a level consistent with therapeutic use and Zuclopenthixol at a concentration of 54 ng/mL consistent with Mr Farrow having received an injection of the antipsychotic medication approximately 24 hours prior to his death. Dr Baker reported that no inferences can be made from the level of Zuclopenthixol detected due to significant post mortem redistribution and there is no evidence that use of antipsychotic medications caused or contributed to death. Dr Baker attributed Mr Farrow's death to natural causes.

Police Investigation

14. The police investigation and preparation of the inquest brief was undertaken by Senior Constable Craig McIntosh of Victoria Police.

Identity

15. The identity of Geoffrey Edward Farrow was without dispute and required no additional investigation. He was visually identified by Ms Jessica Steinborner,[9] the partner of Anthony Farrow, Mr Farrow's son.

INQUEST

16. An Inquest was held in accordance with section 52(2)(b) *Coroners Act 2008* as immediately before death, Mr Farrow was *a person placed in custody or care* as it is defined in section 3 of the Act.

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[9] Ms Steinborner was at the hospital, waiting to see Mr Farrow at the time of his arrest and death.

17. *Viva voce* evidence was obtained from Dr Robert Karoly, Consultant-In-Charge Inner West Community Assessment and Treatment team, NorthWestern Mental Health.

18. Dr Karoly confirmed that this was the first time that he had been involved in the care of Mr Farrow but that he had gained background information about Mr Farrow through his medical records. Dr Karoly described Mr Farrow's records as *an extensive medical record, both with the inpatient service and outpatient service.*[10] As the Consultant Psychiatrist on for the Unit, Dr Karoly reviewed Mr Farrow within 24 hours after Dr Cheong had certified him under section 12AA of the *Mental Health Act 1986* as is required by section 12 of this Act. Dr Karoly's extension of Mr Farrow's involuntary status under section 12AC entitled Mr Farrow to an independent review by the Mental Health Review Board within 28 days of Dr Karoly's decision.[11]

19. Dr Karoly responded to questions about the attendance of the CAT Team at Mr Farrow's home. He said it was not unusual to get a request from police to attend a member of the public they had concerns about but more often than not the request would be from Victorian Police compared to the Federal Police as in Mr Farrow's case. Dr Karoly also said it was not unusual for the CAT Team to attend with police and that in this instance it was a safety matter given Mr Farrow's history of violence.[12]

20. In relation to the medication administered to Mr Farrow whilst an involuntary patient in the John Cade Unit, Dr Karoly stated that Mr Farrow had reported no underlying medical conditions to Dr Cheong when he was being assessed on admission. Nevertheless, even if the mental health treating team had known of the underlying conditions which were identified at autopsy, it would have made no difference to the decision to administer the Olanzapine and Zuclopenthixol as they are commonly used and very safe medications.[13]

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[10] Transcript (T) @ p 7

[11] T @ p 8

[12] T @ p 12

[13] T @ p 14

COMMENTS

Pursuant to section 67(3) of the **Coroners Act 2008**, I make the following comment(s) connected with the death:

1. I acknowledge that Mr Anthony Farrow was concerned about a number of matters to do with the treatment of his father not only in relation to his medical management during his admission at John Cade HDU but with matters dating back to his bankruptcy, term of imprisonment for assault and the involvement of the Federal Police in this admission to John Cade. Save for the medical management of Mr Farrow during the admission between 15 August 2010 and 17 August 2010 I did not investigate the other matters as I formed the view that they were outside the scope of my statutory responsibilities as prescribed in the *Coroners Act 2008.*

2. In respect of the management of Mr Farrow at John Cade Psychiatric Unit I am satisfied that it was both reasonable and appropriate. I found Dr Karoly a credible witness. He was open and direct in his responses to the questions about the management of Mr Farrow.

3. I accept that Mr Anthony Farrow made contemporaneous notes about what his father told him about receiving two intramuscular injections and not just the one that is recorded in the medical records but there is no probative value to attempt to explore this further because in addition to the medical records and Dr Karoly's evidence, toxicological analysis was performed and the medications given to Mr Farrow have been considered as non contributory to Mr Farrow's death. Similarly, apart from the minor misspelling of Mr Farrow's name on the antemortem blood specimens there was nothing inconsistent found on toxicological analysis which supports Mr Anthony Farrow's suspicions that the hospital has provided the Victorian Institute of Forensic Medicine with an other patient's blood for analysis.[14]

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[14] Subsequent enquiries by my Assistant L/S/C Ramsey ascertained the samples were collected at the Royal Melbourne Hospital on the 16th of August, 2008. Dr. Dimitri Gerostamolous, Head Toxicologist, VIFM, advised that although the spelling on the ante mortem samples is incorrect, this often will occur with hospital samples. The hospitals have systems in place when conducting tests to rely on the UR No which is allocated to a patient throughout all their dealing with a hospital. In this case, Mr Farrow's UR number is 1186590 which in turn relates to his date of birth, confirming the sample is from Mr Geoffrey Farrow - as is the spelling on the records.

The UR number throughout his medical history with the Royal Melbourne Hospital is 1186590 and also appears in correspondence from staff members involved with Mr Farrow's care.

Dr Gerostamolous stated they will quite often receive samples with names spelt differently to what appears on other reports and records so this is why they have other checks and recorded information available.

4. Furthermore, I acknowledge that Mr Anthony Farrow did not believe that his father suffered from mental ill health. From reading his father's letters to the Australian Federal Police about his bankruptcy, Mr Anthony Farrow believed his father to be of sound mind.[15] The weight of the evidence is however to the contrary.

FINDINGS

I accept and adopt the cause of death as identified by Dr Baker and I find that Geoffrey Edward Farrow died from natural causes being hypertensive cardiomegaly and ischaemic heart disease.

AND I further find that the medical management of Anthony Edward Farrow at the John Cade Unit, Royal Melbourne Hospital was reasonable and appropriate in the circumstances.

AND I find that there is no causal connection between the admission and medical management of Mr Geoffrey Edward Farrow and his cause of death.

Pursuant to section 73(1) of the **Coroners Act 2008**, I order that this Finding be published on the internet.

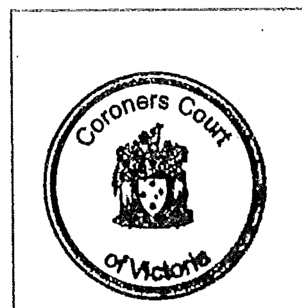
I direct that a copy of this finding be provided to the following:

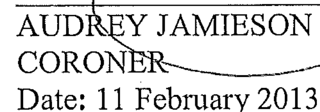
Anthony Ross Farrow

Ms Jan Moffat, Donaldson Trumble Lawyers

Dr Ruth Vine, Chief Psychiatrist

Signature:





AUDREY JAMIESON
CORONER
Date: 11 February 2013

[15] T @ p 23