STATE CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of David Veech
Hearing dates:	26-29 September 2017, Goulburn Local Court
Date of findings:	9 November 2017
Place of findings:	NSW State Coroner's Court, Glebe
Findings of:	Magistrate Harriet Grahame, Deputy State Coroner
Catchwords:	CORONIAL LAW – Death in a residential facility, Fentanyl toxicity
File numbers:	2016/87451
Representation:	Mr J Harris, advocate assisting, instructed by Ms J Mooney, solicitor, Crown Solicitors Office Ms England of counsel, instructed by Laycock Burke Castaldi Lawyers for Lifestyle Solutions, Ms Hyland and Mr Brown Ms L McFee of counsel, instructed by Ms Mitchell, solicitor, MDA Insurance for Dr Imran and Dr Bell Mr R Steward of counsel, instructed by Mr Culleton, solicitor, RMB Lawyers for Mr Woods, Ms McInnes, Ms Dumbleton Mr R Boyd, solicitor for Ms Taylor Mr S Edwards, solicitor, Johnson and Sendall, for Mr Cato Mr S Woods of counsel, instructed by Ms Hinchcliffe, solicitor, Curwoods for Mr Kodimaram and Southern NSW Local Health District

Findings pursuant to section 81 *Coroners Act* 2009 (NSW)

Identity	The person who died was David Veech.
Date of death	David died between 19 and 20 March 2016.
Place of death	David died at 30 Cunningham Drive, Tarlo, NSW.
Cause of death	David died of Fentanyl toxicity.
Manner of death	David died from an accidental overdose. He died after injecting liquid extracted from a Fentanyl patch. David's death occurred when he was inadequately supervised in a facility operated by Lifestyle Solutions.

Recommendations pursuant to section 82 *Coroners Act* 2009 (NSW)

To Southern NSW Local Health District

I recommend that Southern NSW Local Health District liaise with the appropriate person at NSW Health, to provide a copy of my findings and to ask that urgent consideration be given to the need for increased capacity for residential drug and alcohol rehabilitation beds in NSW. This is particularly places that are suitable for patients exiting the criminal justice system with a history of aggression, ambivalent response to treatment or known lack of insight, and for patients with a mental health diagnosis.

To Lifestyle Solutions

I recommend that each of the changes referred to on the document headed "Systems Changes and Acknowledgements Arising from the Inquest and Agreed to by Lifestyle Solutions" be actioned according to the timetable foreshadowed.

I recommend that Lifestyle Solutions conduct an audit of Tarlo IRS in 12 months from this inquest to gauge whether lasting change and improvements in training have been achieved.

Non Publication orders

1. Pursuant to section 74 (1) (b) of the *Coroners Act* 2009, the names of the following, and/or any information that might identify them (including images) not be published.
   a) B[redacted]
   b) G[redacted]
   c) A[redacted]
   d) M[redacted]

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Introduction

1. David Veech died at some point between the evening of 19 March 2016 and the following morning. He was only 35 years of age. He died after having injected an unknown quantity of Fentanyl, an opioid analgesic. At the time of his death David was residing at the Tarlo Intensive Residential Support Service (Tarlo IRS), which is a residential facility operated by Lifestyle Solutions. He was living there because he needed support and supervision.

2. David's death continues to cause profound and ongoing grief to his family and community. The tragic circumstances surrounding David's death call for close scrutiny of the care and support available to him at that time. There is a pressing public need to understand how David was able to access the medication which killed him in what should have been a controlled environment.

The role of the coroner and the scope of the inquest

3. The role of the coroner is to make findings as to the identity of the nominated person, and in relation to the place and date of death. The coroner is also to address issues concerning the manner and cause of the person's death.[1] In addition, the coroner may make recommendations in relation to matters that have the capacity to improve public health and safety in the future.[2]

4. In this case there is no dispute in relation to the identity of David Veech, or to the approximate date, place or medical cause of his death. For this reason the inquest focused on the manner and circumstances surrounding David's death. In particular, the inquest examined how it was that David could have accessed the drug that killed him, given that he was living in a facility that was supposed to have provided close supervision and support.

5. A guiding list of identified issues was circulated prior to the inquest commencing. These issues included examination of the drug and alcohol treatment provided to David, the kind of daily support offered to David at Tarlo IRS, the circumstances surrounding David being prescribed Fentanyl and his subsequent unsupervised access to it.

6. The purpose of an inquest in these tragic circumstances is not to apportion blame or criticize individuals involved in David's care, but rather to see if it is possible to identify opportunities to reduce the kind of risks that he faced. David's family approached this inquest in the hope of preventing other families from suffering a similar tragedy in the future. I commend the bravery they showed.

The evidence

7. The court heard oral evidence over four days and received extensive documentary material, including witness statements, expert reports and photographs.

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[1] Section 81 *Coroners Act* 2009 (NSW)
[2] Section 82 *Coroners Act* 2009 (NSW)

Background

8. David was born in 1980. His parents Christine and Geoffrey separated when he was aged seven and divorced when he was about 14. David had some difficulties at school, but completed year 10. He remained living with his mother until he was about 16. Around that time David was experiencing conflict with his stepfather, resulting in an AVO being taken out. David then spent a short time living with his father before moving into temporary accommodation.

9. David had long-standing issues with alcohol and substance abuse. He commenced smoking cannabis at about 16 years of age, and moved on to amphetamines, quickly developing a habit. David started using heroin at around 20 years of age. He is believed to have been frequently homeless during his twenties, living in hostels and other temporary accommodation. During this time he continued to experience alcohol and other substance abuse issues. He accessed a methadone program for a number of years and was treated at rehabilitation facilities, including two periods at Bloomfield Hospital in 2007 and 2009. In addition to using illicit substances, David accessed and abused prescription medication, including benzodiazepines such as Valium. These were lifelong issues for David and although he had periods of relative good health, he continued to crave substances up until the time of his death.

10. David also experienced mental health issues. Although he was diagnosed with schizophrenia at 16, a later diagnosis suggested that antisocial personality disorder, combined with drug induced psychosis may be more accurate.

11. David is recorded as having suffered a mild intellectual disability, although he appears to have been relatively capable of independent living. David had periods of employment including general labouring, bricklaying and working in the food industry.

12. In the context of his poor mental health and substance abuse, David attempted self-harm and suicide on a number of occasions, resulting in several admissions to hospital. In 2009 he attempted to cut his wrists, the same year he cut his throat and took an overdose. He was detained on an involuntary basis at Cumberland Hospital at Parramatta and the Pialla Unit at Penrith. There were no reported incidents of self-harm while David was in custody from 2009 to 2012. However, from mid-2005 onwards there are further references in the material to David having suicidal thoughts and of making threats of self-harm sporadically.

13. David had a number of criminal convictions, mainly for shoplifting and the possession of drugs. His most significant conviction was in December 2009, when he got into a dispute with a female neighbour about a refrigerator that he had apparently sold her. When the neighbour confronted him he attacked her with a knife, stabbing her in the chest. He was convicted of causing grievous bodily harm with intent and was sentenced to 5 years in custody. He was released in August 2012.

14. Throughout all the difficulties he experienced in life, David remained connected to his family. There is little doubt that at the time of his tragic death he was working on continuing to heal and improve these relationships. His mother described him as an inquisitive and cheeky child who had an enormous love for animals. This strong love of animals and nature continued into adulthood. During his life David had many pets and at the time of his death he was caring for a dog called Tyson, a Staffordshire bull terrier. David's mother explained that he loved Tyson greatly and always made sure that Tyson had the best food and was well cared for. David had been a good athlete as a young boy and remained extremely interested in sport. He had an enormous love for the ocean and was an excellent body boarder. He was artistic and particularly enjoyed drawing and

photographing animals and scenes from nature. David was particularly close to his mother and uncle. He was described as someone who could be an amusing, charismatic and warm companion. While he struggled with significant difficulties, David had much more to give and achieve in life.

David's release from custody in 2012

15. Prior to his release back into the community in August 2012, David was accepted into the Community Justice Programme (CJP). He remained involved in this program until the time of his death.

16. The CJP is funded by Ageing, Disability and Home Care (ADHC), which is now a part of Family and Community Services. It is described as a community-based forensic disability service, providing people with accommodation, clinical services and case management. It is open to people who have an intellectual disability, who have spent time in custody, who are at risk of serious reoffending and who lack access to other services. The primary aim of the CJP is stated to be "to reduce the offending by people with an intellectual disability who have exited a Correctional Centre as they move into the community."

17. The CJP has a number of service models which range from low level drop-in support to intensive residential support. The expectation is that people will be able to transition from intensive support to more independent living depending on their individual needs, as time passes.

18. On entry into the CJP, clinicians from ADHC assess a person to identify their specific needs and behaviour and to devise individual strategies to address them. The person is then allocated to a service provider. From that point forward, the service provider has ongoing responsibility for supporting the person. While ADHC staff remain available for consultation, monitoring and review, they play a reduced role.

19. Lifestyle Solutions (Australia) Limited is a service provider for the CJP. Through a funding agreement, Lifestyle Solutions is funded to provide accommodation and staff to meet the requirements of each of the different levels of service. It is a condition of the funding agreement between ADHC and Lifestyle Solutions that Lifestyle Solutions will assume "the primary role for the provision of casework and clinical services." This includes, for example, therapeutic interventions in areas such as alcohol and other drugs treatment. Lifestyle solutions is also required, under the agreement, to ensure appropriate medical services are engaged to support the person, to maintain communication with other relevant parties such as the Public Guardian and Probation and Parole, and to consider training opportunities for its own staff.

20. It is beyond the scope of this inquest to consider whether or not Lifestyle Solutions complied with all of its obligations according to the terms of its funding agreement. However, in general terms it is quite apparent that Lifestyle Solutions bore significant responsibility for providing David with the kind of support he needed.

21. On his release from custody in August 2012, David was initially placed with a different CJP service provider in Orange. The following year, on 26 July 2013, David was transitioned into the Lifestyle Solutions Wyong drop-in support service. He was provided accommodation by ADHC at West Gosford, where he lived alone with his dog Tyson, and his pet birds.

22. In the background material provided to Lifestyle Solutions by ADHC, David's substance abuse history featured prominently. However, an ADHC assessment from 19 April 2013 stated that David had largely remained abstinent from drug and alcohol use since his release from custody the previous year, although there were still some issues around alcohol and prescription medication. The ADHC transition plan stated that David should be referred to drug and alcohol counselling, but this was not progressed. It appears that David was often resistant to drug and alcohol counselling.

23. David's initial period with the Wyong drop-in service was relatively stable. This may have been partly due to his ongoing supervision by Probation and Parole, which ended in December 2014. However, increasingly aggressive outbursts from early 2015 onwards suggested to staff that he was abusing substances again. Due to his level of hostility, staff would visit David in pairs for their own safety. Staff suspected that David was spending most of his pension on alcohol, and he was also suspected of misusing Tramadol, an opioid analgesic.

24. A risk assessment undertaken by Lifestyle Solutions in April 2015 stated that David was associating with "antisocial peers", arming himself with weapons and that he was known to be abusing alcohol and various prescription medications. It was also strongly suspected that he was using ice, due to the condition of his skin and his recent weight loss. In June 2015, David was charged with shoplifting. He was reviewed by psychiatrist, Dr Basson on 25 June 2015. Dr Basson formed the view that there was a "great deal of evidence" to suggest drug use.

25. Lifestyle Solutions staff believed that David was entering a period of crisis. It therefore became a priority to identify a drug rehabilitation program for him, as soon as possible. However David remained ambivalent about accessing drug counselling. For example, in June 2015, he told staff that he would like to enter a detoxification program, but then quickly changed his mind and subsequently refused to go.

26. A plan was formulated to obtain a Community Treatment Order for David, to stabilise his mental health treatment and a Financial Management Order to prevent him from spending all of his money on drugs and alcohol. While this was being done, in July 2015, David became aggressive at his methadone clinic and was banned from that service. As a consequence, he did not receive methadone for a couple of days and on 29 July 2015 he was admitted to Gosford Hospital after having overdosed on Panadeine, Tramadol and Seroquel. He told staff that he was not suicidal but that he had just wanted to "get high". A review by a different psychiatrist during this admission, found that "David's symptoms are 100% related to substance abuse".[3]

27. Around this time David referred himself to drug and alcohol counselling, but at the end of August 2015 he was again admitted to hospital after injecting $500 of ice, taking a cocktail of other drugs and drinking half a case of beer. He told ambulance officers on this occasion that he wanted to kill himself.

28. On 8 September 2015, David obtained a prescription for Tramadol, ostensibly for back pain, but then took all 20 pills at once. Following this, Lifestyle Solutions suggested that his prescriptions should be obtained by their staff to avoid misuse and David apparently agreed. His then general practitioner, Dr Sutherland also suggested writing to local pharmacies to prevent "doctor shopping".

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[3] Statement of Susan Mary Findlay, Exhibit 1, Tab 91, p 620

29. Following this incident, David signed a statement saying that he wanted to attend rehabilitation for three months. His Lifestyle Solutions support worker at that time, David Jenkins, immediately completed a referral to a rehabilitation service in Armidale, Freeman house. Enquiries were also made with a similar service in Orange.

30. Unfortunately, the following week on 14 September 2015, David was arrested at his home for shoplifting. He resisted arrest and assaulted a police officer in the process. David was bailed from Gosford Local Court with a condition that he attend the MERIT program.

31. On 24 September 2015, Lifestyle Solutions psychologist, Chris Brown contacted ADHC clinicians because he was concerned that the current drop-in service could no longer meet David's needs. Chris Brown thought that David should be transferred to accommodation with 24 hour supervision. David was said to be expressing suicidal thoughts. ADHC advised that Lifestyle Solutions should submit a service change request to obtain a higher level of service from the CJP, obtain guardianship and financial management orders and continue to seek a drug rehabilitation program for David.

32. David attended court on 29 September 2015. That evening David approached council workers who were performing work near his property and threatened them with a large kitchen knife. He was arrested, charged with various offences and taken back into custody. On 30 November 2015, David was sentenced for these and other offences. He received 9 months imprisonment, with a non-parole period which expired on 28 December 2015. In addition David entered into a two-year good behaviour bond pursuant to section 9 of the *Crimes (Sentencing Procedure) Act* 1999.

33. During his time in custody, David was treated for benzodiazepine withdrawal. He continued to demonstrate drug seeking behaviour, trying to obtain Valium and other prescription medicines. Justice Health clinicians stated that he needed further drug and alcohol treatment.

34. Meanwhile, Lifestyle Solutions were continuing their enquiries regarding an appropriate place for David to be released to. On 1 October 2015, Chris Brown wrote a court report that stated "if Mr Veech is released into the community without a detoxification period and appropriate accommodation, the limited support able to be provided by Lifestyle Solutions will not mitigate the high risk of violence that Mr Veech poses to himself, the community and Lifestyle Solutions staff members."[4]

35. However, ultimately the referrals to rehabilitation services, including Freeman House, fell through. Services were reluctant to accept David due to his aggression and his obvious ambivalence towards entering a full time rehabilitation program. Freeman House reportedly stated that it did not accept any referrals from people on remand. Accordingly, despite significant efforts by Chris Brown, no residential rehabilitation service could be identified for David at that time.

36. Guardianship and financial management orders were obtained from the NSW Civil and Administrative Tribunal, commencing 2 November 2015, and a community treatment order from the Mental Health Review Tribunal was obtained on 19 November 2015.

37. In the absence of an identified rehabilitation service, Lifestyle Solutions proposed that David could be transferred into the Tarlo IRS at Goulburn, where there was a vacancy. Chris Brown considered Tarlo IRS would have the capacity to support David but only if he had successfully detoxed first

[4] Statement of Susan Mary Findlay, Exhibit 1, Tab 91, p 369

and had appropriate community conditions such as a Community Treatment Order. Chris Brown said "without these in place, Tarlo will not have the capacity unless they have access to increased staffing, access to a nurse, and security personnel to manage detoxification".[5] Chris Brown also noted when assessing the suitability of the Tarlo IRS, that drug and alcohol services in Goulburn were "limited in capacity and quality".[6] In his oral evidence Chris Brown stated that he always had reservations about the placement at Tarlo IRS.

38. David was discharged from custody and entered Tarlo IRS without first entering a detoxification service or undergoing any period of rehabilitation. It was a recipe for disaster.

Preparations for David's release to Tarlo IRS

39. Some preparations were made by Lifestyle Solutions prior to David's arrival at Tarlo IRS. Chris Brown updated David's Behaviour Support Plan, which gave the following guidelines regarding supervision. David was required to be under "line of sight" supervision in the community at all times. Inside the house the plan said "when it is impossible to maintain 1:1 supervision (e.g. during crisis of another person we support), attempt to persuade David to go to a safe contained area (e.g. bedroom)."[7] It also gave the advice "when David is sleeping: check David in his room every two hours as a rule of thumb".[8]

40. To support this plan, on 21 December 2015 interim approval was given to adopt what is called a "restricted practice" under the relevant ADHC Behaviour Support policy. Such practices are required to be justified and approved by ADHC. These included, relevantly that David should be supervised under "line of sight" in the community and that he have restricted access to his medication.

41. On 24 December 2015, Chris Brown went to Tarlo IRS with David Jenkins, David's former support worker, and they provided training to staff, including training on David's Behaviour Support Plan. Among other things, staff were told that David had a long history of drug dependency and that he would "doctor shop" to source prescription medication. They were also told that he could use aggression to get what he wanted.

42. No other specific training was given to staff prior to David's arrival, for example in relation to drug and alcohol dependency issues, dealing with aggressive people or administering medication. There was no training on how to deal with someone who demonstrated drug seeking behaviour. There appears to have been no discussion about how to handle having two residents in the house with substance abuse issues or how they would interact.

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[5] Statement of Susan Mary Findlay, Exhibit 1, Tab 91, p 586
[6] Statement of Susan Mary Findlay, Exhibit 1, Tab 91, p 588
[7] Statement of Susan Mary Findlay, Exhibit 1, Tab 91, p 257
[8] Statement of Susan Mary Findlay, Exhibit 1, Tab 91, p 257

David's arrival at Tarlo IRS

43. Tarlo IRS is a five bedroom house set in a semi-rural area, outside of Goulburn, NSW. During David's time at the property there were two other residents, B[redacted] and G[redacted] and a fourth person M[redacted] who lived in Goulburn and received drop-in service from the Tarlo IRS. The house was staffed 24 hours a day by a rotating shift of support workers with two working on the "A" shift from 7 AM to 3 PM, two on the "B" shift from 3 PM to 11 PM, and one worker overnight from 11 PM to 7 AM. These staffing patterns reflected the funding levels set by the CJP. In addition there was a manager or coordinator and a "clinical implementer" who both attended during the weekdays and worked from the office in the house.

44. When David was discharged from custody on 28 December 2015 he was taken directly to the residence by support workers. On arrival, he was interviewed by support worker, Tim Peden and the house rules were explained to him. The early period at Tarlo IRS was spent linking David with local services, including, for example, taking him to see his new general practitioner, Dr Imran, his Probation officer in Goulburn, Belinda Thompson and his mental health caseworker John Kodimaram. It should always have been obvious that if the placement was to succeed, David would need co-ordinated support.

Progress with drug and alcohol rehabilitation treatment

45. It was clear from the moment that David arrived at Tarlo IRS that drug and alcohol rehabilitation was an urgent priority. Chris Brown still had reservations about the suitability of the placement, given the entrenched nature of David's problems. Lifestyle Solutions had worked with David by then for some years and was well aware that his issues were serious and longstanding.

46. On 5 January 2016, Lauren Hurst from the Public Guardian contacted the Clinical Implementer at Tarlo IRS, Cara Taufa and asked if any help was needed with "detox" for David. In reply Ms Taufa said that Lifestyle Solutions would arrange some drug and alcohol counselling through the local Community Mental Health Team. It does not appear that there was further contact with the Public Guardian regarding this issue.

47. On 12 January 2016, Chris Brown reviewed David. He later prepared a report for the Mental Health Review Tribunal in which he noted that David was currently in "a highly protective situation" and that the intense monitoring at Tarlo IRS restricted his access to drugs. However, Chris Brown felt that David's primary area of concern remained drug seeking behaviour and medication misuse. There had already been four reported incidents of medication misuse by that stage, involving chewing tablets and nicotine patch abuse. Chris Brown's recommendation was that David receive long-term drug and alcohol treatment and rehabilitation, including that this be a condition of the Community Treatment Order.

48. On 19 January 2016, psychiatrist Dr David Bell reviewed David. In a letter to David's general practitioner, Dr Bell describes how David sought to obtain Valium from him during that review, which he declined. Among other things, Dr Bell said it was a priority that David enter into long-term drug and alcohol rehabilitation. Dr Bell was of the view that David was unlikely to have a schizophrenic illness and formed the view that his most pressing issue was substance abuse.

49. On 29 January 2016, Chris Brown contacted Mr Kodimaram and said that a referral to drug and alcohol rehabilitation was required. He asked Mr Kodimaram "is it possible for this to be organised?"

50. On 9 February 2016, the Mental Health Review Tribunal reviewed the Community Treatment Order and endorsed a treatment plan which had been prepared by Mr Kodimaram. That plan did not specifically refer to attending drug and alcohol counselling or rehabilitation. When questioned about this during the inquest Mr Kodimaram said that the Court had told him, "it's only a variation, nothing will take place".[9] It appeared to have been his understanding that this variation was only a formality to change the names and addresses and that any substantive change would take place at a later time.

51. On 15 February 2016, Chris Brown contacted Mr Kodimaram and suggested that David could be considered for an involuntary drug and alcohol treatment (IDAT) program. Mr Kodimaram's written note in relation to this issue is confused. He refers to "ADAC" being able to offer David "some rehab program". During the inquest he told the court he actually meant IDAT, not ADAC. His written notes record that Chris Brown will contact "ADAC" about it and that he will discuss it with David. This is somewhat contradictory to the evidence given by Chris Brown on this issue. When questioned about it at the inquest, despite the confusion, Mr Kodimaram maintained that he understood an involuntary program was being referred to. He said he discussed it with his colleagues who thought David was unlikely to be given entry to such a program at this stage. His evidence on this point was not impressive.

52. On 4 March 2016, Mr Kodimaram saw David and reviewed the result of a urine drug screen test. This was negative for all substances apart from benzodiazepines, which Mr Kodimaram considered were probably from his pain medication. The test was unsupervised and thus largely unreliable. In any event, David had not been prescribed benzodiazepines and their presence should have been a major warning sign. Mr Kodimaram seems to have missed an opportunity by incorrectly accepting that the benzodiazepine result could have been referrable to a drug that David had been legitimately prescribed. He told the court, "my understanding was that he was taking painkillers and if people take painkillers they can also show positive result for drug (sic)...and he was constantly saying "I am not a drug user...".[10]

53. On 8 March 2016, Dr Bell reviewed David again. At this stage, Dr Bell noted that David continued to seek drugs but he denied any drug or alcohol misuse saying "all the right things" during the interview. The plan was to continue current treatment and Dr Bell felt it was "difficult to know what to specifically offer David at this point in time".[11] Dr Bell's oral evidence made it clear that from his point of view drug and alcohol treatment was still the goal.

54. Mr Kodimaram prepared a mental health care plan the following day. The plan makes reference to drug and alcohol counselling and education to be provided by Mr Kodimaram. No reference is made to rehabilitation services in that plan.

55. Tragically, by the time of his death, no specific drug and alcohol counselling had been provided to David, notwithstanding his significant ongoing issues. David's drug seeking behaviour was clearly evident during his time at Tarlo IRS. He sought Valium from Mr Kodimaram and Dr Bell. He was also drinking, sometimes heavily, at the soldiers club in Goulburn. Lifestyle Solutions staff became sufficiently concerned about David's drinking to raise it with the Probation and Parole Service. As a

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[9] See his discussion of this point at Transcript 28/9/17, page 28 , line 5 onwards
[10] Transcript 28/9/17, page 42, line 16 onwards
[11] Statement of John Kodimaram, Exhibit 1, Tab 88, p 78-79

result, on 11 February 2016, David's probation officer imposed a condition that he must refrain from alcohol.

David's prescription for Fentanyl

56. Perhaps the most significant indication of David's continuing substance abuse problem is found in his interaction with Dr Imran. David first complained to Dr Imran about pain in his ribs on 20 January 2016. David said that he had been assaulted whilst in custody. Dr Imran initially ordered an x-ray and he also prescribed Lyrica or Pregabalin for the pain. The Public Guardian was consulted about this prescription, although given the terms of the Guardianship Order it appears that David was able to consent to receiving medication.

57. The x-ray showed mild spondylosis in David's spine, but no rib fractures. David returned to Dr Imran on 1 February 2016, still complaining of pain and so Dr Imran provided further medication.

58. David returned to Dr Imran on 19 February 2016. On this occasion he complained of sharp pain and he asked Dr Imran for Norspan patches which contain the opioid analgesic, Buprenorphine. David had received these patches from a previous GP. However, Dr Imran refused, having read a report by Dr Bell at this stage and fearing possible drug abuse. Dr Imran reports that David was very upset about his refusal to supply medication.

59. Dr Imran also ordered a CT scan. The scan results were available by 3 March 2016. They showed no abnormality, and yet David still complained of severe pain. Accordingly, Dr Imran referred David to a pain management clinic at Liverpool Hospital and ordered a nuclear bone scan. The results of that scan were available on 14 March 2016. They confirmed that David had suffered a recent fracture of the left ninth and tenth ribs, and possibly a further fracture on his right. In those circumstances Dr Imran felt he had exhausted all other options. With a proven reason for pain and the pain management clinic appointment still two months away, Dr Imran prescribed David Fentanyl transdermal patches. Dr Imran's evidence was that he "did his best to avoid a Schedule 8 opioid"[12] but felt that he had run out of options in the face of David's pain. He chose the lowest possible dose of Fentanyl patch, preferring it to the Norspan patch David had requested "because it's a shorter acting medicine...and if something goes wrong we can remove the patch and it will be cleared from the body much earlier than Norspan." He believed staff could remove the patch and that tablets would be "more risky". He had confidence that "David was in a controlled environment where medications are locked and administered by staff".[13]

60. Fentanyl is a "Schedule 8 drug", meaning that it is a drug considered to be addiction producing, and is listed in Schedule 8 of the Commonwealth Poisons Standard. The prescription, possession and use of Schedule 8 drugs is tightly controlled by the *Poisons and Therapeutic Goods Act* 1966 (NSW). The associated regulations also specify how such drugs should be stored and what records must be kept in relation to their use. However there is a relevant exemption in section 23 of the Act which provides that "a person who... is assisting in the care of, another person... is not guilty of an offence in relation to the possession or supply of the drug if the person is in possession of the drug for the sole purpose of administering, or assisting in the self-administration of, the drugs to the other person and does so in accordance with that prescription."

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[12] Report of Dr Imran, dated 15 March 2017, Exhibit 1, Tab 81
[13] Report of Dr Imran, dated 15 March 2017, Exhibit 1, Tab 81

61. As a result the storage and handling of the Fentanyl patches within a facility such as Tarlo IRS is not subject to the regulation but is governed by the relevant policies of Lifestyle Solutions and ADHC. Lifestyle Solutions's policies required that medication be kept in a locked cupboard, and that documentation provided by the general practitioner had to be completed each time it was administered. Staff were not required, at the time David was living in the house, to check that all medication was accounted for each time it was administered.

62. Some staff working at Tarlo IRS had received training in relation to the administration of medication, others had not. None appeared to have received specific training regarding the use of transdermal patches, or the risks that they may present. At the time of these events, all medication at Tarlo IRS was kept in a locked medication cupboard within the staff office. There were two sets of staff keys, which included the keys to the medication cupboard and to the other rooms. There was no strict policy that required staff to keep keys on their person, although some staff members did. Staff members were not required to sign for the keys on their arrival. As a result, the keys were, from time-to-time, left on the desk within the staff room. It also became apparent, after David's death, that the medication cupboard itself was not actually secure and that it could be accessed by simply pulling firmly on the handles. While the staff office would normally be locked if unattended, it was by no means always locked. There were two doors to the office, one leading from the lounge area and one from the laundry room. The corridor leading from the house to the laundry room was blocked, but only by a relatively low cupboard and it would have been possible for someone to access the corridor and the rear office door by climbing over it.

Issues with David's Fentanyl patches

63. Dr Imran prescribed one Fentanyl patch to David every 72 hours, in accordance with a regular protocol. The prescription was filled on 14 March 2016 and two boxes each containing five patches were obtained and placed in the medication cupboard by support worker, Simon Woods. Simon gave David his first patch that afternoon. David's next patch was due on 17 March 2016.

64. However, early in the morning of 16 March 2016, David began asking for another patch. He asked support worker Lisa Healy for a patch at 4:30 AM that day, but she explained that night staff could not administer medication. When the next shift started at 7 AM, David approached Leah Muscarella and Lucy Taylor for a patch. Leah explained that David was not due for a patch until the following day. She also inquired after where his last patch had gone. David said that he had "flushed it down the toilet". Leah prepared an incident report outlining what had happened. However it does not appear that any staff member realised the real risk of abuse that now presented itself.

65. The following day, 17 March 2016, David asked Leah for his patch at beginning of the shift. He was given it and told not to take it off until the next patch which was due in three days time. However, later that day David claimed the patch had come off while he was removing his shirt. Staff searched for the patch but it could not be located. David claimed that the patches did not stay on, and accordingly Leah booked an appointment with Dr Imran for Monday 21 March 2016, to consider changing to tablet medication. Again it appears that no staff member properly understood the serious implications involved if David was diverting his medication for intravenous use.

The events of 19 and 20 March 2016

66. On 19 March 2016, David started the day in an elevated mood, upset because he had no tobacco. He then spent the day out of the house with his housemate, B[redacted] and staff person, Simon Woods. They had a barbeque at Crookwell and returned to the house at around 1:45 PM. The new shift, Chris Cato and Tim Peden arrived at about 3 PM. Within about half an hour of his arrival, Chris Cato noticed that David was lethargic, he was slurring his speech and combining words. Chris considered the possibility that this might indicate David was under the influence, or but also thought it could indicate that he was really tired. He later wrote a note to this effect in the progress notes.

67. The other housemate, B[redacted] was interviewed by police during the investigation into David's death. He told police that at some point on 19 March 2016, although he could not recall exactly when, he saw David coming out of the staff office. B[redacted] said that David went outside and showed him "these morphine things"[14] and gave one to him. B[redacted] explained that he tried to prepare the Fentanyl to inject it, by heating it, but he burnt it by mistake. B[redacted] said he then asked David for a second patch, which David gave him although, "he got a little bit angry about at me".[15] B[redacted] also said that at dinner time, about 6 PM, David asked B[redacted] for his Serepax or Oxazepam medication, and in the circumstances B[redacted] felt obligated to give it to him. B[redacted] also said he told support staff "something's up with Dave".[16]

68. It is not known whether this account is reliable and B[redacted] did not give oral evidence at the inquest. B[redacted] has an intellectual disability and he had previously stated that his recollection was unclear. However given that Oxazepam was evident, in a low level, in David's post mortem toxicology results and that he was not prescribed that medication, it is possible that B[redacted]s account on this issue is accurate. He also accurately revealed to staff and police where he had hidden the second Fentanyl patch, inside a shed on the property.

69. It is established that after the evening meal, Chris Cato left premises to visit and supply medication to M[redacted] the "drop-in" client who lived in Goulburn. He was gone from the premises for up to an hour. During this time, while Tim Peden was alone in the property, one of the other residents, G[redacted] became incontinent, and Tim had to wash and assist him. Tim says that while he locked the office door to the lounge, he did not lock the door to the laundry. It is always possible that David used this opportunity to enter the office through the laundry door. However, if that was the time when David acquired the Fentanyl, it does not explain how B[redacted] came to receive two patches from David prior to the evening meal. There were certainly other times David could have gone to the cupboard. It may even be that David accessed the medication cupboard on a number of different occasions.

70. David went to bed at about 9 PM. At this stage, according to Tim Peden, David was still slurring his words, although Tim said this was not unusual following the evening medication. David came back out of his room to go to the toilet at some stage, and he was last seen by staff at around 10:30 PM.

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[14] Transcript of interview with B[redacted] Exhibit 1, Tab 14, p 4
[15] Transcript of interview with B[redacted] Exhibit 1, Tab 14, p 5
[16] Transcript of interview with B[redacted] Exhibit 1, Tab 14, p 5

71. Lucy Taylor commenced her shift at about 11 PM. She completed a shift handover with Chris Cato and Tim Peden. She agreed that she was told that David had been lethargic in the afternoon, but she just assumed it would mean that David would be quiet as a result. She did not see David at the start of her shift, as he was already in bed, with his door closed.

72. During the night shift, Lucy did not check on David at all. She did checks the other two residents and performed various other tasks. She stated in oral evidence that she was awake all night. Lucy was aware that David's Behaviour Support Plan recommended that he should be checked every two hours during the night. However, Lucy said that she had real concerns for her own safety. On 22 January 2016, David had made threats about her, accusing her of stealing his tobacco. She had previously seen him behave in an aggressive manner. From the time of the specific threats she said that she stopped checking on David during the night, unless his door was open.

73. Lucy Taylor was not the only staff member to avoid checking on David during the night. On 9 March 2016, David apparently complained to support workers Chris Cato and Tim Williams that Simon Woods was waking him up when he checked on him during the night. David is reported to have told these workers that he did not want to be checked any more. It was Simon Wood's evidence that he was given a "direction" to that effect by another staff member. He said he later sought to clarify the policy with April Dumbleton and left messages about this on her mobile phone. In her oral evidence, she did not recall having contact with him in relation to this issue, but agreed that if he had called during her time off she may have deleted his message.

74. Simon Woods gave extensive evidence about this issue at the inquest. It was not impressive. He produced what he said was a contemporaneous record of his reported concerns.[17] The dates did not appear to match when the conversations are said to have taken place and they are written in an unusual narrative style for a personal contemporaneous note. I find them difficult to rely upon. Nevertheless, while I do not accept there was ever a "direction" not to check on David, I accept that it was a matter staff discussed in the lead up to David's death.

75. In any event, on 20 March 2016, Simon Woods and Sue McInnis commenced work at 7 AM. Lucy Taylor performed a shift handover and recorded in the progress notes that she had "nil contact with David".[18]

76. David did not get up during the morning, which was unusual. Simon Woods made breakfast for G[redacted] and then woke B[redacted] David was still not awake at 9:25 AM when Simon Woods left the property with B[redacted] leaving Sue McInnis alone with David and G[redacted] Simon Woods returned at about 11 AM. Sue McInnis told him that David was still not awake and they became concerned and decided to check on him. By this time he had not been seen for over twelve hours.

77. Staff used the master keys to open David's door. They found him lying unresponsive on the floor with a syringe near his body. His dog, Tyson, was in the room with him. Simon Woods checked for vital signs, but David was quite obviously dead. Simon Woods called an ambulance and the police attended. At some stage that morning, Simon checked the medication cupboard in the office and he discovered that one whole box of Fentanyl patches was missing. Lifestyle Solutions management were informed of David's death and arrangements were made for more senior staff to become involved.

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[17] Exhibit 4
[18] Lifestyle Solutions – Progress Notes, dated 19 March 2016, Exhibit 1, Tab 31, p 458

78. Police searched David's room and found a Fentanyl patch in a spoon, an empty wrapper on the floor and an empty box which would have contained five patches in a cupboard. If B[redacted]s account is reliable, this would mean that two patches from the box remained unaccounted for.

79. It is not known where David obtained the syringe. None of his medication required a syringe to be used. Of possible relevance is that in January 2016 there had been an incident where B[redacted] had overdosed on painkillers, using a syringe. Following that incident, the syringe and painkillers had been confiscated. Following David's death some painkillers and syringes were discovered on the top shelf of the medication cabinet. It is believed that these may have been the ones confiscated from B[redacted] and it is therefore possible that this is where David obtained a syringe.

Autopsy and toxicological testing

80. A limited autopsy was conducted at Goulburn Base Hospital Mortuary on 24 March 2016 by Dr John Docker. This revealed a needle puncture mark on David's right cubital fossa, the inside of his elbow, consistent with the use of a syringe. Dr Docker identified the cause of death as a "drug overdose".

81. A toxicology report demonstrates that David had a fatal level of Fentanyl in his blood. He had also ingested two drugs which he had not been prescribed, Oxazepam and Hydrocodone. The evidence does not clearly reveal how or when he obtained these substances. However he may have received at least one of those drugs (Oxazepam) from B[redacted] his fellow resident.

82. An expert report was obtained from a consultant forensic pharmacologist Dr John Farrar. He confirmed that David's death was as a consequence of Fentanyl toxicity. He stated that Fentanyl was present at a sufficient concentration to have caused a rapid death, irrespective of the consumption of other drugs. The level of Fentanyl was in the upper range reported in other Fentanyl fatalities. It is not possible to estimate the number of patches David had used or injected or the duration over which he did so. Oxazepam was present at a sub-therapeutic concentration and would not have had a significant sedative effect. The level of Quetiapine in David's blood was well into the toxic range. Dr Farrar considers that it is likely that David had been stockpiling this drug to have reached such a level. While Hydrocodone was found, David had not been prescribed this drug. Dr Farrar noted that while drug concentrations may be affected by post-mortem redistribution, it did not affect his conclusion regarding the fatal level of Fentanyl.

Was David's death intentionally self-inflicted?

83. A finding that a death is self-inflicted must not be made lightly. The evidence should be extremely clear and cogent in relation to intention. In my view the weight of authority suggests that the proper evidentiary standard to be applied to a coronial finding of intentional taking of one's own life is the *Briginshaw* standard.[19] While the first Autopsy Report suggested that David's death was "apparent suicide", I reject that opinion as based on entirely faulty reasoning. The doctor appears to have placed some weight on the "deliberate misapplication of the drug" as somehow indicating an intention to die. I note that while an amended report confirmed that the doctor was of the view that "an accidental overdose is not excluded", he stated that he "was not aware of any conclusive findings either way".

[19] *Briginshaw* v *Briginshaw* 60 CLR 336

84. In my view there is absolutely no evidence to suggest that David's death was intentionally self-inflicted. There was no suicide note or any kind of final communication. There was no apparent change in mood or behaviour in the period leading up to his death. He was actively involved in caring for his dog and had future plans. While he had, in the past, been suicidal, there was no indication that he was in that state in the period before his death. On the other hand, there is ample evidence to support a finding that David had a history of dangerous and at times reckless drug use. There is no way to control the amount of Fentanyl one would receive when taking that drug by injecting it after "washing" a patch. In my view the evidence clearly establishes that David Veech died of an accidental drug overdose.

Who was responsible for providing the support David required?

85. Lifestyle solutions had a primary role with respect to casework and the provision of therapeutic services for David. For this reason much of the inquest focussed on its involvement with David. However it is important to note that there were a number of other agencies involved in David's life during the time he spent at Tarlo IRS. These included ADHC, Goulburn Community Health Service, the Probation and Parole service,[20] the Public Guardian,[21] and the New South Wales Trustee and Guardian.

86. With so many agencies and organisations involved it would have been beneficial for David, if an inter-agency meeting had been held soon after his arrival at Tarlo IRS. This would have enabled each organisation involved to have a clear understanding of their role and ensured that they worked together and shared a common direction. The obvious agency to convene that meeting was Lifestyle Solutions.

87. The lack of a co-ordinated approach meant that it is possible certain agencies believed that other agencies were taking responsibility, when they were not.

The care provided by Doctor Imran

88. Dr Imran gave oral evidence at the inquest. He gave the impression of being a thoughtful and conscientious doctor. At the first consultation, Dr Imran was provided with limited information about David's relevant medical history, most of which came from David himself. It appears that Dr Imran did not know that there was a Guardianship order in place[22] and he did not receive detailed information from Lifestyle Solutions about David's prior drug and alcohol issues. He should have been informed that David had a history of multi-drug abuse, including an addiction to heroin. He should have been told that David had previously been on a methadone program. This information was available to Lifestyle Solutions and, with David's permission, should have been disclosed at the outset. This was a significant lost opportunity.

89. Nevertheless, Dr Imran had a clear general understanding that some patients seek pain medication inappropriately. He approached his task with a healthy suspicion following David's specific request for Norspan. Dr Imran watched David carefully in the waiting room, where he

[20] David was subject to parole and had also entered a good behaviour bond. He was required to accept the reasonable directions of his parole officer, including in relation to drug and alcohol treatment. His parole or bond could have been revoked if he was in breach of a relevant condition. It is apparent that The Probation Service was relying on Lifestyle Solutions for up-to-date information in relation to David. However, when contacted by Lifestyle Solutions in relation to David's drinking, the Service became involved.

[21] The Guardianship order imposed on 2 November 2015 was a limited order, not a plenary order. That order had limited relevance in the circumstances of David's death.

[22] Dr Imran, oral evidence Transcript 26/9/17, page 30, line 1 onwards

appeared to be in less pain, than in the surgery.[23] Dr Imran delayed prescribing a Schedule 8 drug. However, once the nuclear scan showed that there was a physical reason for the pain David reported, he felt he had "no option except to treat his pain". He chose the patch, believing it was a safer option than tablets, which he knew could be crushed and injected. He noted that Dr Bell had advised against benzodiazepines, but had not referred to opiates. Dr Imran prescribed Fentanyl, but he remained concerned.

90. It must be remembered that Dr Imran always saw David in the company of a staff member from Tarlo IRS. He cannot be criticised for believing that the medication would be kept in an appropriate locked environment and given in a supervised manner.

91. At the time of prescribing Fentanyl, Dr Imran had not heard of the practise of extracting Fentanyl from a patch for the purpose of injecting it.[24] The prevalence of "bathing" or "stripping" Fentanyl patches within the intravenous drug using community is something he would now consider in a similar situation. He was not aware of the real dangers of "washing" used patches and would now make sure a suitable disposal arrangement was in place. In my view Dr Imran's limited understanding of the dangers of Fentanyl abuse in March 2016 is likely to have been shared by many country general practitioners.

92. While the unsupervised use of Fentanyl had tragic consequences for David, I understood Dr Imran's rationale for prescribing that drug at the time. I offer no criticism of Dr Imran or the honest way he approached this inquest.

The support provided by Dr Bell and Goulburn Community Health Centre

93. Dr Bell is a psychiatrist and Visiting Medical Officer (VMO) working with a number of Community Mental Health Teams, including the Southern NSW Local Health District.

94. Dr Bell saw David on two occasions, 19 January 2016 and 8 March 2016. He had the opportunity to review a limited number of David's past medical records and to make his own observations. While he could not positively exclude schizophrenia, his own diagnosis was that David suffered a severe polysubstance misuse disorder and Antisocial Personality Disorder.[25] He explained that in his view, a number of David's past episodes were more likely to have been caused by drug induced psychosis rather than have been evidence of schizophrenic illness.[26] I accept his opinion on this issue. He gave the impression of being a knowledgeable and able practitioner.

95. Right from the start Dr Bell saw the main issue which needed urgent attention was the drug misuse disorder. He stated that David required a long term drug and alcohol rehabilitation program, preferably longer than six months in duration. Dr Bell had first-hand exposure to David's aggressive drug seeking behaviour when David became threatening and hostile during his first appointment as it became clear that Dr Bell would not prescribe him Valium.[27]

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[23] Dr Imran, oral evidence Transcript 26/9/17, page 38, line 25 onwards
[24] Dr Imran, oral evidence Transcript 26/9/17, page 43, line 20 onwards
[25] Report of Doctor Bell, dated 26 July 2017, Exhibit 1, Volume 4, Tab 87
[26] For discussion of this point see Transcript 29/9/17, page 6, Line 25 onwards
[27] Transcript 29/9/17, page 8, line 40 onwards

96. Dr Bell told the court that while he was of the firm view that long term residential rehabilitation was necessary, drug and alcohol counselling would have been a "good start" while waiting for a rehabilitation place.[28] In the meantime Dr Bell tried to warn David's doctor against prescribing benzodiazepines.

97. Dr Bell's plan is recorded in the Community Health Team's file note on 19 January 2016.[29] Present at the meeting with Dr Bell was John Kodimaram, the social worker attached to the Goulburn Community Mental Health team and a worker from Lifestyle Solutions. Among other things, Dr Bell noted that discussion with Probation and Parole should take place, as he saw that the best treatment option was a long term rehabilitation service. He noted that urine drug screening should also be done by Probation and Parole, so that it was supervised and reliable. He noted that drug and alcohol counselling should be arranged. I offer no criticism of Dr Bell's approach. He appears to have understood what needed to be done. It was not his responsibility to book David into a residential rehabilitation or to arrange referral to a compulsory program through Probation and Parole. His clear plan should have been executed by others.

98. John Kodimaram was questioned specifically about Dr Bell's request that Probation and Parole were contacted in order to organise drug and alcohol rehabilitation after the 19 January meeting. He said he understood it was the plan but he thought "It is not immediately, it is long-term, long-term to be done". His evidence on this issue was unimpressive.

99. There was really no co-ordinated response to what was an appropriate plan. There is no evidence that Probation and Parole were contacted after the meeting and informed of what was needed in this regard. Equally there is no evidence that the Lifestyle Solutions worker communicated the content of what was discussed back to her organisation for follow up.

100. A crucial person in the picture was John Kodimaram. He was David's case manager and "mental health clinician" within the Goulburn Community Health Centre. One must assume that Dr Bell expected the plan to be implemented or coordinated by John Kodimaram.

101. John Kodimaram's own training was as a social worker. He came into contact with David almost as soon as David arrived in the area and first conferred with him in person on 30 December 2015.[30] He was not a drug and alcohol worker by training and told the court that he would have referred David to another worker in his service to access this type of counselling, when the time was right.

102. John Kodimaram saw his role as trying to establish rapport with David. He told the court that David continually denied any drug seeking behaviour. However, it is quite clear that there was objective evidence to the contrary. Mr Kodimaram told the court that he intended to build a relationship with David. He explained that from the start David had told him that he did not have a drug and alcohol problem, "so there is no point for me to talk with him (about this issue) because he- you know, "I am not drug and alcohol problem""[31] Mr Kodimaram believed that because David did not admit he had a problem, no referral could be usefully made at that time.

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[28] Transcript 29/9/17, page 10, line 13 onwards
[29] Progress notes, Exhibit 1, Vol 4, Tab 88, page 56 onwards.
[30] Statement of John Kodimaram, Exhibit 1, Vol 4, Tab 88
[31] Transcript 28/9/17 page 54, line 25 onwards.

103. Surprisingly when questioned about this issue by his own counsel during the inquest, Mr Kodimaram told the Court that if he had asked David to attend a six month voluntary program on 8 March 2016, David would have consented.[32] On the evidence before me, I do not share Mr Kodimaram's confidence on this issue. Nevertheless, I am of the view that David should have been referred to a drug and alcohol counsellor, at the very least. It was not a magical solution to his longstanding issues, but it was a necessary step that should have been taken. Although well meaning, Mr Kodimaram appears to have been out of his depth in dealing with David's substance abuse issues. I accept that his stated aim was to establish rapport, but I do not believe that he had the skills to do it. David was in need of a practitioner who understood how to work with a client, who had a long history of ambivalence to treatment and who was known to manipulate treatment providers. I acknowledge that Mr Kodimaram was faced with a difficult task.

The support provided by Lifestyle Solutions

104. There were numerous extremely significant failings in the care and support offered to David by Lifestyle Solutions at Tarlo IRS. Those inadequacies created the environment of risk in which he died. No one person associated with the Lifestyle Solutions is singly responsible for the tragedy, but as Ms Katrina Hyland, frankly stated in her evidence, Lifestyle Solutions not only "failed its staff... it failed David Veech".[33] She agreed that many aspects of the way Tarlo IRS operated were sub-standard or plainly inadequate.[34]

105. I my view these failings include the following;

- Tarlo IRS was from the start an inappropriate placement for David Veech. He needed strong supervision and expert drug and alcohol treatment, neither of which was available at Tarlo IRS. With hindsight, Lifestyle Solutions should have recognised the message they were getting from Chris Brown and refused to go ahead with the placement.[35]
- Staff at Tarlo IRS were quite ill-equipped to deal with two residents who had strong drug seeking behaviours. In January 2016, staff called an ambulance after B[redacted] was found to have overdosed. It now appears that the drugs and syringes from that incident remained on the premises until after David's death. There is evidence that these two residents shared drugs. There were no strategies in place to deal with this issue.
- Supervision was clearly lacking at the facility. I accept Lucy Taylor's evidence that she was fearful of David, but that she felt unsupported in raising the issue with management. She was a young woman in an isolated country residence. There were sometimes problems with the telephone line. She had been threatened with violence at work by David. Lucy's understandable fear meant that she did not then comply with the requirements in place for David's supervision during the night shift. Management should have known that this was a problem. There were references to this and other issues in the progress notes, but they were either not read or not appreciated by management. I accept that staff had raised the night staff ratio with management prior to David's death, but that it had been ignored. At the time of his death, David had not been seen for approximately 12 hours in clear violation of the recommendation in his Behavioural Support Plan (BSP). Management should have

[32] Transcript 28/9/17 page 60, line 25 onwards
[33] See for example her oral evidence on this issue at Transcript 29/9/17, page16, line 15 onwards.
[34] See her evidence at Transcript 29/9/17, Page 14, line 20 onwards
[35] It should be noted that Chris Brown remained concerned about the placement, even after David had gone to live at Tarlo IRS Transcript 27/9/17, page 84, line 37 onwards

been aware that checking was not happening consistently, according to the BSP, and should have taken steps to address the issue.

- Changeover procedures at Tarlo IRS were poor and provided each following shift with little useful information. Even when staff made notes, they were often left unread.
- Staff were completely ill-equipped to understand the severity of David's substance abuse issue. They had no training in dealing with drug seeking behaviour or in developing strategies on how to manage it. Nobody appears to have had even the most basic training in relation to drug and alcohol issues. On the evening of David's death he was identified by a staff member as lethargic or drowsy, this should have triggered concern.
- Staff had no understanding of the specific drug David had been prescribed and seemed quite unaware that Fentanyl patches are frequently washed or bathed for intravenous use. They had no training on how dangerous the drug can then become, given its strength and the fact it is being delivered in an uncontrolled manner. Staff did not understand that even a partially used patch can be removed and washed for intravenous use. There was no protocol for the proper disposal of patches.
- There was a clear lack of co-ordination around all aspects of David's medication management. The Clinical psychologist, Chris Brown was not informed that David had been prescribed Fentanyl.[36] There was also inadequate sharing of information about David's longstanding drug issues by Lifestyle Solutions with his general practitioner.
- Staff were for the most part ill-equipped to deal with aggressive behaviour and appear to have been unsupported by management in relation to this issue. While some staff members were provided training on how to deal with aggressive behaviour, others were not. Staff concerns about resident aggression meant supervision became patchy at best.
- The physical surroundings were simply inadequate to provide safety. The medicine cupboard was insecure and the office where medication was housed was frequently unlocked or unattended.
- There were no adequate controls on the distribution of medication. Proper records were not kept and there was inadequate daily checking of medication stock. It appears that confiscated syringes and medication were left on the premises for weeks.
- There were significant gaps in the written policies governing all aspects of the running of the house. Even when there were relevant written policies, staff admitted that they were not always aware of their content.[37]
- There appears to have been limited understanding of how to develop a co-ordinated plan for someone with complex needs such as David. There appears to have been no co-ordinated approach to bring all the agencies involved together. While staff took David to the Community Health Centre, there was no follow up about whether that organisation was actually providing any access to drug and alcohol treatment once David arrived at Tarlo IRS.

[36] See discussion of this point at Transcript 27/9/17, page 93 line 10 onwards
[37] See for example the evidence of April Dumbleton on this issue 28/9/17, Transcript page 103, line 15 onwards

What improvements have Lifestyle Solutions made since David's death?

106. Lifestyle Solutions informed the court that since David's death a number of lessons have been learnt and changes made locally at Tarlo IRS. Some of these changes were set out in the statement of Susan Findlay, the Executive Leader – Operations.[38] They included upgrading the medication cabinet, and changing policies and protocols in relation to the procurement, management and administration of Schedule 8 drugs, new policies for strictly monitoring the keys at Tarlo IRS, changing the nightshift arrangements by introducing a monitored system of hourly checks, improving shift handover procedures at Tarlo IRS, and restricting access to the office at Tarlo IRS. These policies are included in a "Tarlo Operational Practice Manual" which has now been completed.

107. The court was also assisted by a comprehensive statement and oral evidence from Ms Katrina Hyland. She occupies the position of Practice Improvement Specialist with Lifestyle Solutions and has been in that role since April 2017. She told the court that as a result of David Veech's death (and ongoing investigations conducted by the NSW Ombudsman) a number of further areas of improvement had been identified.[39] These changes went well beyond Lifestyle Solutions operations at Tarlo IRS and had state-wide effect. They involved significant internal restructuring of the organisation and the assistance of outside consultants. I do not intend to re-iterate the entire content of her detailed statement but relevantly she informed the court that on 15 August 2017, Lifestyle Solutions had engaged an external specialist to conduct an independent health review of the CJP Intensive Residential Support Services. She also informed the court that a Medications Safety Review Committee had been convened. This committee which reports directly to her aims, among other things, to improve medication safety across the organisation. Ms Hyland was able to inform the Court that staff training has now been given priority in the organisation. She acknowledged staff training "could have been better in the past".[40]

108. Ms Hyland was a strong witness who appeared to understand the kind of cultural change needed. She spoke candidly about significant weaknesses in the organisation in the past. There was a rapid staff turnover and what she described as "a disconnect between board and management". She spoke about decision making practises not always being transparent and a range of other past internal problems.[41] In her view there had already been a large cultural shift within Lifestyle Solutions and she was confident that the new CEO, Mr Hyland, was actively driving change. She told the court that she herself had been brought back into the organisation to assist in problem solving and improving the services offered. Put plainly, part of her role was in "cleaning up" a flawed organisation.

109. As the inquest progressed and further opportunities for improvement arose, Lifestyle Solutions prepared a supplementary document outlining further charges that would be made. They are to be commended for their proactive approach. The document entitled "Inquest into the death of David Veech -Systems Changes and Acknowledgments Arising from the Inquest and Agreed to by Lifestyle Solutions"[42] was tendered on the final day of the inquest. It sets out a number of further changes or acknowledgements made (or planned) as a result of David's death. It includes reference to:

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[38] Exhibit 1, Vol 5, Tab 91
[39] See her oral evidence 29/9/17, Transcript page 5, line and her statement at Exhibit 1, Vol 3, Tab 80B
[40] Statement of Katrina Hyland, Exhibit 1, Vol 3, Tab 80B, par 47
[41] Transcript, 29/9/17, page 30, line25 onwards
[42] Exhibit 8

- a policy in relation to the disposal of transdermal patches;
- a policy in relation to the "Management of drug seeking behaviour" which will be applicable to intensive residential care premises, such as Tarlo IRS, run by Lifestyle Solutions;[43]
- a policy ensuring that the relevant clinical psychologist will be made aware of any changes in the type of prescription medication prescribed;[44]
- a policy ensuring that the Behavioural Support Plan will stipulate that the clinical psychologist will review and approve changes to the Behavioural Support Plan and make sure that staff are re-trained in relation to any proposed changes;
- A policy ensuring that a treating doctor will be informed of the person's circumstances (provided they or their guardian consent) so that the practitioner may make informed decisions about the person's medical care;
- A policy that commits to improving communication with all relevant agencies in relation to the needs of clients, including where possible by organising case management meetings with other service providers; and
- A policy that will ensure that there is an appropriate key registers in all Lifestyle Solutions residential care facilities.

110. The Court was informed that all of these further changes should be implemented by 31 March 2018.

The need for recommendations

111. It was Lifestyle Solutions' ultimate submission that the changes already made, along with those foreshadowed, obviated the need for any formal recommendations. The Court was told that the organisation is in the process of significant change and restructure and that out of a leadership team of seven, five members are new. There is now a huge emphasis on training and on formulating policy to ground strong clinical practise. The Court was assured that these changes are not "window dressing" but demonstrate a sincere desire for change across the organisation. It is noted that the new CEO sat through these inquest proceedings to provide timely instructions on further changes as they emerged. I accept the approach the organisation has taken to these proceedings has been positive and useful.

112. Counsel for Lifestyle Solutions urged the Court to accept that Lifestyle solutions had completed a thorough audit of all their processes and had already made significant changes. While I accept that, I remain concerned about the inherent difficulties involved in effecting long term cultural change. Many of the same staff members working at the time of David's death remain at Tarlo IRS. I observed some of them give evidence and it is clear that they still require further training and support in relation to the introduction of the new policies and procedures foreshadowed by senior staff. I am of the view that a future audit of that service should take place to ensure that this occurs, as planned.

113. Once placed at Tarlo IRS, David was at risk because the service was both substandard and inappropriate. While the workers were no doubt well-intentioned, they were ill-equipped to deal with his complex needs and they were unsupported by the organisation they worked for. Tarlo IRS

[43] See also Exhibit 7
[44] See Exhibit 6

appeared to have operated as an unsupported outstation. Even when Lifestyle Solutions had appropriate policies in relation to some of the issues raised, they were unknown to Tarlo staff or were irrelevant to their day-to-day working lives.

114. I am satisfied that Lifestyle Solutions understands the magnitude of its failings and has attempted to put better systems in place. However, it is early days after such a tragedy and a demonstrated ongoing commitment to high quality care is necessary to prevent further loss of life. It is for this reason prudent to consolidate Lifestyle Solutions plan into a formal recommendation.

115. Quite apart from the operation of Lifestyle Solutions, the tragedy of David's death also calls for sincere consideration of whether there are further systemic improvements that can be made to strengthen the support available for vulnerable people battling substance abuse issues in the context of the criminal justice system.

116. It is apparent that there remains an urgent need for governments to create more placements in residential rehabilitation centres throughout NSW that will take patients with mental health issues or who have a history of violence. While there is sometimes a view expressed within the sector that only motivated people will succeed, more research also needs to be done into ways of working with the ambivalent client. These issues are well known to any person working within the criminal justice system. On a daily basis our courts are informed about the lack of availability for structured residential care.

117. There have been frequent calls to expand residential rehabilitation services in NSW and yet the problem remains. Part of the reason David ended up at Tarlo IRS was because, despite Chris Brown's extensive efforts, nothing else could be found. I urge the NSW Department of Health to address this long standing gap within our health system as a matter of urgency. I was informed during closing submissions that this is an issue that NSW Health has previously considered. NSW Health was not represented at this inquest and has therefore not had notice of any proposed recommendations. Nevertheless, the issue is too important to disregard. I therefore intend to recommend that Southern NSW Local Health District liaise with the appropriate person at NSW Health, in order to provide a copy of my findings and to ask that urgent consideration be given to the need for increased capacity for residential drug and alcohol rehabilitation beds in NSW. This is particularly for places that are suitable for patients exiting the criminal justice system with a history of aggression, ambivalent response to treatment or known lack of insight, and for patients with a mental health diagnosis.

Conclusion

118. David's death was a terrible tragedy. It affected his family and many of the staff who had cared for him at Tarlo IRS. His death was preventable. Had he been placed in an appropriate and secure environment, without access to Schedule 8 drugs, he may be alive today. Once again I offer my sincere condolences to David's parents and their respective families. I thank Christine Micallef, in particular, for her brave participation in this inquest and for her courage in shining a light on the deficiencies of the system existing at the time of David's tragic death.

Findings pursuant to section 81 *Coroners Act* 2009 (NSW)

The findings I make under section 81(1) of the Act are:

Identity
The person who died was David Veech.

Date of death
David died between 19 and 20 March 2016.

Place of death
David died at 30 Cunningham Drive, Tarlo, NSW.

Cause of death
David died of Fentanyl toxicity

Manner of death
David died of an accidental drug overdose. He died after injecting liquid extracted from a Fentanyl patch. David's death occurred when he was inadequately supervised in a facility operated by Lifestyle Solutions.

Recommendations pursuant to section 82 *Coroners Act* 2009 (NSW)

To the Southern NSW Local Health District

I recommend that Southern NSW Local Health District liaise with the appropriate person at NSW Health, to provide a copy of my findings and to ask that urgent consideration be given to the need for increased capacity for residential drug and alcohol rehabilitation beds in NSW. This is particularly places that are suitable for patients exiting the criminal justice system with a history of aggression, ambivalent response to treatment or known lack of insight, and for patients with a mental health diagnosis.

To Lifestyle Solutions

I recommend that each of the changes referred to on the document headed "Systems Changes and Acknowledgements Arising from the Inquest and Agreed to by Lifestyle Solutions" be actioned according to the timetable foreshadowed.

I recommend that Lifestyle Solutions conduct an audit of Tarlo IRS in 12 months from this inquest to gauge whether lasting change and improvements in training have been achieved.

I close this inquest.

Magistrate Harriet Grahame
Deputy State Coroner
9 November 2017
NSW State Coroner's Court, Glebe