STATE CORONER'S COURT
OF NEW SOUTH WALES

Inquiry	**Inquest into the death of Terry Riordan**
Hearing dates:	26 July – 28 July 2016
Date of findings:	30 September 2016
Place of findings:	NSW State Coroner Court - Glebe
Findings of:	**Deputy State Coroner H Barry**
Catchwords:	Coronial Law; police investigation; "concern for welfare"; medical record keeping.
File number:	2015/112961
Representation:	**Ms E Sullivan assisting instructed by Ms J Geddes Crown Solicitor's Office** **Mr P Madden representing Constable F Ozols** **Mr B Longville representing Senior Constable Matheson** **Mr B Haverfield representing Commissioner of Police NSW** **Mr C Jackson representing Dr M Hartman** **Ms E Raper representing Northern NSW Local Health District** **Mr Boss representing the Family**

Findings:	**I find that Terry Riordan died on 14 or 15 April 2015 at unit 12 /5 – 9 Norton Street Ballina from multi drug toxicity as a result of ingesting methadone and amitriptyline. I am unable to make a finding that the drugs ingested by Terry Riordan were with the intention of ending his life.**

I have been assisted in the writing of this decision by Ms Sullivan's excellent written submissions.

INTRODUCTION

THE INQUEST

1. The role of the Coroner as set out in s.81 of the *Coroner's Act 2009* (the Act) is to make findings as to:
   (a) the identity of the deceased
   (b) the date and place of the person's death
   (c) the physical or medical cause of death; and
   (d) the manner of death, in other words, the circumstances surrounding the death.

2. This primary focus of this inquest is the manner of Terry's death and the care and treatment Terry received from health professionals prior to his death, and the response of the NSW Police Force in relation to a 'concern for welfare' call following a telephone call from Terry's mother on the evening of 14 April 2015.

BACKGROUND

3. Terry Riordan was 45 years old when he died. He was found deceased on the morning of 15 April 2015 at his home in Ballina.

4. He had a long history of mental health issues and medical problems and for some period before his death his health had been deteriorating. He suffered from seizures in the three years prior to his death and there had been periods of admission into psychiatric facilities for depression.

5. Terry was known to be an abuser of prescription medication and was often seen to be under the influence of drugs.

6. In January 2014, Terry was the victim of a serious home invasion in which he sustained a blow to the head from an axe. Following that event his

mental health deteriorated further. In addition, he lost weight and became paranoid.

7. In November 2014, Terry was charged with assault occasioning actual bodily harm against his partner and at the time of his death he was required to report daily to police as a condition of bail. He was due to attend court for sentencing in relation to that matter on 23 April 2015, and had expressed concerns to a number of people about the possibility of a gaol sentence.

8. Terry had two brothers, Michael who is two years older and John who is nine years younger. He was close to his mother and his brothers and was Michael's best friend.

9. As a young man, Terry attended Ballina High School and was a talented football player. At age 18 years he became a player with the South Sydney Juniors football Team. Sadly, his promising career was ended by an assault which resulted in a skull fracture, leading to the onset of depression.

10. A child, Jack, was born to Terry and his then partner in the late 1990s. Terry later commenced a relationship with Michelle McLennan. Michelle had a younger daughter, Tiarna, from a previous relationship. Terry and Michelle had two children together: Tyler in 2002 and Misty in 2008. Their relationship lasted about 16 years but was plagued by domestic violence abuse by both partners.

11. Terry's mother, Mrs Edge, gave a statement to the court. She described Terry as a good and loving father. She further described Terry's close bond with his brothers and his kindness to his family and to people he hardly knew. Mrs Edge described Terry as having a "heart of gold".

12. Following his death, Mrs Edge stated that she had been approached by a number of people who attested to Terry's kindness. These were people

who were often homeless and told her how Terry had offered them a bed in his house and food until they were able to re – establish themselves.

13. After the assault in January 2014, Mrs Edge stated that Terry never really recovered and his life changed. Terry's mother and family are left with an overwhelming sense of loss and sadness.

Autopsy and Cause of Death

14. As to cause of death, the Court had the benefit of the:
    (a) Autopsy report by Dr Rexson Tse and Professor Tim Lyons dated 20 May 2015 and a supplementary report by Dr Rexson Tse and Professor Tim Lyons dated 22 June 2015; and
    (b) Report of toxicologist Professor Alison Jones dated 3 June 2016.

Autopsy report of Dr Rexson Tse

15. Dr Tse opines that the direct cause of Terry's death was "mixed drug toxicity". He noted that the toxicology screening showed a range of prescription medication including:
    (a) amitriptyline (a tri-cyclic anti-depressant – 1.2mg/L);
    (b) citalopram;
    (c) opioids; and
    (d) benzodiazepines.

16. Whilst Dr Tse commented that the mechanism of death would be the individual and synergistic effect of the drugs on the central nervous system, he considered that the relative contribution of each drug to the death could not be determined with "absolute confidence" by autopsy. Dr Tse stated that a forensic toxicologist ought to be consulted to interpret the specific toxicological results.

17. Dr Tse otherwise noted that there were no natural disease processes recognised during the autopsy. He also observed no marks or injuries such as to indicate any third party involvement.

Toxicology Report of Professor Alison Jones

18. Professor Jones interpreted the results of the toxicology post-mortem blood screening as follows:

    (a) amitriptyline (1.2mg) and nortriptyline (0.62mg) as in the "toxic and potentially fatal ranges";

    (b) citalopram (0.11mg/L) as in the therapeutic range;

    (c) diazepam (0.41mg/L) and nordiazepam (0.34mg/L) as in the therapeutic range;

    (d) oxycodone (0.21mg/L) and oxymorphone (0.006mg/L) as representing "therapeutic or supratherapeutic blood concentrations (i.e. dosing just above the top of the normal therapeutic range) but not fatal concentrations";

    (e) temazepam (0.02mg/L) as representing subtherapeutic levels (being a metabolite of the diazepam ingested); and

    (f) methadone (0.62mg/L) as in the "potentially fatal range".

19. The presence of THC (0.004 mg/L) and THCA (0.036mg/L) was also noted, with the concentration suggesting the recreational use of cannabis by Terry.

20. Professor Jones opined that Terry's death "occurred due predominantly to a combination of overdose of amitriptyline and methadone". In her view, it was the combination of the two drugs, namely amitriptyline in the toxic and potentially fatal range, and methadone, being in the potentially fatal range, that would have caused profound respiratory depression and coma. More specifically, Professor Jones stated:

"In the case of amitriptyline, cardiac arrhythmias are an additional potential cause of death and the risk of this is exacerbated by hypoxia due to any respiratory depression. In my view, either the overdose of methadone alone, or the overdose of amitriptyline alone in Mr Riordan could potentially have caused death. In combination, they were much more likely to cause death than either drug alone."

21. Professor Jones also noted that the presence of diazepam and oxycodone in therapeutic doses would be expected to have contributed to Terry's respiratory depression and coma, "but in isolation would not have caused death at these doses". Similarly, while citalopram at a therapeutic dose might have contributed to the risk of death after the amitriptyline overdose, "it would not have caused death in its own right" given the particular concentration.

22. Professor Jones opined that the timing of the overdose of amitriptyline and methadone is difficult to assess given the time of ingestion is unknown. However, the presence of active metabolites of a number of the drugs indicated that Terry was "alive for at least a few hours after ingestion of the overdose", such that his liver could metabolise the drugs.

23. Additionally, Professor Jones commented that the "snoring" reported by police attending Terry's unit on the evening of 14 April 2015 "probably represented" his obstructed and laboured breathing after the overdose, although she could not exclude it as a simple snore.

24. Ultimately, Professor Jones concluded that the most likely time of death was "sometime in the early hours of the morning of 15 April 2015".

25. Based on the uncontested and clear expert reports of Dr Rexon Tse and Professor Alison Jones, there would seem no doubt that Terry died from multiple drug toxicity, and that the death was predominantly due to a combined overdose from amitriptyline and methadone (although either drug alone could have been responsible for Terry's death).

26. The methadone was illegally obtained by Terry without prescription. The circumstances in which it may have been obtained were explored during the inquest, following numerous investigations by the officer in charge. Ultimately, however, that matter could not be elucidated, given the label on the bottle had been tampered with.

27. The amitriptyline was prescribed to Terry by his GP, Dr Hartmann on a regular basis during the period 2014 to 2015, The last was on 13 April 2015 during his final consultation with that doctor. The prescription (of 50 tablets), together with a prescription for other medication (namely Oxycontin (28 tablets) and diazepam (50 tablets)) was dispensed by a pharmacy in Ballina that same day.

MANNER OF DEATH

28. In his oral evidence, Detective Senior Sergeant O'Reilly, believed that Terry self-ingested the medications on which he had overdosed and there were no suspicious matters surrounding the death.

29. The evidence of Dr Tse was that there were no marks or injuries such as to indicate any third party involvement in the death and similarly, the evidence of Senior Constable Gary Kennedy of the Lismore Crime Scene, (Forensic Services), who inspected Terry's unit closely, photographing each room in detail, formed the view that "there were no indications of suspicious or unusual circumstances or trauma" in relation to Terry's death.

Did Terry intend to take his own life?

30. Suicide may not be presumed – it must be proven by evidence. Further, it is generally accepted that before making such a finding, the *Briginshaw (Briginshaw v Briginshaw (1938) 60 CLR 336)* standard of clear, cogent and exact proof of evidence ought to be applied.

31. There are undoubtedly some references in Terry's medical records to him having had periods of suicidal ideation – for example:

(a) Dr Hartmann, in his statement, states that Terry talked about suicide many times.

(b) In a record dated 9 March 2015, Terry told the Mental Health Assessment Line that he had attempted suicide in November 2014 by crashing his car and that no one knew of the attempt; he also reported ongoing suicidal ideation.

(c) A note dated 28 March 2015 (from Lismore ACS) records the following:

> *"The client reported regular suicidal ideation. "If I could wake up dead tomorrow …", with some recent vague planning including cutting wrists and shooting self. Denied access to firearms but reported "I could find them if I want to." Has been resisting so far from acting on these thoughts, however is concerned that its becoming more difficult. Currently ambivalent intent. Client reported that risk is likely to escalate if sent to jail. "If sent to jail I would try to kill myself …".*

32. That record also refers to an attempted suicide in 1984 by "jumping";

33. Additionally, in February 2015, Terry's cousin Wayne recalled Terry stating that he felt like driving his car into a tree as he did not want to go to gaol. Mr Les Coulstock who gave evidence at the inquest said that he saw Terry the night before he died, and that Terry "had had enough" of what was going on in life, and wanted to end it. Some doubt may attend Mr Coulstock's recollection of events, given that he and Terry had evidently had an argument in the weeks prior to Terry's death; Mr Coulstock's statement was some 10 months after the event (being obtained in February 2016); and certain details that he gave evidence about did not accord with other objective evidence.

34. There is considerable evidence to suggest that it was not Terry's intention to take his life as at 14 April 2015. One or two days prior to his death, Terry visited Shanen Craig in the same unit complex as his own; on this occasion, she described him as "drinking spirits straight from the bottle" and "eating his Oxycontin like skittles". She also stated:

> *"Terry was really worried about going to gaol. I don't know what for but he didn't want to go to gaol. Terry told me he had a plan to take pills, ring the ambulance to say he was going to kill himself and get taken to the Richmond Clinic so he wouldn't go to gaol." In response, Ms Craig told him that he was mad and could not be sure he would survive, to which he responded – "I've done it before. I know what I'm doing".*

35. There is no doubt, as the evidence reveals, that Terry was becoming increasingly forgetful and was "chaotic" in relation to managing his medication. It is conceivable that he may have forgotten that he had previously ingested amounts of amitriptyline and methadone. Notably, Terry's brother Michael had seen Terry during the day of 14 April 2015 and found him "off his gut on medication", with others such as Dylan Mott and Phillip Flood observing him behaving strangely also. In such circumstances, Terry's capacity to recall what medication he had previously ingested would likely have been significantly compromised.

36. There was other medication found in Terry's unit that he could have taken to attempt to ensure a fatal overdose – for example, a further blister pack of endep (amitriptyline) with only five tablets missing.

37. Mrs Edge gave evidence that Terry had never expressed any thoughts of suicide and that she did not believe that he had intentionally overdosed on medication.

38. No suicide note was left and on 30 March and 6 and 8 April 2015 when the AT service called Terry to check on his welfare, he reported no suicidal ideation or thoughts of self-harm.

39. In Dr Hartmann's statement he said that during the consultation on 13 April 2015 (being Terry's last contact with any medical or mental health service), he did not express any suicidal ideation (although it is noted that Dr Hartman referred him to the Ballina Mental Health Team on that date, the referral noting that Terry "*feels he is not coping with his current situation*").

40. Dr Wilson opined in her Report dated 7 June 2016:

"I suggest that in the hours and days before his death Mr Riordan was highly distressed and looking for relief from his emotional pain and that as a result, he took a large amount of amitriptyline as well as methadone. This lead to increasing side-effects, which could have included confusion, hallucinations, respiratory depression and resulted in his death.

41. On the material available, I am not satisfied that there is sufficient evidence to be reasonably satisfied that Terry intended to take his own life.

Care & Treatment Provided By Richmond Clarence Network Acute Care Services (RCNACS)

42. On 9 March 2015, Mrs Edge contacted the Mental Health Assessment Line to raise concerns about Terry; he was then triaged by a specialist over the phone; there was further follow up with Mrs Edge that evening.

43. On 12 March 2015, Terry was booked for a mental health assessment but Mrs Edge telephoned to change the date to 16 March 2015.

44. On 16 March 2015, Terry was seen by clinical nurse specialist RN Vaughan Beek for a mental health assessment; his complex personal and medical history was noted; the initial management plan included contacting Terry's GP (Dr Hartmann) and a review by Dr Rose (psychiatric registrar) at Lismore Community Mental Health Service; at this time, Terry was a client under the care of the Assessment Team;

45. On 18 March 2015, RN Beek spoke with Dr Hartmann to advise him of Terry's contact with Mental Health Services and of the planned review by Dr Rose (on 19 March 2015).

46. On 19 March 2015, Dr Rose, psychiatric registrar, reviewed Terry for approximately 40 minutes. Terry attended that appointment with his mother. Prior to the meeting, Dr Rose reviewed Terry's notes from his earlier contact with the Mental Health Assessment Line team. Dr Rose stated in oral evidence that Terry told her about his medication regime, and that he was "nodding off" periodically. He requested medication to help him sleep, though she was concerned that he was already taking too much sedating medication. She believed that the addition of a sedative, given the level of sedation that she observed would be potentially dangerous.

47. Dr Rose questioned Terry about any thoughts of suicidal ideation or self – harm. He denied any such thoughts. She determined that Terry was not "mentally ill" within the meaning of the *Mental Health Act.* A voluntary admission was proposed in order to review his medication and for diagnostic purposes.

48. Terry declined this suggestion and became "agitated". She was able to "de-escalate" the situation, but despite her best efforts and on raising again the suggestion of voluntary admission, Terry again became agitated and the interview concluded.

49. In her oral evidence, Dr Rose confirmed her impression that Terry had developed oxycontin and valium dependence with secondary effects of anxiety and panic attacks. Her treatment plan was as follows:

- Voluntary inpatient care for diagnostic clarification and medication review

- No change to his medication regime until there was a clear picture of longitudinal mental state - due to his level of sedation she was concerned about providing anything that could sedate him further.
- A safety plan was created with Mrs Riordan which she agreed to. Mrs Riordan was to contact emergency services if she became concerned for Terry's safety.
- Terry was to continue interactions with the pain clinic.
- A recommendation was made for the engagement of a psychologist to support Terry to deal with numerous psychosocial stressors and to encourage him to consider a medication review via a referral through Terry's GP.
- A note "Please contact GP with concerns of prescription medication dependence and the possible usefulness of same", was left as a request for an AT staff member to make contact with the GP to discuss Terry's prescription medication.

50. On 24 March 2015, RN Burns telephoned Dr Hartmann who confirmed he would see Terry regularly and accepted the transfer of care following discharge from the ACS.

51. On 29 March 2015, RN Martin Gallagher contacted Terry, (who was not keen to talk), and reported that he hadn't slept for seven days. A note records: "*Little point in pushing this man @ present – try again tomorrow*";

52. On 30 March 2015, RN Beek telephoned Terry. Terry was apparently having a better day and denied suicidal ideation or thoughts of self-harm.

53. On 3 April 2015, RN Burns attempted to contact Terry on his mobile twice and both calls were unanswered.

54. On 6 April 2015 – RN Burns spoke with Terry who was at home resting; he had no thoughts of self-harm or suicidal ideation but did not think the Cipramil Dr Hartmann had prescribed was helping.

55. On 8 April 2015 – RN Burns telephoned Terry to follow up. Terry denied thoughts of self-harm or suicidal ideation, although his mood continued to be up and down. He was happy to be discharged from the service at that stage. He said he had the phone numbers for the Mental Health Assessment Line and Lifeline and would contact them as required.

56. On 13 April 2015, Dr Hartmann wrote a referral to the Ballina Mental Health Team (which was faxed to the Lismore ACS that day) stating:

"*Thank you for getting involved in the care of Terry Riordan with a long history of mood and social problems. He feels he is not coping with his current situation."*

57. Later that day, around 2.30pm, Terry's case was discussed at an ACS team review meeting. The notes recorded that the plan was for Dr Rose to liaise with Terry's GP (Dr Hartmann) but that he was not to be accepted for care by the Assessment Team at that time.

58. It is evident from the documented contact and attempted contact with Terry between 9 March 2015 and 13 April 2015, that numerous attempts were made by RCNACS to provide Terry with mental health support and to ensure that when he was discharged from the service. Terry's care was then to be assumed by his GP.

59. In her oral evidence, Dr Rose presented as a careful and considered witness. She was evidently concerned about Terry's welfare and wanted him to be admitted to hospital in an attempt to assist with issues relating to his medication and also for diagnostic purposes – he was not amenable to this course. Dr Rose's clinical notes are detailed and clear (extending over four pages), and set out her observations and impression of Terry, as well as a proposed treatment plan. The notes also record her willingness to further assist if required.

60. The only matter arising with respect to the care provided by RCNACS was the basis upon which a determination was made at an informal ACS Team review meeting on 13 April 2015 for the Assessment Team to defer accepting the care of Terry in response to Dr Hartmann's referral of the same date, given a note in the 'mental health acute care book' on that date which stated: *"Dr Rose will liaise with GP. Not for ACS. On board for p/c Dr Rose 1/7."*

61. Registered Nurse Coleman, who attended the meeting on that date, stated that there was discussion about the referral at the clinical team meeting. She noted that from the referral, there was no indication that Terry was "acutely unwell or at imminent risk". She also noted that Terry had been discharged from the ACS after a period of care from 9 March to 8 April 2015. The clinical team accordingly made the decision that it was "unlikely" that Terry required further input from the ACS at that time. RN Coleman further stated:

"This decision was based on recent contact with Mr Riordan that indicated he had ongoing engagement with his GP, expressed a plan to organise a Mental Health Plan through his GP to see a psychologist, had not expressed suicidal ideation and was aware of how to access services as required."

62. RN Coleman also referred to Terry's interview with Dr Rose on 19 March 2016, at which time Terry had declined inpatient admission.

63. At the meeting, it was also proposed that Dr Rose would contact Dr Hartmann to liaise with him.

64. Dr Rose gave evidence at the inquest and did not recall attending this meeting on 13 April 2015 because of other clinical commitments. However, she was later contacted by a colleague who asked her to speak with Dr Hartmann to clarify the referral. On 14 April 2015 Dr Rose was unable to do so due to her workload (and a note was entered in Terry's medical records confirming this). On 15 April 2015, however, Dr Rose

attempted to contact Dr Hartmann, but he was unavailable (as stated on his automated voicemail system).

65. In circumstances where (as stated by RN Coleman) there was no clear urgency or crisis apparent from Dr Hartmann's referral (which was faxed to the ACS, in contrast to the patient presenting at the hospital with the referral) -,and against the background of Terry's somewhat limited engagement with the service during March, coupled with the plan for Dr Rose to make contact with Dr Hartmann to clarify the basis of the referral, the decision to defer accepting Terry into care on 13 April 2015 and to follow up with Dr Hartmann appears both reasonable and appropriate.

THE RESPONSE OF NSW POLICE

'Concern for welfare call'

66. An issue explored at the inquest was the response of officers from the NSW Police Force to Mrs Edge's "concern for welfare" call on the evening of 14 April 2015.

67. Sometime in the evening on 14 April 2015 – Senior Constable Danielle Ford reviewed the automated bail reporting system (ABRS) and noted that Terry had not yet reported to Ballina Police station, which was "unusual" as he would generally report in the morning; she telephoned Michael Riordan (Terry's brother) to explain her concern about him reporting; Michael said he would notify his brother.

68. Prior to 9.12pm, Mrs Edge telephoned Ballina Police Station and spoke with Constable Fiona Ozols stating that she was concerned that her son had not reported for bail and requesting police to check on him; she said that she told Constable Ozols that Terry had had a bad day, had been to the doctor and his medication was being changed and conveyed information which formed the basis of the CAD message recorded as:

Terry Riordan resides at location, inft is the mother of POI, POIs brother has attended location trying to raise POI, without success, however can hear someone inside unit. POI resides at location by himself. POI has been a bit depressed lately, inft concerned for POIs welfare."

69. The message was created at 9.12pm and given a priority '3' by Senior Constable Ford. The only source of the information for the job was Constable Ozols, who conveyed the information to Senior Constable Ford, likely in the form of a note (given Mrs Edge's phone number was recorded in the CAD informant details). Constable Ozols gave evidence that she had requested that Senior Constable Ford put the job onto CAD to ensure she did not forget it.

70. At around 9.13pm VKG (police radio) broadcast the concern for welfare job;

71. Between 10.53 and 10.57 pm – Senior Constable David Matheson and Constable Ozols attended Terry's unit (12/5-9 Norton Street). They walked up the stairs to the unit and knocked on the front screen door. There was no response to the knocking, nor to the call "Terry". Senior Constable Matheson then walked to the glass sliding door (that opened into the dining kitchen area) which was open. He called out again – "Terry it's the police". The officers could hear someone snoring. The officers then walked in through the glass door to the hallway, remaining there for around 30 seconds. During this time, consistent breathing and snoring was heard. Senior Sergeant Matheson told Constable Ozols: "He is breathing. We are not going to wake him up".

72. Later, Senior Constable Ford was advised by one of the attending officers that Terry was asleep at home; she confirmed with her supervisor, Sergeant Craig Norton that "no formal action [was] required" regarding Terry's failure to report.

73. At 3.31am, Senior Constable Matheson entered the following "action text" into CAD:

"POI ASLEEP IN HIS BED, POLICE COULD HEAR THE POI SNORING".

74. At 5.06am, Sergeant Craig Norton verified the CAD message relating to the concern for welfare job, considering the action taken by responding police to be appropriate.

75. At some time prior to completing her shift at 6.00am, Senior Constable Ford entered the following into the ABRS system:

"FTA [Fail to attend] – POI observed by police during CFW check to be asleep in his unit, POI has recently changed medications".

76. At 8.45am, Mrs Edge called '000' to raise the alarm about finding her son apparently deceased.

77. At 8.51am, Paramedics from the NSW Ambulance Service attended the scene, finding Terry "*deceased on examination*".

78. During the hearing, there was a factual issue about the content of Mrs Edge's telephone call with Constable Ozols, which formed the basis of the CAD message created by Senior Constable Ford at 9.12pm.

79. Ultimately however, there is no need to resolve the precise terms of the conversation, there being no doubt on the basis of the CAD narrative that Mrs Edge conveyed that she was concerned about the welfare of her son Terry, and requested that police check on him.

80. There was tension in the evidence as to the nature of the 'job' Constable Ozols and Senior Constable Matheson understood they were attending relative to the contemporaneous documentation relating to Mrs Edge's 'concern for welfare' call.

81. It was the clear position of both officers that they were never attending a ‘concern for welfare’ job, but rather checking on Terry because of his breach of bail. Constable Ozols gave evidence that she believed she was assisting Terry to report with bail, while for his part Senior Constable Matheson understood that he was attending the premises at Norton Street to see if Terry was there and to speak with him in relation to failing to report. Additionally, both officers gave evidence that they never saw the ‘concern for welfare’ CAD job created by Senior Constable Ford until after Terry’s death, nor heard the broadcast of the ‘concern for welfare’ job by VKG some- time around 9.13pm. In oral evidence, Sergeant Norton stated that he had heard the VKG broadcast of the job and knew that a Ballina car crew was attending – he thought the nature of the job was “following up on bail conditions”. Consistent with the officers’ stated understanding of the job, after attending, Senior Constable Matheson also consulted Sergeant Norton in relation to taking no action for Terry’s breach of bail and an entry confirming this was entered onto the ABRS system by Senior Constable Ford.

82. In contrast, the CAD job created by Senior Constable Ford at 9.12pm on 14 April 2015 (based on her “interpretation” of information given to her by Constable Ozols from the conversation with Mrs Edge) made no reference to checking on Terry for breach of bail and was put as a ‘concern for welfare’ job.

83. Little turns on this discrepancy. Both officers attending the premises were concerned not to wake Terry, being fearful of a possible violent confrontation.

84. Senior Constable Matheson knew Terry to be into drugs, and that he could be violent. He was also aware of warnings on the system relating to Terry (which included a mental health warning, an ‘approach with caution’ warning and also reference to Terry having a ‘level of resistance’ (striking and kicking [at police]). Finally, he was also aware that Terry was a victim of a violent home invasion in 2014.

85. Constable Ozols was also familiar with Terry, having known him during her three years of service at Ballina Police Station. She had seen him sometimes appearing dishevelled and drug affected (slurring his words). Notably, she was also involved in the investigation of the home invasion incident in January 2014.

86. Constable Ozols gave evidence that she was concerned that it was "*extremely likely*" they would be injured if Terry awoke, while Senior Constable Matheson told the Court he believed there would be a violent confrontation.

87. Indeed, Mrs Edge told the Court that since the serious assault and home invasion in January 2014 (about which both officers were aware), Terry had become paranoid and was sleeping with weapons. It is also noted that Michael Riordan, Terry's brother, was apparently reluctant to go into Terry's unit on the evening of 14 April when he went upstairs to remind him about reporting for bail, due to personal violence incidents.

88. I find the decision not to wake Terry was justified, given the time of night, and the officers' knowledge of Terry and the recent home invasion.

89. In the circumstances, it follows that even if (contrary to their evidence) Constable Ozols and Senior Constable Matheson believed they were attending a concern for welfare, they would have been unlikely to have woken Terry and checked on his physical well-being.

90. Moreover, even assuming the officers were attending a concern for welfare check on Terry at this time, the evidence is that Terry was alive and breathing (both Constable Ozols and Senior Constable Matheson hearing his "regular snoring" or rhythmic breathing). As noted above, the officers would clearly have been concerned not to wake Terry, for reasons that appear justified.

91. Both Senior Constable Matheson and Constable Ozols conceded that absent sighting Terry, they could not be sure that the snoring/breathing they heard was in fact him.

92. Both officers assumed that it was Terry who was snoring. This assumption was based on the knowledge that Terry lived alone. It was also believed that Terry was unlikely to have absconded and it was therefore unlikely that someone else was asleep in his room.

93. In addition Constable Ozols was concerned about the power police had to enter Terry's unit, there being no intention to arrest Terry.

94. Senior Constable Matheson stated that they entered the unit "*in good faith*".

95. Section 9 of the *Law Enforcement and Responsibilities Act 2002* confers on police the power to enter premises in emergencies if the police officer believes on reasonable grounds that…

> *(1)(b) a person has suffered significant physical injury or there is imminent danger of significant physical injury to a person and it is necessary to enter premises immediately to prevent further significant physical injury or significant injury to a person.*

96. Attending officers believed they were attending neither an emergency nor a concern for welfare check. Even if they had been of that belief, on hearing the snoring, they were justified in leaving the premises. Their evidence is clear; they attended in order to assist Terry with his bail obligations and any continued presence, when a decision had already been made not to affect an arrest, would have been unlawful.

The decision to take no action concerning the breach of bail

97. As set out in Detective O'Reilly's statement and confirmed in his oral evidence, in dealing with a breach of bail, officers are trained to take into account four key matters, based on the facts as known to them – namely:

(a) The relative seriousness or triviality of the failure;

(b) The personal attributes and circumstances of the person such as cognitive, mental or physical impairment;

(c) Whether the person has a reasonable excuse for the failure; and

(d) Whether an alternative action to arrest is appropriate in the circumstances.

98. Officers then have six options to deal with an identified breach of bail – namely: 1) take no action; 2) issue a warning to the person: 3) issue a notice to the person requiring the person to appear before an authorised justice; 4) issue a court attendance notice; 5) arrest the person without warrant and take the person as soon as practicable before a court or authorised justice; or 6) apply to an authorised justice for a warrant to arrest the person.

99. The training module relating to the new bail legislation underscored that the action police choose in dealing with a breach of bail should be relevant to what bail is there to mitigate and is connected to the notion of "unacceptable risk". An emphasis was placed on the fact that: "Arrest is not the only option when you detect someone breaching their bail". Moreover, a failure to comply with the conditions of bail does not constitute an offence.

100. Records confirm that both Senior Constable Matheson and Constable Ozols had completed the on-line training modules relating to the new approach to bail (including breach of bail).

101. It was the evidence of both Constable Ozols and Senior Constable Matheson that there was never any intention to arrest Terry for his failure to report for bail, having regard to the following matters:

(a) Terry was known to be forgetful in reporting for bail, sometimes attending four times a day;

(b) The victim of Terry's alleged offence was incarcerated;

(c) Terry's prior reporting history was "relatively good";

(d) Terry's residence was known to police and it was not believed he was a flight risk (Constable Ozols' evidence was that she did not believe he would leave town given his family ties to the area).and

(e) It was known that Terry had drug and alcohol issues (Terry would often appear dishevelled and at times drug affected, slurring his words) and that he was medicated (Senior Constable Matheson gave evidence that Terry would sometimes refer to this when reporting for bail).

102. I find the decision of the officers to take no action in response to the breach of bail to be appropriate in the circumstances.

103. Terry's failure to report was discussed by Senior Constable Matheson with Sergeant Craig Norton, the shift supervisor at Ballina Police station on the evening of 14 April 2015. Sergeant Norton understood that the officers had entered Terry's unit, seen him asleep and heard him snoring. In oral evidence, Sergeant Norton told the Court that he had formed the impression from what he was told that the officers had sighted Terry. He now understood they did not do so, but nonetheless considered their actions to be appropriate. Sergeant Norton also understood that the officers had decided not to wake Terry given the late hour, possibility of intoxication and potential for unnecessary conflict. Determining to take no action was a course with which Sergeant Norton agreed given that Terry was still in Ballina and there was no indication he would fail to appear for court. Sergeant Norton was also aware of Terry's background, which

included the issue of previous warnings arising from his attending late or on incorrect days. Sergeant Norton believed this was a result of his drug and alcohol abuse. Additionally, in oral evidence, Sergeant Norton stated that taking Terry into custody "may have caused more issues".

The priority given to the job relating to Terry

104. Four officers were working on the evening shift at Ballina Police Station from 6pm to 6.30am – namely, Senior Constable Danielle Ford (on station duties), Sergeant Craig Norton (as the supervisor), and Senior Constable David Matheson and Constable Ozols as the response crew (in Alstonville 18).

105. Concerns were expressed by the representative of Terry's family to the effect that whilst the "job" concerning Terry was entered into CAD around 9.12pm, the officers did not attend Norton Street until 10.53pm (approximately 1 hour and 40 minutes later). Terry's residence is located some 150 metres from the Ballina Police Station. The job was given a priority 3 categorisation by Senior Constable Ford, which both Constable Ozols and Senior Constable Matheson thought was appropriate.

106. Constable Ozols gave evidence that at the time of the entry concerning Terry, she was involved in a serious matter involving the preparation and service of a Provisional Apprehended Domestic Violence Order in which the defendant was threatening to kill the victim. After completing that task, police attended Terry's residence. This was a question of police prioritising jobs and resources and I do not find that police responded inappropriately in the circumstances.

CARE & TREATMENT PROVIDED BY DR MARTIN HARTMANN

107. Dr Hartmann, a medical practitioner for the last 25 years, provided a statement to police dated 20 July 2015. He had been Terry's treating GP for 17 years (since 1998). During that time, Dr Hartman stated that Terry had battled depression and substance abuse issues and had talked of

suicide many times, although he was not aware of any attempts at suicide.

108. Dr Hartman described Terry's substances of choice as alcohol and THC and believed Terry to be "very compliant" with medications prescribed.

109. A "permanent feature" of Terry's life as noted by Dr Hartmann was "violence" – he was regularly in conflicts with people involving physical violence. In the weeks prior to his death, Dr Hartmann stated that: "Terry was going through a particularly difficult patch with violence and depression in association with his wife".

110. The last occasion Dr Hartmann saw Terry on 13 April 2015, he stated:

> *"He was lucid and rational and showed no sights of intoxication. He was upset about the situations he was facing with regards to his wife (in gaol) and children (in foster care). Terry did not express any suicidal ideas to me though. I prescribed Endep 100 mg nocte as well as his regular Oxycontin 40 mg (28)."*

Report of Dr Hester Wilson (07/06/2016)

111. Dr Hester Wilson prepared a report for the purposes of the inquest, and also gave evidence. Dr Wilson is a general practitioner with 26 years of clinical experience, including in general practice, mental health and addiction medicine working in both primary and specialist settings. Dr Wilson has a Masters in Mental Health, and a speciality in the practice of addiction medicine.

112. At the outset, Dr Wilson noted in her report the challenging nature of Terry's presentation, stating:

> *"Mr Riordan's history of complex multi-morbidity on a background of significant social, financial, family and interpersonal impairment. He was noted to suffer a number of mental health issues including*: depression,anxiety,panic attacks, bipolar disorder, *personality disorder,*

antisocial traits, psychotic symptoms, recurrent suicidal ideation, threats of self-harm, and three past suicide attempts.

He had a significant drug and alcohol history including methamphetamine use, amphetamine use, cannabis use, prescribed opioid dependency, prescribed benzodiazepine dependency and hazardous alcohol use …".

113. In addition, Terry had a number of physical issues including chronic back pain, shoulder pain, jaw pain and migraines.

114. Notwithstanding the complexity of Terry's health conditions, Dr Wilson's report raised a number of concerns in relation to Dr Hartmann's treatment of Terry, primarily being as follows:

(a) The adequacy of Dr Hartmann's consultation notes, which Dr Wilson considered to demonstrate little evidence of comprehensive assessment, diagnosis and treatment planning, or the documenting of objective treatment outcomes;

(b) A potential failure to consider that Terry might have been at risk from multiple psychoactive and sedative medications;

(c) A potential failure to take particular steps (such as contacting the PBS prescription shopping hotline, registering Terry with the NSW Pharmaceutical Unit as a dependent person, or complying with s. 28 of the *Poisons and Therapeutic Goods Act 1966*) when prescribing medication to him;

(d) An apparent failure to record any suicide risk assessments that may have been undertaken;

(e) The apparent lack of referral of Terry to specialist teams (such as a specialist pain team or the local drug and alcohol team) to case manage his needs;

(f) The circumstances in which some prescriptions were prescribed to Terry, including the authorization of some scripts via telephone, and

(g) The basis for prescribing Terry:

i. multiple anti-depressants concurrently in March 2015 (that is, Citalopram, Amitriptyline and Doxepin);and

ii. two benzodiazepine medications (Oxazepam and Diazepam) and also the long-term use of that medication;

115. A number of measures could have been taken by Dr Hartman to address Terry's complex medical presentation including:

(a) Consulting a psychiatrist for a review of Terry's medication (given that he was evidently having difficulty finding an effective anti-depressant, prescribing them concurrently and also engaging in 'off' label prescribing); notably, Medicare includes an item number for such consultations;

(b) Referral to a drug and alcohol service - although it must be appreciated that Terry may have been unlikely to engage with such a service, it is not apparent that Dr Hartmann ever considered this option or offered it to Terry;

(c) Referral to a pain specialist to deal with Terry's many ongoing physical issues causing apparently chronic pain issues, requiring medication; and

(d) Preparing a detailed mental health care plan for Terry that included referral to a psychologist for psychological support.

116. Dr Hartman's referral of Terry to the Ballina Mental Health Team on 13 April 2015, the basis for him doing so falls short on adequate explanation. The evidence of both Dr Andrea Rose (psychiatric registrar) and also Dr Wilson, however, was that the referral contained little useful information and gave little description of the assessment or indication as to Terry's current state of risk.

Poor prescribing practices

117. Dr Hartmann's approach to prescribing medication for Terry appears to have been ill-considered, and was not apparently informed by current guidelines as to prescribing of drugs of dependence, particularly with respect to benzodiazepine and opioid medication (as noted in Dr Wilson's report).

118. Dr Hartmann particularly seems to have failed to consider that Terry might have been at risk from the concurrent prescribing of multiple psychoactive and sedative medications. Specifically, Dr Wilson noted that:

(a) It was unclear why multiple anti-depressants were prescribed concurrently in March 2015 (that is, citalopram, amitriptyline and doxepin). The prescribing of multiple medication increases the risk of side effects and the prescription of multiple anti-depressants is best done with specialist psychiatric advice;

(b) It was also unclear why two benzodiazepine medications (oxazepam and diazepam) were prescribed concurrently or used on a long-term basis. Dr Wilson noted that there are few clinical reasons to continue benzodiazepines long term or to use them concurrently as the risks outweigh the benefits and there is an increasing move towards use of these medications for short-term use only.

(c) On 27 January 2015, Dr Hartmann also apparently failed to consider that Terry's presentation relating to difficulties with his memory may have been caused by the medications prescribed.

119. Concerns also arise in that Terry's clinical records from 2009 refer to a conversation a health worker had with Dr Hartman (on 28 July 2009) in which Dr Hartmann apparently states that he "knows Terry well", and that he is a "known poly drug abuser, benzo's, cocain, ETOH …".The note raises the prospect that notwithstanding Dr Hartmann's awareness that Terry was an abuser of benzodiazepine medication, he continued to prescribe these medications to him from 2009.

120. The basis for Dr Hartmann's prescribing of various medications is difficult to determine, given the deficient nature of his medical records, as detailed below.

Inadequate medical records

121. As set out in Dr Wilson's report, she considered Dr Hartmann's notes to be "inadequate", and that they did not meet the guidelines for good clinical practice.

122. In this regard, two guidelines were tendered into evidence, and specify the following in relation to medical records:

(a) *'*Good Medical Practice: A code of Conduct for Doctors in Australia*'* (2009):

"Maintaining clear and accurate medical records is essential for the continuing good care of patients. Good medical practice involves:

8.4.1 Keeping accurate, up-to-date and legible records that report relevant details of clinical history, clinical findings, investigations, information given to patients, medication and other management."

(b) *RACGP – Standards for general practices (4th ed)*

Standard 1.7 refers to the content of patient health records, and notes: "Our patient health records contain sufficient information to identify the patient and to document the reason(s) for a visit, relevant examination, assessment, management, progress and outcomes".

A reference to "indicators" notes that patient health records should also record (relevantly) the following, where clinically significant: date of consultation, patient reason for consultation, relevant clinical findings, diagnosis, recommended management plan, "any medicines prescribed for the patient (including name, strength, directions for

use/dose frequency, number of repeats and date medicine started/ceased/changed)", any referral to other health care providers or health services, and any special advice or other instructions.

123. Moreover, Part 4, r. 7 of the *Health Practitioner Regulation (New South Wales) Regulation 2010* also requires that practitioners keep records relating to each patient in accordance with Schedule 2. Schedule 2, clauses 1 and 2 relevantly include the following requirements:

<u>Information to be included in record</u>

…

(2) A record must include the following:

(a) any information known to the medical practitioner who provides the medical treatment or other medical services to the patient that is relevant to the patient's diagnosis or treatment (for example, information concerning the patient's medical history, the results of any physical examination of the patient, information obtained concerning the patient's mental state, the results of any tests performed on the patient and information concerning allergies or other factors that may require special consideration when treating the patient),

(b) particulars of any clinical opinion reached by the medical practitioner,

(c) any plan of treatment for the patient,

(d) particulars of any medication prescribed for the patient.

(3) The record must include notes as to information or advice given to the patient in relation to any medical treatment proposed by the medical practitioner who is treating the patient.

(4) A record must include the following particulars of any medical treatment (including any medical or surgical procedure) that is given to or performed on the patient by the medical practitioner who is treating the patient:

(a) the date of the treatment,

(b) the nature of the treatment,

(c) the name of any person who gave or performed the treatment,

(d) the type of anaesthetic, if any, given to the patient,

(e) the tissues, if any, sent to pathology,

(f) the results or findings made in relation to the treatment."

2 General requirements as to content

(1) In general, the level of detail contained in a record must be appropriate to the patient's case and to the medical practice concerned.

(2) A record must include sufficient information concerning the patient's case to allow another medical practitioner to continue management of the patient's case.

(3) All entries in the record must be accurate statements of fact or statements of clinical judgment.

…".

124. On any view, Dr Hartmann's medical records of his consultations with Terry fail to comply with the foregoing requirements.

125. Dr Hartmann was Terry's doctor from August 1998 until his death in April 2015 – some 17 years. During this period, his notes indicate that Terry attended his clinic on over 130 occasions. However, the total sum of Dr

Hartmann's clinical notes is eight handwritten pages. Some entries are comprised only of a date and a ["] (ditto) marking.

126. Further, it is apparent that the notes omit certain very significant information For example, in the last few months of Terry's life;

(a) On 10 March 2015, Terry was referred for a CT scan to exclude frontal lobe damage – neither the fact of referral, nor the results are noted in the records;

(b) On 30 March 2015, zyprexa (10mg), an anti-psychotic medication, was prescribed – the notes do not indicate why it was prescribed;

(c) On 13 April 2015, Dr Hartmann referred Terry to the Ballina Mental Health Team – neither the fact of referral, nor a copy of the referral are contained in the notes or records;

(d) On 13 April 2015, Dr Hartman prescribed oxycontin– 28 tablets, endep (amitriptyline) - 50 tablets, two repeats and diazepam – 50 tablets; only the endep was noted in his clinical notes.

127. Additionally, Dr Hartmann's statement also refers to Terry talking of suicide many times – however his notes contain two entries only in this regard in 1998 (to "death thoughts") and in 2005 ("suicidally depressed 1/12 ago"). A patient expressing suicidal ideation is a clearly significant matter that ought to have been noted on each such occasion in Dr Hartmann's clinical notes.

128. As Dr Wilson stated, while there may in fact have been very good reasons for the clinical decisions made, that is not apparent from the notes. There is no evidence that treatment plans or objective treatment outcomes were documented, discussed or acted on with Terry, a process that would have allowed for some assessment as to the efficacy of the approach, and change of treatment as needed. The records also largely fail to set out information relevant to Terry's clinical history or the particulars of

medication prescribed (other than the name and on some occasions the dose).

129. I find that Dr Hartmann's notes are grossly inadequate and for this reason and for the criticisms raised by Dr Wilson, I will refer Dr Hartman to the HCCC for investigation.

CONCLUSION

130. Information from Terry's family and other witnesses in the days before Terry's death paint a picture of what Dr Wilson describes as a "deeply unwell man, with very poor emotional regulation; cycles of intoxication and withdrawal." He was becoming "increasingly confused" and according to Dr Wilson was probably "looking for relief from his emotional pain"

131. The tragedy of this matter is that although Terry's mother and family rallied around him, they were not able to prevent his death. Mrs Edge was determined to seek assistance for Terry, contacting mental health services and accompanying him to appointments with his GP. Mrs Edge stated that after the assault in January 2014, she "slowly watched him die."

132. A number of professionals were involved in the care of Terry. The evidence reveals that staff at RCNACS managed Terry's case in a professional, appropriate and commendable manner. Dr Rose and the health professionals from RCNACS were careful and thorough in their treatment of Terry and demonstrated concern for Terry within the constraints of the *Mental Health Act* and Terry's own reluctance to fully engage with what was being suggested.

133. The police were aware of Terry's difficulties and apart from their failure to actually sight Terry on the night of 14 April 2015, their response revealed attempts to assist this man who at times was chaotic, potentially dangerous and troubled by mental illness. Senior Constable Ford,

concerned about Terry's failure to report on bail, spoke with Terry's brother Michael with a view to having Terry attend the station so he could be processed and thus avoid any anxiety. The decision to take no action on Terry's breach of bail was also a response to Terry's particular circumstances and personal attributes and demonstrated a degree of concern and compassion by the attending police at Terry's residence.

FINDINGS

134. I find that Terry Riordan died on 14 or 15 April 2015 at unit 12 5 – 9 Norton Street Ballina from multi drug toxicity as a result of ingesting methadone and amitriptyline. I am unable to make a finding that the drugs ingested by Terry Riordan were with the intention of ending his life.

Deputy State Coroner H Barry

Glebe

30 September 2016