CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Julian Horne
Hearing dates:	17-18 May 2021
Date of findings:	18 June 2021
Place of findings:	Coroners Court, Lidcombe
Findings of:	Magistrate Harriet Grahame, Deputy State Coroner
Catchwords:	CORONIAL LAW – Alcohol related death, treatment for alcohol use disorder, involuntary treatment, IDAT, Managed alcohol programs (MAPS), Assertive Community Management.
File Number:	2016/306892
Representation:	**Counsel Assisting**: Mr C McGorey of counsel instructed by Ms J de Castro Lopo, DCJ Legal **Ministry of Health and South Eastern Area Health Service:** Ms L Boyd Solicitor Advocate instructed by Ms F Read, Crown Solicitor's Office
Findings:	The findings I make under section 81(1) of the *Coroners Act 2009* (NSW) are: ***Identity*** The person who died was Julian Horne. ***Date of death*** He died on 12 or 13 October 2016.

	Place of death He died at 2/27 Ridge Street, Lawson NSW. ***Cause of death*** He died of acute alcohol intoxication. ***Manner of death*** Julian died in the context of having longstanding alcohol issues, during a severe relapse of his condition.

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Introduction

1. This inquest concerns the tragic death of Julian Horne. Julian died in his home sometime between 12 and 13 October 2016. He was 47 years of age. During the preceding six weeks Julian was taken to hospital emergency departments on more than 11 occasions. He was intoxicated and unconscious or barely conscious. On each occasion, after sobering up, he left as soon as possible, often "against medical advice". Despite some offers of detoxification, there is no evidence that he attended a drug and alcohol counsellor in the community, saw a psychiatrist or attended AA meetings during this period. Julian was aware of his options and it appears that he was left to seek treatment when he was ready.

2. Julian's death from acute alcohol intoxication came after many years of problematic alcohol use and struggle. His sister, Kirsten Campbell told the court that "he sought every imaginable way to calm that beast. CBT didn't touch the sides. Pharmacology made it worse, or just took the edge off. He tried multiple residential groups, group programs, self-help…he explored various psychiatric diagnoses...constantly in search of a way to understand himself and release himself. Despite all the relapses and damage, more than anything he wanted to be a good dad and be normal and able to provide for his family." In her view he was "just not neurotypical" and his difference became a source of enormous pain to him.

3. Julian's sister told the court that Julian was a remarkable and multidimensional man. He had a passion for learning, particularly a love of literature, poetry and philosophy. He loved music, debate and the interplay of ideas. He was a talented professional writer, competitive bike rider and a lover of nature. He also lived with deep existential anxiety which brought him unbearable pain and distress. She saw his binges with alcohol as his only way to manage the pain he felt.[1]

4. Dr Fisher, one of the doctors who had contact with Julian at Nepean Hospital over a number of years described him as educated, thoughtful, and passionate about learning. She said that throughout his struggles his love of his family was always apparent.[2]

5. For obvious reasons this inquest focused on his drinking but it is abundantly clear that Julian was so much more than his struggle with alcohol. He is greatly missed by those who loved him.

[1] A transcript of Kirsten Campbell's insightful family statement is annexed to the findings. Annexure B
[2] Statement of Dr Fisher, Exhibit 1, Tab 13, page 2

Alcohol related deaths

6. It is necessary to place Julian's death in its wider social context prior to a close examination of the particular facts surrounding his death.

7. The court was told that in Australia alcohol causes over 5000 deaths per year and for each death about 19 years are prematurely lost.[3] There is also a significant and growing impact on our hospital system. One study suggests that 35% of those presenting to NSW public hospitals screened positive for problematic substance use.[4] The most recent point prevalence study conducted in NSW Emergency Departments (ED) found that one in seven ED presentations, or around 14%, were related to alcohol related harm.[5]

8. While many alcohol related deaths are routinely certified by medical practitioners and thus not reported to the court, coroners still face the impact of alcohol use on a daily basis. Deaths from acute and chronic alcohol use are common. Many deaths recorded as the result of disease or injury also have alcohol as the root cause and as a result any figures officially given are very likely to be under-estimates.

9. Dr Nadine Ezard spoke eloquently about the need to better address the harms caused by alcohol. She expressed the view that even though alcohol is the most commonly used drug in Australia we are not collectively paying sufficient attention to its impact. She suggested "it's something we need a bigger conversation about…It's not just about abstinence and stopping young people from having their first drink, or decreasing the recommended number of drinks per person per day. It's actually about a larger picture around what harms are caused by alcohol and how we can address them. There's almost a 20 year treatment gap from when people first experience harms from alcohol use to seeking treatment. So we need to be changing that conversation and closing that gap."[6]

10. I share Dr Ezard's view about the need to encourage a wider conversation. While numerous alcohol related deaths are referred to the coroner each year, these inquiries are rarely finalised with significant investigation or court proceedings. In NSW, inquests are routinely dispensed with in the vast majority of alcohol related deaths, where the focus is usually on a narrowly defined determination of cause and manner of death. For this reason, coroners in NSW have rarely looked carefully at the big picture when faced with a death apparently

[3] *Guidelines for the Treatment of Alcohol problems, Haber, Lintzeris, Proude and Lopatko, June 2009.* Attached to the statement of Dr Ezard, Exhibit 1, Tab 15A
[4] *Evaluation of NSW Health Drug and Alcohol Liaison Services, November 2014 (CHERE and NDARC).* Attached to the report of Dr Ezard, Exhibit 1, Tab 15 A
[5] Statement of Dr Lai Heng Foong and Dr Carmel Crock, Australasian College for Emergency Medicine, Exhibit 1, Tab16, page 3
[6] Transcript, 17/5/21 page 26, line 20 onwards

caused by acute alcohol intoxication or fully interrogated the background causes or range of available treatment options.

11. Julian's sister, mother and others in his family and friendship group, worked very hard during Julian's life to assist him and advocate for better treatment. After his death Julian's sister generously participated in these proceedings in an attempt to shine a light on treatment gaps and missed opportunities in his care. Many families shy away from these kinds of public inquiries because of the stigma that can still attach to uncontrolled alcohol use. I thank Kirsten for her generosity and assistance. Her love for her charismatic brother was always apparent and her insight into his challenges was profound. Once again I offer my sincere condolences to Julian's family. It is clear to me that he was a creative and well-loved man who is greatly missed.

The role of the coroner and the scope of the inquest

12. 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 their death. The coroner is also to address issues concerning the manner and cause of the person's death.[7] A coroner may also make recommendations, arising from the evidence, in relation to matters that have the capacity to improve public health and safety in the future.[8]

13. In this case there was no dispute in relation to identity of the deceased or to the date, place or medical cause of death. However, the manner or circumstances of Julian's death required significant investigation. In particular it was necessary to examine the treatment options that were available to him over the years and specifically during his final episode of drinking.

The evidence

14. The inquest proceeded some years after Julian's death. This occurred for a number of reasons. One of the issues of particular interest to the family was whether Julian should have been placed in involuntary treatment. NSW has an involuntary treatment regime called the Involuntary Drug and Alcohol Treatment (IDAT) Program. During the preparation of the inquest it became clear that a major evaluation of the IDAT program was being undertaken. It was appropriate to wait for that to be completed. While the IDAT Process Evaluation Report[9] was finalised in July 2019, the court waited for the Data Linkage Evaluation[10] which was received in October 2020. COVID 19 necessitated a further adjournment of proceedings and

[7] Section 81 *Coroners Act* 2009 (NSW).
[8] Section 82 *Coroners Act* 2009 (NSW).
[9] Exhibit 1 Tab 17 Final Report to the NSW Ministry of Health, Vuong and Ors.
[10] Exhibit 1, Tab 17 'A Data Linkage Evaluation of the Outcomes of the NSW Involuntary Drug and Alcohol Treatment (IDAT) Program'

the subsequent delays in listing meant that the inquest was not heard until almost five years after Julian's death.

15. The court took evidence over two hearing days. The court also received extensive documentary material. This material included witness statements, medical records and government evaluation reports. The court heard oral evidence from two of Julian's treating doctors and from a number of experts in the fields of drug and alcohol and emergency medicine.

16. While I am unable to refer specifically to all the available material in detail in my reasons, it has been comprehensively reviewed and assessed.

17. A list of issues was prepared before the proceedings commenced[11]. These questions directed the focus of the evidence presented in court. However, as is often the case, a hearing tends to crystallise the issues which are really at stake. For this reason, after dealing with the chronological facts, I intend to distil my reasons under a small number of broad headings.

18. The focus of the inquest centred on systemic challenges, rather than judging the conduct of specific individuals involved in the provision of health services to Julian. It was acknowledged that he was a complex patient who presented challenges to all those tasked to assist him. Ultimately the evidence did not suggest a single or straightforward remedy that could have saved Julian's life. Nevertheless potential for improvement in the range of services offered was revealed.

Fact finding and chronology

19. Prior to commencing the hearing a summary of uncontested facts was circulated and agreed upon. I accept that this document, which is annexed to these reasons, sets out an accurate summary of the evidence before me and I adopt it.[12] The information contained summarises the evidence and provides the necessary background to understanding Julian's final weeks and ultimately his death. It should be read in conjunction with these reasons.

[11] List of Issues prepared by Counsel Assisting:

1.What treatment options were available to medical practitioners who had contact with or treated Julian regarding his abuse of alcohol during the period March and October 2016 (both voluntary and compulsory treatment options)?

2. Are there other treatment options, not yet in effect in New South Wales (particularly the Blue Mountains/Penrith area), that might have assisted medical practitioners in the management or treatment of Julian's use of alcohol during that period? If so, what?

3. What training do doctors working in Emergency Departments receive regarding treatment pathways for persons presenting with severe and ongoing alcohol abuse issues (e.g. referrals for assessment for admission to the IDAPT program, etc) and how are patients assessed or referred for assessment while they are admitted to Emergency Departments?

[12] Annexure A

20. Julian's death occurred at some point during 12 or 13 October 2016. I accept the opinion of the forensic pathologist that it was caused by acute alcohol intoxication. I note that Julian had a number of superficial injuries and abrasions which the forensic pathologist did not consider causally related to his death. Unfortunately risk of fall or injury is a significant and ongoing problem for anyone who is frequently intoxicated.

What treatment did Julian receive in the months before his death?

21. As is clear from the chronology, Julian's history of problematic drinking was long standing. It had commenced by the time he was 23 years of age and continued on and off until his death. There were periods of abstinence, one of which lasted a couple of years. Over the years there were also periods of significant engagement in treatment, including attendance at rehabilitation centres, psychiatric consultations, community based counselling and regular attendance at twelve step programs.

22. Dr Fisher, who had significant contact with Julian, described his issues with alcohol as arising from a struggle with depression and anxiety.[13] There is evidence that he was at times prescribed medication to assist in the treatment of these conditions. His sister told the court she believed he was not neurotypical. At some points in his life he developed positive therapeutic relationships with treatment providers and with his psychiatrist.

23. Julian's alcohol use was characterised as primarily constituting a binge pattern. His most dangerous drinking was uncontrollable, sometimes lasting weeks and often involved drinking until black out. Julian would resort to methylated spirits or other non-beverage alcohol if he was unable to purchase wine. In these phases he had been hospitalised due to unconsciousness and even placed on life support. In Dr Fisher's view Julian "was very unusual in his use of alcohol, he would consume it rapidly and in large doses."[14]

24. Julian's sister, Kirsten Campbell described his drinking as having been rooted in feelings of psychological pain and it is clear that towards the end of his life a relationship breakdown appeared to exacerbate his drinking.

25. The court looked closely at the six week period before his death. Even taking his past into account, this period seems particularly extreme. From 1 September up until his death in mid-October 2016, Julian had at least 11 admissions (not including multiple admissions on the

[13] Statement of Dr Fisher, Exhibit 1, Tab 13, page 2
[14] Statement of Dr Fisher, Exhibit 1, Tab 13, page 2

same day) to numerous hospital emergency departments in the Mid North Coast and Nepean/Blue Mountains areas.[15]

26. During this period Julian was taken to various hospitals by ambulance and by NSW Police having been found severely affected by alcohol or actually unconscious. He was removed from trains or train stations on numerous occasions either partly conscious or heavily intoxicated. He was seen to be drinking methylated spirits and on one occasion returned a blood alcohol reading of 0.374[16]. He frequently left hospital against medical advice and was seen to be drinking again almost immediately upon release. His family were desperately worried and called both NSW Police and various hospitals for assistance. Julian's sister described the experience of trying to get him help during this period as "like shouting into outer space."[17]

27. Once Julian arrived back in the Blue Mountains area in late September 2016, his drinking continued despite being in contact with services and medical staff with whom he had a long history and family members who continued to offer him support. His death some time on 12 or 13 October 2016 was shocking, but with the benefit of hindsight it is clear that he had been at risk of death for weeks, given the level of his continuing alcohol use.

What voluntary treatments are available in NSW for people with severe alcohol issues such as Julian?

28. When reviewing Julian's contact with medical services, the court was keen to find out what options would have been potentially available to Julian in the last weeks of his life. It is clear that over the years he had engaged with a variety of services which provided varying degrees of temporary relief.

29. Dr Ezard, Clinical Director of the Alcohol and Drug Service at St Vincent's Hospital, NSW referred the court to the National Guidelines for the Treatment of Alcohol Problems.[18] The national guidelines outline the most widely used evidence-based interventions including brief interventions, motivational approaches, cognitive behavioural therapy informed approaches including coping skills training, behavioural self-management (controlled drinking), and relapse prevention. The guidelines discuss pharmacotherapies, self-help programs,

[15] These admissions are set out in Annexure A
[16] There are various Blood alcohol readings in the medical records. .374 was recorded during the admission of 11-12/10/2016
[17] Family statement – Transcript 18/5/21, page 29, line 34
[18] *Guidelines for the Treatment of Alcohol problems, Haber, Lintzeris, Proude and Lopatko, June 2009.* Attached to the statement of Dr Ezard, Exhibit 1, Tab 15A

withdrawal management and rehabilitation services and aftercare programs as well as providing information about the range of other options available.

30. The court was also assisted by the Chief Addiction Medicine Specialist, from NSW Ministry of Health, Dr Anthony Gill. He was able to provide a broad overview of the range of services and programs available in NSW to address the risky or harmful use of alcohol and other drugs. He told the court that in 2019/20 alcohol was the most common drug people sought treatment for in NSW with 13,389 individuals accessing treatment, representing 36% of all individuals accessing treatment services.[19] He explained that Local Health Districts and specialty networks deliver a range of alcohol and other drug services including withdrawal management (detoxification) services, hospital drug and alcohol consultation liaison, outpatient and community based counselling and case management, substance specific services such as opioid substitution treatment, specialist services such as substance use in pregnancy services, criminal justice diversion programs and involuntary treatment.[20]

31. While these services exist, it must be clearly stated that treatment for alcohol use disorder in Australia is both delayed and under-met.[21] A review conducted in 2014 found that fewer than half of those seeking treatment for alcohol and other drugs are able to access treatment.[22] Dr Gill acknowledged resourcing issues, specifically that there can be a significant wait for a detoxification bed, especially for patients with more complex needs requiring withdrawal management.[23]The need for greater resources in this sector is pressing.

32. Dr Gill elaborated on the services most relevant to Julian. He told the court that there were now services in some local health districts, including Nepean Blue Mountains Local Health District (NBMLHD), which catered for people who were identified as having severe substance use issues. The Assertive Community Management (ACM) program provides intensive case management services for people with severe substance dependence and complex needs. The program was not in place at the time of Julian's death but had been developed in the years since.

33. Dr Gill informed the court that the ACM program is tailored to meet the needs of the client group, it aims to stabilise and reduce drug and alcohol use and reduce preventable hospital presentations. The goal is to improve general health and social function and improve access to long term treatment and care.[24]

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[19] Statement of Dr Anthony Gill, Exhibit 1, Tab15B
[20] Statement of Dr Anthony Gill, Exhibit 1, Tab15B [4]
[21] Statement of Dr Ezard, Exhibit 1, Tab 15 page 3
[22] See Dr Ezard's reference to Ritter, A et al *New Horizons: The review of alcohol and other drug treatment services in Australia*. Sydney Drug Policy Modelling Program
[23] Transcript 17/5/21 Page 30 onwards
[24] Statement of Dr Anthony Gill, Exhibit 1, Tab15B [15-16]

34. In oral evidence Dr Gill explained that this program, which is based on a pilot initially run in South Eastern Sydney Local Health District, aims at identifying people with the most challenging and severe conditions and attempts to engage them and link them to services and programs.[25] Patients may be identified through regular attendance at emergency departments. He told the court the program "differs from drug and alcohol services as they are typically operated, in that it does provide an outreach component and so more actively engages people."[26] This component and the longer term focus aimed at linking the patient to services appropriate to that individual are crucial to its success.

35. Dr Ezard, who also had significant experience with the program, told the court that one of the strengths of the program is its multi-disciplinary nature. She explained that the package of care can include families being involved and the input of a social worker.[27]This was an issue close to the heart of Julian's family. Kirsten Campbell identified the difficulties they experienced in attempting to support his treatment.

36. Dr Gill explained that LHDs have some autonomy in how they structure their ACM programs, but on the information available to him Julian would seem to meet the criteria, had the program been available in 2016.

37. This opinion was not however shared by Dr Karen Fisher, Clinical Director of Drug and Alcohol Services at Nepean Blue Mountains Local Health District. Dr Fisher had significant contact with Julian over a number of years. Dr Fisher told the court that she was "not sure that it would help him."[28] She told the court "I wish I could look at it and say yes, it would have. Certainly the way in which assertive case management and community management works within our LHD is that we take people who are pre-IDAT who are having trouble coordinating appointments, turning up for care, addressing things like finance, housing, medical appointments, ensuring the continuity of follow up that they need to restore them to health, that they are proactively helped to reach those goals. Julian wasn't necessarily not turning up to appointments, he wasn't necessarily not turning up to specialist appointments".[29] She thought perhaps assisting him with transport to see his psychiatrist may have been helpful, but had doubts about whether you would "case manage someone who was in this terrible period of intoxication."[30]

[25] Transcript 17/5/21 Page 5, line 34 onwards
[26] Transcript 17/5/21 Page 5 line 44-46
[27] Discussion of these issues is found at Transcript 17/5/21, Page 7, line 15 onwards
[28] Transcript 17/5/21 Page 21, line 46
[29] Transcript 17/5/21 Page 21, line 45 onwards
[30] Transcript 17/5/21 Page 22 line 10

38. Dr Gill also told the court about the workings of hospital Drug and Alcohol Consultation Liaison Services. [31] Ideally Julian would have benefitted from contact with a service such as this. These are now located at most major hospitals across NSW during regular business hours. At other times or in smaller hospitals staff can contact the Drug and Alcohol Specialists Advisory Service (DASAS) 24/7 to assist in the management of patients presenting with alcohol and other drug related concerns, or contact the nearest community based alcohol and other drug service to assist in the management of the immediate needs or provide the necessary referral information for ongoing care.[32]

39. Dr Gill explained that people may access alcohol and other drug services in a number of ways such as through presentation to a hospital emergency department or by contacting the 24 hour Alcohol and Other Drug Information Service by telephone. Presentation at an emergency department should give a patient access to a drug and alcohol referral if appropriate.[33]

40. Voluntary programs are of course only relevant if the patient is willing to participate and it appears that in the last weeks of his life, Julian was not able or did not want to engage with what was offered to him. There was certainly no assertive follow up. While actually intoxicated Julian's judgement was clearly impaired. His sister suggested that once sober he would have been well aware of the options and how "un-useful [they] would be, because he had done it a dozen times and most of it did not meet his needs."[34]

41. In this context it is useful to reflect on Dr Ezard's review of the care available to Julian. She urged us to move away from language like "absconding" and "discharged against medical advice" to concepts of premature discharge. She suggested that what is really going on in these circumstances is "that we as a health service are not meeting their needs. So accepting that Mr Horne had fluctuating capacity at this particular time when he was in crisis and often intoxicated, we still were not meeting his needs". [35] In her view a fully functional, funded and supported Consultation Liaison Service and ACM team might go some of the way, but perhaps other options also need consideration.

What is the role of the Emergency Department in the treatment of patients such as Julian?

42. While Julian had received various interventions in the past, during the last six weeks of his life his primary point of contact with the medical system was through his largely involuntary

[31] Statement of Dr Gill, Exhibit 15B [5]
[32] Statement of Dr Gill, Exhibit 15B [5]
[33] Statement of Dr Gill, Exhibit 15B [5]
[34] Family Statement Transcript 18/5/21 page 30, line 34 onwards
[35] Transcript 17/5/21, Page 16, line 7 onwards

presentations to NSW hospital emergency departments. Julian was brought to hospital by ambulance or police in varying states of semi consciousness. On each occasion he appears to have left as soon as he was able. The chronology makes clear that numerous practitioners did their best to care for Julian and that some made significant efforts to re-engage him in Drug and Alcohol treatment. However it is also apparent that during this six week period the treatment he received was necessarily reactive and *ad hoc*.

43. The court heard evidence from one of a number of emergency doctors who treated Julian during this period. It should be made clear that no particular criticism is made of this doctor. The court's purpose was to better understand the role of an emergency department doctor in treating a complex patient such as Julian.

44. Dr Rong Fan first saw Julian on 26 September 2016 when he was taken to the Emergency Department at Blue Mountains Hospital with alcohol intoxication. He had been found by his mother unresponsive at his own home, smelling of methylated spirits.

45. Dr Fan is a staff specialist in Emergency Medicine and has been a fellow of the Australian College of Emergency Medicine since 2013.[36] He told the court that on first treating Julian he was already aware of him from his frequent attendances at that hospital on multiple earlier occasions. Dr Fan stated that he was "aware that Mr Horne had previously accessed the Drug and Alcohol Service at Nepean Hospital on multiple occasions including self-referrals, admissions for alcohol detoxification, self-discharges against medical advice and ongoing relapse prevention counselling."[37] Dr Fan explained that although he had some awareness of Julian's longstanding contact with the local health district, back in 2016 he would not have had access to all Julian's records from his own local health district and certainly not from other health districts. He stated that although advances in electronic record management now allow some access to previous discharge summaries, it was not always reliable.[38] Dr Fisher confirmed this and stated that one can now go to a part of the electronic record called HealtheNet, but it involved "going into a separate Tab", "opening up a new clinical portal" and "you'd have to have a good reason" to pursue it.

46. The fact that Dr Fan and others in his position were operating with such a partial picture is disturbing. With hindsight it is easy to see the ever-growing risk in the situation as Julian careered down the New South Wales coast through various presentations at regional emergency departments. Nobody, including Dr Fan, ever seemed to get a complete picture.

[36] Statement of Dr Fan, Exhibit 1, Tab12
[37] Statement of Dr Fan, Exhibit 1, Tab12 [14]
[38] Transcript 18/5/21, Page 17, line 10 onwards

47. Dr Fan outlined the medical monitoring which occurred during his first consultation with Julian, including checking his level of consciousness and vital signs. Blood tests, an electrocardiogram and chest X-ray were also undertaken along with other standard treatments such as a Thiamine injection. No particular abnormalities were identified and Julian's level of consciousness improved fairly quickly. When he left for the evening, Dr Fan told the night shift doctor that Julian was not to be discharged until he was "fully alert and could mobilise safely on his feet".[39]

48. In oral evidence Dr Fan explained that from an emergency medicine point of view, his primary concern was that a decreased level of consciousness can involve a threat to the airways or breathing which is potentially life threatening.[40]

49. Dr Fan said he also gave Julian his "own brief counselling" where he told him something like "you have a serious problem that's ruining your life. There is not an easy solution to the problem and I know it's easier said than done, but you want to give up alcohol. The most important thing you need is the will to do so."[41] He also told Julian to follow up with the Drug and Alcohol Service at Nepean Hospital. No formal referral was made as it was in the middle of the night and anyway Julian was already familiar with the service.

50. The next time Dr Fan saw Julian was during his presentation at the same hospital on the 11-12 October 2016. Dr Fan told the court that while Julian was meant to see the Drug and Alcohol Clinical Nurse Consultant (D&A CNC) on 12 October 2016, the nurse was not in fact working that day. Dr Fan explained that when he saw Julian that morning Julian was awake and sober. "I told him that the D&A CNC was not available to review him today. If he was serious and had the will to stop his drinking that day, I could call the Drug and Alcohol Consultant (doctor) at Nepean to check if a bed was available for voluntary admission. (If a bed had not been available, which is commonly the case, the patient is usually advised to call and follow up with the service on a different day)." Apparently Julian then advised Dr Fan that he "just wanted to go home and did not wish to see the Drug and Alcohol Team that day".[42] Dr Fan noted that he was by then aware that Julian had recently self-discharged, against medical advice, on 6 October 2016 and this was also a factor in him "not persisting" with encouraging Julian to have further involvement with Drug and Alcohol Services at that time.[43]

51. In oral evidence Dr Fan explained that the focus and priority of the emergency doctor is with treating any life threatening issues. Referral to drug and alcohol Services are made if

[39] Statement of Dr Fan, Exhibit 1, Tab12 [15]
[40] Transcript 18/5/21, page 16, line 10 onwards
[41] Statement of Dr Fan, Exhibit 1, Tab12 [17]
[42] Statement of Dr Fan, Exhibit 1, Tab12 [21]
[43] Statement of Dr Fan, Exhibit 1, Tab12 [22]

appropriate and available. In his experience becoming deeply involved in the drug and alcohol issues of a patient like Julian is not realistic, given the other responsibilities involved in working in an emergency department[44]. He explained his expertise in treating acute intoxication, but once a patient is stable it is appropriate to refer them to a drug and alcohol specialist. He had never referred a patient to IDAT and on the one occasion he had raised it with a Clinical Nurse Consultant with regard to a different patient, he had been rebuffed.[45] He was of the view that most emergency doctors would have had little contact with the IDAT program.

52. It was clear that Dr Fan needed the assistance of a Drug and Alcohol health worker. He agreed that having a worker embedded in the emergency department would be helpful.[46] His medical interventions were no doubt highly appropriate. However it is most unlikely that his "short counselling" of Julian, stressing as it did a need for Julian to find the "will" to give up alcohol, was of any benefit whatsoever. In the absence of the Drug and Alcohol Clinical Nurse Consultant, there was little Dr Fan could do. The court understood that Dr Fan saw his role as emergency intervention. I have no doubt he saved lives that night. However it is also clear that he was unsupported and ill-equipped to provide Julian with anything more than basic medical care. In my view there needed to be a Drug and Alcohol worker, nurse or social worker, able to obtain a full history and tasked with having a conversation about ongoing care and ways to reduce Julian's risk. As it was, Julian left hospital with an ongoing treatment plan for him to follow up Drug and Alcohol Services himself, essentially when he felt ready to engage. His family, who had contacted a number of hospitals over the preceding weeks were not informed[47] and no home visit was arranged.

53. The court was greatly assisted by Dr Lai Heng Foong. Dr Foong co-authored the Australian College for Emergency Medicine's (ACEM) response to issues raised at the inquest and gave oral evidence. The court was grateful for her expertise and insight.

54. The ACEM explained that management of withdrawal of AOD is a core competency for emergency physicians. The curriculum for specialists also includes drug and alcohol related harms and alcohol dependence.[48] The ACEM identified that the gap in providing care to patients with severe drug and alcohol issues is not necessarily one of lack of knowledge, but the lack of resources to manage care comprehensively and effectively. It stated "the immediate barrier is the lack of a referral system, especially after hours, to voluntary AOD

[44] Discussion of these issues at Transcript 18/5/21, page 24
[45] Transcript 18/5/21 page 24, line 20 onwards
[46] Transcript 18/5/21 Page 23, Line 15
[47] Kirsten Campbell told the court in her family statement that Julian's mother and former wife also made contact with Hospitals during the final six weeks.
[48] Response of the Australasian College for Emergency Medicine, Exhibit 1, Tab 16, page 2

rehabilitation programs and support services such as social work, housing and job assistance.[49]

55. Dr Foong noted that improving referral pathways requires embedding AOD clinical specialists, such as AOD Clinical Nurse Consultants in EDs to initiate optimal therapy and provide continuity of care as patients transition from ED to AOD specialist management.[50]

56. Dr Foong gave cogent evidence about ways frequent presenters to EDs can be identified and monitored for ongoing care. She explained using the example of mental health frequent presenters currently operating at her hospital. She outlined the way in which a scheme can work, for example, if a patient presents six times to an ED within the LHD in three consecutive months, they will be placed on a list of patients to be reviewed. [51] They drop off the list only if they stop presenting to the ED, The Court heard that the frequent presenter working group had 'actively managed quite a few of our patients and then they've left our list'[52]The process involves supporting patients to have stronger engagement with outpatient treatment which in turn improves health outcomes.

Should Julian have been placed in involuntary treatment?

57. The court was particularly concerned to examine whether involuntary treatment was appropriate for Julian. This concern was raised by his family and there is evidence that Julian's sister was trying to have this option considered around the time of his death.

58. Kirsten Campbell, Julian's sister, told the court that in the final weeks of Julian's life she became so worried about Julian's drinking, particularly methylated spirits, that she contacted a number of the hospitals where he presented and urged them to consider his issues as mental health issues, rather than just "alcohol issues".[53] She told a variety of practitioners that she did not believe he any longer had capacity and requested consideration of holding him pursuant to mental health legislation. When her concerns were not acted upon by the end of September 2016 she began to look for other options and discovered the existence of involuntary alcohol treatment in NSW. She stated that "in 2010, Julian at one point had been detained and stabilised under the pilot of this Act at Nepean Hospital. It seemed like an obvious option. I could not believe that nobody who had been involved to date had known about it. Or if they did, they did not think it was an option and that it had taken the research of family to find it."[54]

[49] Response of the Australasian College for Emergency Medicine, Exhibit 1, Tab 16, page 2
[50] Response of the Australasian College for Emergency Medicine, Exhibit 1, Tab 16, page 5
[51] Transcript 18/5/21 page 9 line 5 ff
[52] Transcript 18/5/21 page 9 line 45f
[53] Statement of Kirsten Campbell, Exhibit 1, Tab 10 [4-7]
[54] Statement of Kirsten Campbell, Exhibit 1, Tab 10 [9]

59. The court heard that scheduling under the *Mental Health Act* (2007) has limited use for patients who frequently present at Emergency Departments with severe alcohol intoxication who are risk of harm.[55] Dr Ezard stated that use of the Act "is, in practice limited to detaining a person until they are sober enough to be assessed for acute risk of harm to self or others, within the limits of an acute setting, and limited to no more than three times in one rolling calendar month". It was her experience that "the Schedule is usually lifted and the patient discharged from the facility once no longer considered intoxicated on alcohol, expresses no immediate plans of harm to self or others and is deemed safe to leave the facility."[56] This seems to accord with the manner in which the Julian was from time to time detained under the Act.

60. As Dr Ezard pointed out the *Mental Health Act* (2007) was not designed to respond to alcohol dependence and there is no strong body of evidence to suggest that detention under the Act is effective care once the immediate risks posed by acute alcohol intoxication have resolved.[57]

61. There is considerable philosophical debate among experts about the efficacy of involuntary treatment and limited Australian research on its effectiveness[58]. It is certainly beyond the scope of these reasons to do more than refer to some of the differences of opinion that exist. Dr Foong noted that in considering the option, it is important to weigh up the possible benefit of treatment versus the imposition to the patient's civil liberties.[59] Others believe that a patient must show "motivation" before any useful treatment can begin and thus oppose all forms of mandatory treatment.[60] Others like Dr Nixon see it as an important "last resort" option that has the capacity to save lives.

62. Involuntary treatment is not available in all Australian states[61], but there is an involuntary treatment program in NSW. Nevertheless, Dr Foong explained a patient would rarely be transferred directly to IDAT from an emergency department and thus most emergency physicians would not have been personally involved in the assessment and recommendation of a patient for the IDAT Program.[62]

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[55] For discussion of this issue see Statement of Dr Ezard, Exhibit 1, Tab 15, page 1
[56] For further discussion of this issue see Statement of Dr Ezard, Exhibit 1, Tab15 page 1
[57] Statement of Dr Ezard, Exhibit 1, Tab 15, page 1
[58] I note Dr Ezard referred the court to a comprehensive review which suggests that the evidence does not on the whole suggest improved outcomes related to compulsory treatment approaches and some studies suggest potential harms. "*The effectiveness of compulsory drug treatment: A systematic review"*. International Journal of Drug Policy 2016
[59] Response of the Australasian College for Emergency Medicine, Exhibit 1, Tab 16, page 2
[60] Statement of Dr Nixon, Exhibit 1, Tab 14, page 4
[61] Civil commitment legislation exists in NSW, Victoria and Tasmania. Response of the Australasian College for Emergency Medicine, Exhibit 1, Tab 16, page 2
[62] Response of the Australasian College for Emergency Medicine, Exhibit 1, Tab 16, page 3

63. The IDAT Program[63] provides involuntary treatment as a last resort for people with severe substance dependence where less restrictive means have not been effective or are not appropriate. The Program commenced in 2012.[64] Treatment exists pursuant to the *Drug and Alcohol Treatment Act* 2007. Treatment lasts for 28 days, with an option to extend for up to three months where a patient has a drug or alcohol brain injury and additional time is needed to carry out treatment and plan discharge. This is followed by community based care for up to six months.

64. The IDAT program provides twelve beds that operate out of two gazetted treatment units, one in Northern Sydney LHD (4 beds) and the other in Western NSW LHD (8 beds).

65. IDAT programs are not acute admission services, they are planned treatment for people who have not responded to other treatments, where clinical evidence presented by a medical practitioner is carefully considered by a magistrate to confirm the dependence certificate. The IDAT program is a treatment of "last resort."[65] The Act mandates that a dependency certificate can only be written where no less restrictive option of treatment is available.

66. The total number of patients sent to an IDAT program is very small. In many years sitting as a Local Court Magistrate, I can recall being asked to make an order only once despite dealing with hundreds of people experiencing serious alcohol dependence.

67. The court was assisted by a statement provided by Dr Leon Nixon, who was formerly the Director of the IDAT Unit at Bloomfield Hospital at Orange NSW. Dr Nixon was a fellow of the Australasian Chapter of Addiction Medicine of the Royal Australasian College of Physicians. He has practised in the field for many years.

68. Dr Nixon reviewed Julian's medical records and was asked to comment on whether he would have been a suitable candidate for the IDAT program. It was Dr Nixon's view that from at least 2009, Julian met the criteria for severe substance dependence. "Clearly he was at risk of harm with overdoses requiring intubation, consumption of non-beverage alcohols such as methylated spirits and mouthwash, and falls with head strike, as well as the toxic levels of alcohol… He had previously achieved and maintained abstinence for extended periods. Of particular note, following a relatively long admission he moved from refusing to consider residential rehabilitation to accepting referral. "[66] In Dr Nixon's view, by the time Julian arrived back in the Blue Mountains at the end of September and into October 2016, he would have been eligible and would likely have benefitted from the program.

[63] Summary information taken from the Statement of Dr Gill, Exhibit 1, Tab 15B [5]
[64] Dr Ezard report Exhibit 1, Tab 15 page 3
[65] Statement of Dr Nixon, Exhibit 1, Tab 14, page 5
[66] Statement of Dr Nixon, Exhibit 1, Tab14, page 2

69. I note that Dr Gill shared Dr Nixon's view that Julian would have been likely to be eligible.

70. Dr Fisher disagreed. She stated that there was no missed opportunity in not considering the IDAT program. In her view Julian "never refused treatment and actively sought ways to be well, engaging voluntarily with psychiatric and drug and alcohol services."[67] In oral evidence she explained, "he did not say to people when they said, "Hey, do you want to go to Nepean and try a withdrawal?" he did not say, "No I don't want anything to do with this." He came to us, he may not have stayed, but he came to us, he stayed overnight. Again, he had that pattern of being safe enough to make a terrible decision in the morning."[68] She likened his decision making to a diabetic who eats cake – it doesn't mean you have refused treatment for diabetes.

71. In oral evidence Dr Fisher also explained in her view that the IDAT program would not assist someone like Julian whose pattern of use was binge drinking. She stated "the problem would be, for example you take someone who's binged and they may binge for … eight weeks, they may stay in IDAT for two to three months. In six months' time, that's not going to stop a binge because the binge, by definition, has got periods where they're not drinking. What works really well is when someone has got a demonstrated daily pattern of usage for a prolonged period of time and they've never had an interruption, so IDAT can often interrupt for the first time the substance…that they've never been without to experience life. That wasn't – that's not a binge drinker."[69]

72. In any event, as we have seen Dr Fan did not consider IDAT during the final admission and there is no evidence that any other emergency doctor or Drug and Alcohol specialist considered it in the preceding weeks.

73. Even if Julian had been eligible and a bed available, it is very difficult to know how effective that form of treatment would have been. The recent evaluation of the program, published in 2019, showed that among the 105 people who were eligible and followed up six months post admission there was a reduction in alcohol consumption, use of ambulance, ED and unplanned hospital admissions, as well as improvements in physical health, psychological wellbeing and quality of life.[70]To better understand whether these improvements were related to the intervention a further study involving a control group was required. An evaluation team then proceeded to analyse health service data comparing 277 IDAT patients to a control group selected with similar characteristics but who had not participated in an IDAT over 12

[67] Statement of Dr Fisher, Exhibit 1, Tab 13, page 5
[68] Transcript 17/5/21, Page 12, line 11 onwards
[69] Transcript 17/5/21 Page 14, line 22 onwards
[70] *An evaluation of outcomes in the NSW involuntary Drug and Alcohol Treatment IDAT Program* (2019) Vuong T, Sotade O, Beadman K, Ritter A. Drug Policy Modelling Program UNSW. Exhibit 1,

months before or 12 months after. The results published in 2020 were somewhat surprising. There appeared to be no statistical difference in emergency department presentations or hospital admission between the two groups. The authors wrote "we hypothesised that the IDAT group, having received the intensive IDAT treatment program, would have improved health status (as reflected in lower ED presentations and unplanned hospital admissions) compared to the control group who received treatment as usual. This did not appear to be the case."[71] While described as "not statistically significant" there was also a slightly higher mortality rate in the IDAT group compared to the control group. The authors noted that "on these measures, there is no net advantage for IDAT as an intervention relative to treatment as usual."[72]

74. Dr Gill expressed a more optimistic view of the statistics suggesting that given both groups achieved beneficial outcomes, "it is in fact a positive thing to say that these people who weren't accepting treatment voluntarily achieved an outcome…the same as those who were. That's one way to look at it."[73]

75. It should also be noted that there are some rather significant barriers to entry to an IDAT program even when clinicians identify it as the appropriate option. A dependency certificate can only be written when there is an IDAT bed available. Dr Nixon told the court that with only 12 beds available across NSW, there is "always a waiting list".[74] This delay can cause difficulties in finding and referring a patient when a bed eventually becomes available.

76. The program is resource intensive[75]and very limited in its reach. The court saw no compelling evidence that the program is more effective in the long term than "business as usual".

77. While there may be varying opinions about whether Julian would have been assisted by involuntary treatment, in my view he would certainly have been eligible, had a practitioner been minded to commence the process. The court and Julian's family wondered whether there could be an argument that a short period of enforced sobriety could have provided a circuit breaker and prevented his death, but I note that Dr Gill advised that there really is no evidence base to support that theory of treatment. [76] I accept his expertise on this issue.

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[71] *A Data Linkage Evaluation of the Outcomes of the Involuntary Drug and Alcohol Treatment (IDAT)* (2020) Vuong T, Larney S, Ritter A, Drug Policy Monitoring Program UNSW, Exhibit 1 Brief Tab 17
[72] *A Data Linkage Evaluation of the Outcomes of the Involuntary Drug and Alcohol Treatment (IDAT)* (2020) Vuong T, Larney S, Ritter A, Drug Policy Monitoring Program UNSW, page 4
[73] Transcript 17/5/21, page 22, line15 onwards
[74] Statement of Dr Nixon, Exhibit 1, Tab 14, page 2
[75] Over the first four years, the cost of the IDAT program was estimated to be $32,474,955 (assuming only 26% of IDAT patients receiving aftercare) or $33,009,593 (if it is assumed that 100% of IDAT patients receive aftercare): Note 71 ibid
[76] Transcript 15/6/21, page 21, line 32 onwards

The need for diversified options and greater focus on harm reduction strategies

78. Alcohol is used in a problematic way by many in the community who never seek treatment or ever have a diagnosed condition. Alcohol use disorder has been characterised as a chronic relapsing condition.[77] However, even for those actually diagnosed with the condition, symptoms and risk can manifest in a variety of ways. It follows that we need a variety of treatment options to cater for diverse needs.

79. Until recently management of problematic or chronic alcohol use has been primarily focussed on abstinence. A common approach being that patients are offered a withdrawal service and then encouragement to attend inpatient rehabilitation or a twelve step program or community based counselling. From time to time pharmacotherapies are involved, either to assist in stopping alcohol or drug use or because a dual diagnosis has been identified. Controlled drinking programs are also sometimes available to assist participants in attaining treatment goals of reduced alcohol use.

80. Examining Julian's journey suggests the need for expanding treatment options and experimenting with different approaches. His story was one of an intelligent man who had, over the years, tried pretty much all of the conventional treatments he had been offered.

81. His attendance at various emergency departments during the final weeks of his life ensured for a time his short term physical survival. His airways were protected, he was stabilised until he was sober enough to walk, his vital signs were monitored and he was given thiamine. Beyond that from time-to-time he was offered consultations with drug and alcohol practitioners and hospital detoxification, neither of which he took up. He was not considered for involuntary treatment as an IDAT patient nor was ongoing detention under the *Mental Health Act* considered.

82. One cannot help but wonder if what he needed, at least in the short term, does not yet exist in NSW. There seems to be a need to further investigate harm reduction programs for those with intractable alcohol dependence. While Julian was described as a "binge drinker" by a number of doctors, his final binge lasted a number of weeks of uncontrolled and increasingly desperate use. His risk on trains and at train stations and drinking alone was extreme. His use of methylated spirits and other non-beverage alcohol was particularly concerning.

[77] Statement of Dr Ezard Tab 15A [4]

83. Dr Ezard referred the court to the existence of managed alcohol programs. Pioneered in Canada in the 1990s as a response to the weather-related freezing deaths of homeless men, they operate in a voluntary non-coercive program model. The Canadian centres are generally provided as a residential facility for people who have experienced long-term homelessness and chronic and severe alcohol dependence, dispensing regulated amounts of alcohol at set times under supervision. In addition, possible benefits of the program might include a safe environment, improved nutrition and stabilisation of concurrent medical problems.[78] No program such as this exists in NSW, although a currently unfunded proposal has been developed by St Vincent's Specialty Network to trial a managed alcohol program in the inner city of Sydney.

84. While I do not suggest that the exact program described in the Canadian literature was appropriate for Julian, it certainly offers food for thought. We clearly need to trial managed alcohol programs and assess their capacity to assist particular groups of alcohol users. Julian needed a way to survive the binge and developing new programs to reduce the kind of risks he faced may call for novel strategies. The *ad hoc* treatment he received after presenting to hospital emergency departments, while life-saving in the short term, was not able to adequately address his ongoing risk of harm.

85. At the conclusion of evidence, no one solution stood out as being the most suitable and most likely to have been of assistance to Julian but ways of potentially strengthening the support he was offered emerged.

The need for recommendations

86. Counsel assisting put forward a number of recommendations for the court's consideration.

87. Section 82 of the *Coroners Act 2009* confers on a coroner the power to make recommendations that he or she may consider necessary or desirable in relation to any matter connected with the death with which the inquest is concerned. It is essential that a coroner keeps in mind the limited nature of the evidence that is presented and focuses on the specific lessons that may be learnt from the circumstances of each death.

88. I note that a number of the proposed recommendations were not supported by counsel for the Ministry of Health and the relevant LHD. It was suggested that some of the proposed recommendations might even go so far beyond matters sufficiently related to the cause and manner of Julian's death as to be inappropriate. This was specifically put, for example, in

[78] Statement of Dr Ezard, Exhibit 1, Tab15. See also Response of the Australasian College for Emergency Medicine, Exhibit 1, Tab 16, page 2

relation to a recommendation relating to the controlled drinking (managed alcohol) trial and in relation to supporting the availability of disulfiram.

89. I have considered this issue carefully. Manner of death has been considered by the higher courts on a number of occasions. In *Conway v Jerram* (2010) 78 NSWLR 371 Barr AJ explained at [52] (in a passage supported by Campbell JA's remarks denying leave to appeal [2011] NSWCA 319 at [39]) that the phrase "manner of death" should be given "broad construction to enable the coroner to consider by what means and in what circumstances the death occurred." On the application for leave to appeal in *Conway,* Young JA explained that the scope of an inquest is a matter for the coroner to determine and the appropriate scope depends on all the circumstances of the case (at [47]), while acknowledging that "a line must be drawn at some point which, even if relevant, factors which come to light will be considered too remote" [49].

90. It is clear from the authorities that "manner of death" is a phrase that is not readily susceptible to a tight definition. The issue of 'remoteness" will be dependent on the facts of each case. A common sense approach has sometimes been urged. Clearly it would have been inappropriate to examine every single medical intervention Julian had in relation to his drinking. For this reason the court focussed primarily on the final weeks of his life. Nevertheless it was also important to review the context of these final contacts with health providers to properly understand what he had been offered over the years and what treatment was indeed available or appropriate in October 2016. To view his final presentation in isolation is to potentially miss the complex interplay of factors leading up to his death.

91. I am therefore satisfied that in the circumstances of this case, a proper investigation of the manner of Julian's death involves both an understanding of his prior treatment and a broad review of what was available and what he could have been appropriately offered.

92. Further, I note Barr AJ's observation in *Conway* at [63] that once the evidence justifies the calling of an inquest and an inquest is duly held "the power of a coroner to make recommendations about matters of public health and safety seems apt to enable the coroner to consider matters outside the scope of what may be considered necessary to determine the manner and cause of death." The power of course does not arise until there is an inquest. Nevertheless, I do not feel constrained to strictly limit any recommendations to evidence arising from evidence of events occurring on or around the time of his final presentation.

93. I accept that it is now clear that some of the matters raised in evidence about treatment options may not have been appropriate for Julian at the time of his death. In my view that

does not require me to ignore these matters when considering my duties pursuant to section 82 of the *Coroners Act.*

94. I intend to deal with each of the proposed recommendations in turn.

To Ministry of Health and the NBMLHD:

1. **Her Honour's findings in this Inquest, along with the transcript of the family statement given by the family in the hearing on 18 May 2021, be considered by the Ministry and the NBMLHD with a view to considering if any lessons can be drawn from Julian's death and improvements made to the management of patients with severe alcohol disorders like that of Julian (which include periods of abstinence along with periods of severe binge drinking to the point of being life threatening) (noting that NSW Health recently received the findings of an evaluation of the IDAT program).**

   I note that the Ministry of Health and NBMLHD had no objection to this recommendation and I intend to make it.

To the Ministry of Health:

2. **NSW Health prioritise the assessment and determination of the controlled drinking trial (managed alcohol) proposal for inner city Sydney in the South Eastern Sydney Local Health District.**

   Counsel for the Ministry of Health and NBMLHD correctly pointed out that any such trial would not be undertaken by South Eastern Sydney LHD. I agree the recommendation should be re-worded to reflect that the proposal relates to the St Vincent's Specialty Network.

   Further it was suggested that there are always competing priorities for research funding and that these should only be decided based on "the usual pathways" administered by the Office for Health and Medical Research. The court is certainly aware of the difficulties of assessing competing research priorities. However, the compelling nature of the evidence before this court suggests that this proposal is most worthy of special consideration.

   In the Ministry's submission the recommendation "cannot be said to arise from the manner and cause of the death of Mr Horne". For reasons already stated I do not share the view that I am so tightly constrained. In any event, the evidence was initially relevant because of the nature of some of Julian's drinking. He was found intoxicated on trains and public

places on numerous occasions, he drank methylated spirits and other non-beverage alcohol, from time to time his family bought him alcohol to stop his use of more dangerous liquids. He was offered referral to Drug and Alcohol Services for a managed detoxification. He refused. I note that Dr Fisher, the Clinical Director of Drug and Alcohol Services at Nepean Hospital did not think he would benefit from the IDAT program[79] or indeed the services of an ACM program.[80] What was then available to him? If he was determined to keep drinking, it is necessary to discover if that could occur more safely. Could his risk of death be reduced?

The court was very keen to examine all the available harm reduction options available for someone in his position and was surprised to discover the lack of options in this space. In investigating these issues the court became aware of the Canadian model of Managed Alcohol Programs[81] and subsequently of an Australian proposal which would involve the support of both NSW Health and the Department of Communities and Justice to fund the housing component.

In my view the challenging nature of Julian's condition requires deep reflection and creative thinking. The court accepts that after close consideration of the issues, it is impossible to positively state that some kind of managed alcohol program was appropriate for Julian in the last weeks of his life, but it is clear that these kinds of initiatives are most worthy of further investigation. Managed alcohol programs of any sort have not been trialled in NSW, but there is a pilot ready to run. I note and accept Dr Ezard's view that "a managed alcohol program may have offered Mr Horne the opportunity to reduce his binge pattern of use, reduce his non-beverage alcohol use, and provide a setting in which he could engage in more intensive treatment of co-existing mental health conditions, as well as a physically safe environment." I accept that Dr Ezard's capacity "to predict whether this type of service would have changed the outcome for Mr Horne is limited by the lack of Australian evidence for or experience of this type of intervention."[82]

The importance of a trial is obvious. The weight of the evidence before me demonstrates the pressing need for developing *more* options aimed at reducing harm – aside from just programs which are abstinence-based. A controlled drinking trial may not have saved Julian's life, but as a coroner I cannot ignore the fact that it is likely to assist other vulnerable citizens. I am also of the view that the commencement and evaluation of such a trial will likely help spark thinking about creating other non-abstinence based options for

[79] Transcript 17/5/21, page 25, line 32 onwards
[80] Transcript 17/5/21, page 21, line 46
[81] "There is a place": Impacts of managed alcohol programs for people experiencing severe alcohol dependence and homelessness" Pauly et al. *Harm Reduction Journal* (2019) 16;70 Brief Tab 18.
[82] Statement of Dr Ezard, Exhibit 1, Tab 15A, [4]

someone like Julian. The evidence is in my view compelling and I strongly urge immediate consideration of a trial without further delay.

The court was surprised at the lack of available harm reduction options for someone in Julian's position. While the Medically Supervised Injecting Centre (MSIC) has been in place in Sydney for twenty years, it seems extraordinary that we have not trialled more harm reduction programs for those at serious risk with alcohol.

I intend to make the recommendation in the following terms:

That NSW Health prioritise the assessment and determination of the St Vincent's Specialty Network's controlled drinking trial (managed alcohol) proposal so that it can be commenced forthwith.

I also intend to send a copy of these findings to Department of Communities and Justice, who was not represented at this inquest but who have a significant role to play in the potential success of this important proposal.

NSW Health prioritise undertaking and completing the evaluation of the Assertive Community Management (ACM) and Drug and Alcohol Consultation Liaison Programs (including but not limited to consideration of how families of patients with severe alcohol or drug issues are engaged by health providers *and* themselves are able to meaningfully engage to provide support and information about the patient and any concerns they have).

This recommendation was partly supported by the Ministry of Health and the NBMLHD. It was noted that there is already a plan to evaluate the Assertive Community Management program. It was also noted that it was up to each individual LHD to assess how best to implement their ACM program.

Julian's family were concerned that it was difficult for them to have input into his care. The evidence demonstrated that although they were anxious to assist Julian, it was very difficult to get information about his care or to find out what was happening. Dr Ezard expressed the view that one of the strengths of the ACM program was its ability to work with families where appropriate.

Of course patients have a statutory right to privacy, however as stated in the Ministry's submission, given the very large volume of clinical records it was unclear what had been

recorded as Julian's wishes in this regard. Pro-active support and structured contact with family through an ACM could have clarified this issue.

In my view, notwithstanding Dr Fisher's opinion, the weight of the evidence before the court was that the more intensive support that could be offered by a robust ACM would have been beneficial to Julian and potentially offered his family greater input into his care.

NSW Health to consider (a) whether there are means of NSW Health promoting or lobbying the Commonwealth as regards improving the availability of Disulfiram medication within Australia (including but not limited to its potential inclusion on the PBS scheme) and (b) whether it would be appropriate to do so taking into consideration the findings made in this inquest.

This recommendation was not supported by the Ministry of Health or the NBMLHD for a variety of reasons including the fact that NSW Health's Drug and Therapeutics Committee plays no role in the registration or subsidy of pharmaceuticals. The court accepts that. It was also submitted that given that Disulfiram was discontinued from the Australian market by the Therapeutic Goods Administration (TGA) on 4 February 2021 the issue of subsidising the drug did not really arise.

Both Dr Gill and Dr Ezard saw some use for the medication, although I accept that both also noted its limitations. In my view one of the lessons of this inquest is that practitioners need a variety of options, it follows that extending the pharmacological options available to Drug and Alcohol specialists is to be encouraged.

While complicated, I have not been persuaded that the recommendation is without merit. The recommendation merely calls for further *consideration* of the issue and I intend to make it.

NSW Health to consider (a) whether there are means of NSW Health promoting the data capture as recommended by the ACEM with the relevant Commonwealth agency responsible for that data collection and (b) whether it would be appropriate to do so.

This recommendation arose from the thoughtful submissions made by the College of Emergency medicine. The ACEM submitted that the addition of alcohol related data elements to the National Minimum Dataset for National Non-admitted Patient Emergency Department Care (NNAPEDC) would provide a clearer picture of the extent of alcohol related ED presentations and an evidence base to inform and evaluate the impact of alcohol related policy reforms.

It was not supported by the Ministry of Health or NBMLHD who submitted it would "be an enormous task using limited resources for an unproven and unidentified benefit".

I accept ACEM's submission that the data would be useful to inform best practice.

I have not been persuaded against making the recommendation, which involves further *consideration* of the issue.

NSW Health consider engaging with the ACEM to develop training modules for Emergency Department clinicians as regards treatment options for patients presenting to EDs with severe alcohol disorders.

This recommendation also arose from the submissions of College of Emergency Medicine. Dr Gill appeared broadly supportive of the idea of working with the ACEM in building engagement and interest in Addiction Medicine.[83]

I note the Ministry of health stated the following. "The Ministry is prepared to discuss with College and ask them to first identify "gaps" in the training of Fellows in ED medicine about Drug & Alcohol treatment and whether there is interest in such training." The Ministry would also review existing relevant training modules on "My Health Learning".

I intend to make the recommendation.

NSW Health consider examining the feasibility of:

(a) Providing support for, embedding a Clinical Nurse Consultant (CNC), specialising in alcohol and drug issues, within Emergency Departments during after-hours, where appropriate, noting the evidence that persons with severe alcohol disorders presenting to EDs frequently do so *after hours* (not during business hours when Drug and Alcohol Services typically operates).

Embedding CNCs in emergency departments, particularly after hours and on weekends was suggested by ACEM as the best way to improve referral pathways to both voluntary and involuntary treatment. Embedding staff with this specialty may also help to change the culture of busy emergency departments.

It was not supported by the Ministry who submitted that appropriate pathways for Drug and Alcohol services already exist. However I was persuaded that there may be a need for

[83] Statement of Dr Anthony Gill, Exhibit 1, Tab15B [25]

consistency and a less haphazard transition of care of such patients from emergency departments to other treatment areas. An embedded CNC position within EDs may well assist in addressing this shortfall.

In my view, the recommendation has merit and I urge its *consideration*.

(b) Providing support for, the establishment of a Working Group for specific hospitals or across particular LHDs concerning persons identified to be frequently presenting to EDs within a specified periods with severe alcohol or drug related issues (noting the evidence of Dr Foong as regards the Working Groups at the Bankstown Hospital that currently operates for frequent presenters in the context of Indigenous and Mental Health).

The benefit of identifying those patients frequently presenting to emergency departments for alcohol related issues is obvious. Rather than each presentation being looked at in isolation as a single and completed interaction, hospitals should be able to track frequent presenters in an attempt to improve their care. Dr Foong gave compelling evidence in relation to how "frequent presenters" can be identified and services improved[84].

The Ministry did not support this recommendation. It was submitted that the recommendation was "problematic and lacking robust evidence." I disagree and urge further *consideration* of the proposal.

Findings

95. The findings I make under section 81(1) of the *Coroners Act 2009* (NSW) are:

Identity

The person who died was Julian Horne

Date of death

He died on 12 or 13 October 2016.

Place of death

He died at 2/27 Ridge Street Lawson NSW.

Cause of death

He died of acute alcohol intoxication.

[84] Transcript 18/5/21 Page 8 onwards

Manner of death

Julian died in the context of having longstanding alcohol issues, during a severe relapse of his condition.

Recommendations pursuant to section 82 *Coroners Act 2009*

96. For the reasons stated above, I recommend that

To Ministry of Health and the NBMLHD:

1. **My findings in this Inquest, along with the transcript of the family statement given by the family in the hearing on 18 May 2021, be considered by the Ministry and the NBMLHD with a view to considering if any lessons can be drawn from Julian's death and improvements made to the management of patients with severe alcohol disorders like that of Julian (which include periods of abstinence along with periods of severe binge drinking to the point of being life threatening) (noting that NSW Health recently received the findings of an evaluation of the IDAT program).**

To the NSW Ministry for Health

2. **NSW Health prioritise the assessment and determination of the St Vincent's Specialty Network's controlled drinking trial (managed alcohol) proposal so that it can be commenced forthwith.**

3. **NSW Health prioritise undertaking and completing the evaluation of the Assertive Community Management (ACM) and Drug and Alcohol Consultation Liaison Programs (including but not limited to consideration of how families of patients with severe alcohol or drug issues are engaged by health providers *and* themselves are able to meaningfully engage to provide support and information about the patient and any concerns they have).**

4. **NSW Health consider (a) whether there are means of NSW Health promoting or lobbying the Commonwealth as regards improving the availability of Disulfiram medication within Australia (including but not limited to its potential inclusion on the PBS scheme) and (b) whether it would be appropriate to do so taking into consideration the findings made in this inquest.**

5. **NSW Health consider (a) whether there are means of NSW Health promoting the data capture as recommended by the ACEM with the relevant Commonwealth agency responsible for that data collection and (b) whether it would be appropriate to do so.**

6. **NSW Health consider engaging with the ACEM to develop training modules for Emergency Department clinicians as regards treatment options for patients presenting to EDs with severe alcohol disorders.**

7. **NSW Health consider examining the feasibility of:**

    a) **Providing support for, embedding a Clinical Nurse Consultant (CNC), specialising in alcohol and drug issues, within Emergency Departments during after-hours, where appropriate, noting the evidence that persons with severe alcohol disorders presenting to EDs frequently do so *after hours* (not during business hours when Drug and Alcohol Services typically operates).**

    b) **Providing support for, the establishment of a Working Group for specific hospitals or across particular LHDs concerning persons identified to be frequently presenting to EDs within a specified periods with severe alcohol or drug related issues (noting the evidence of Dr Foong as regards the Working Groups at the Bankstown Hospital that currently operates for frequent presenters in the context of Indigenous and Mental Health).**

Conclusion

97. The inquest offers no simple solutions to improving the care given to Julian. Nevertheless there is utility in reviewing his treatment and in searching for new approaches.

98. I offer my sincere thanks to counsel assisting, Chris McGorey and his instructing solicitor Janet de Castro Lopo for their hard work and enormous commitment in the preparation and conduct of this inquest. I thank the experts who were willing to assist the court.

99. Finally, once again I offer my sincere condolences to Julian's family. I acknowledge that the pain of losing a loved one in these circumstances is profound and that their grief is ongoing. I hope his family understand that the inquest was conducted out of respect for Julian's life.

100. I greatly respect Kirsten Campbell's decision to participate in these difficult proceedings on behalf of the family. I understand her motivation to achieve change and I thank her again for her courage and grace in such circumstances. I urge everyone involved to take the time to read her family statement which I have attached to these reasons.

101. I close this inquest.

Magistrate Harriet Grahame

Deputy State Coroner

18 June 2021

NSW State Coroner’s Court, Lidcombe

Annexure A

Inquest into the death of Julian Horne

Outline of non-contentious facts

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1. Julian Horne (**Julian**) was born 17 May 1969.

2. Julian (23) married in about 1993 aged about 23. He had three children, Jeremiah Horne (31.07.93), Oliver Horne (21.11.97) and Rosie Horne (18.11.99). Julian divorced from his wife in about 2010. He is survived by his children, his mother, Wendy Horne, sister, Kirsten Campbell (**Campbell**), and brother, Alasdair Horne. He held various types of employment including working as a teacher for a time.

3. Between about 2008 and his death in 2016, Julian resided in the Blue Mountains area. As at 2016 he resided alone in a rented unit at 2/27 Ridge Road, Lawson. His mother and younger brother resided in Winmalee (approx. 20 kilometres from Lawson) and Mount Victoria respectively.

4. Julian's difficulties with alcohol onset by the time he was 23. His family have reported that his abuse of alcohol was connected to his depression, anxiety and poor self-esteem issues[85]. Julian's mother considers that Julian's alcohol abuse had become much heavier by the birth of his third child. Julian appeared to struggle with the breakdown of his marriage and depression and severe alcohol abuse thereafter.

5. A drug and alcohol counselling record made on 4 April 2016 recorded:

> "…On presentation [Julian] was dressed in work clothes otherwise groomed neatly and appropriately behaved. He engaged in the assessment process without difficulty and indicated his sincerity in wanting to address his alcohol dependence….He indicated a binge pattern of alcohol use in which his drinking becomes uncontrollable and he will drink until he blacks out having been taken to hospital on several occasions due to unconsciousness and unable to arouse. He has been on life support in the past due to toxic levels of alcohol. Despite history [Julian] does not present with brain damage, he is able to provide history, is attending a university course while working in landscaping. He also has a degree and has worked as a teacher. He is polite and participates easily in discussion and exploration of his issues and triggers. He currently is in a relationship however they do not live together; he lives in a rented accommodation. His binge pattern can last 1 to 3 weeks, the last occurred 4/52 ago and it lasted 2.4 weeks, he drank till he blacked out and does not know how much he drank, he indicated that he has resorted to methylated sprits when unable to purchase alcohol. He remains in surprisingly good health and does not have difficulty with the current physical labour he is employed in…. He also attends AA since 30 yrs of age and *has been to rehab 6 times from age 31*. His drinking started in adolescence and advanced to daily use and then to long binge pattern by age 30. Impact on life has included Marriage breakdown,

[85] W Horne WS [4]

> homelessness, loss of professional career, and jail sentence. He has three children aged 22, 18 and 16, they live with his x-wife and he has contact with them. [Julian] indicated emotional struggles which he associated with self-perception and related to the dynamic between himself and his father…he continues to carry the self-talk and inflicts it on himself…"

Supports

6. The support and treatment Julian received with his alcohol abuse included:

   (1) ***Family and friends:*** Julian received ongoing support from his mother, siblings and friends.

   (2) ***General practitioner*****:** Julian attended the Balance Springwood Family Practice (**Balance Springwood**) between 2005-2008 and again between 2010-2016. His primary doctors were Dr Rodney Keevill (2006 to 2012) and Dr Derek Browning (2013 to 2016). He was prescribed Quetiapine and Lovan (fluoxetine) by Dr Browning between September 2015 to October 2016.[86]

   (3) ***Psychiatric*****:** Julian attended Dr Mark Walker, psychiatrist, on several occasions.

   (4) ***Blue Mountains and Nepean Hospitals:*** Julian had numerous admissions to Blue Mountains and Nepean Hospitals Emergency Departments (**ED**) (amongst others).

   (5) ***Drug and Alcohol Services:*** Julian was engaged with Drug and Alcohol Services. That included counselling at various times including in 2016 and spending short periods the Nepean Hospital's detoxification unit.

   (6) ***Other:*** Julian attended alcoholic anonymous (**AA**) at various times. He also received assistance, at various times, from services such as *We Help Ourselves* (**WHOs**) and Aftercare.

Hospital and rehabilitation contact in 2000 to 2011 (non-exhaustive)

7. **2000:** between 16 April and 1 June 2000, Julian (30) was admitted to the Blue Mountains Hospital wanting detoxification. It was documented that he had previously been to Westmead for detoxification.

8. **2005:** on 23 August 2005 Julian presented to the Blue Mountains Hospital wanting alcohol detoxification. He was transferred for drug and alcohol management at Nepean Hospital under the care of Professor Weltman.

9. **2007:** on 9 March 2007 Julian was brought to Blue Mountains Hospital by ambulance. He had lacerations to his arm and was intoxicated. He reported a long history of alcohol abuse, binge drinking and multiple detoxification admissions. Stated he had completed 10

[86] Balance Springwood Family Practice, medical records

months at “Grow Community” (a non-government organisation that operates a Residential Rehabilitation Program for recovery and prevention of mental ill-health and drug and alcohol addiction)[87].

10. On 8 October 2007, Julian presented to the Blue Mountains Hospital requesting detoxification. He reported being in the “Riley Home, Surry Hills” for about 3 to 4 weeks before leaving. He was referred to Drug and Alcohol Services. Contact was made with the Centre for Addiction Medicine (**CAM**), Nepean, who advised Julian had been admitted for detoxification previously. CAM unwilling to admit Julian as unable to plan for post discharge treatment. Julian was provided contact numbers for the Alcohol and Drug Information Service Intake and that of his previous Drug and Alcohol counsellor (Chris Gilles).

11. On 19 November 2007 Julian was brought by ambulance to the Blue Mountains Hospital. It was documented he had been binging on alcohol the preceding few weeks and wanted to detoxify. He was accepted for Drug and Alcohol rehabilitation at Surry Hills.

12. On 29 November 2007 Julian presented to the Blue Mountains Hospital requesting detoxification. Documented that detoxification had been organised a few days earlier but he had not made it and an application to be made to enforce the *Inebriates Act 1912*.

13. On 3 December 2007, a magistrate made orders under the *Inebriates Act 1912.* Julian is bailed to attend Nepean Hospital Detoxification and to then be transferred to the Salvation Army’s William Booth Rehabilitation Service Program (10 months duration).

14. **2008:** on 21 April 2008 Julian was brought by ambulance, intoxicated, to Nepean Hospital Emergency Department. Julian declined admission for detoxification. Assessed by psychiatry but discharged as assessed as not meeting the criteria for involuntary admission under the *Mental Health Act 2007.* Appointment scheduled with a social worker for the following week. In June and August 2008 Julian had several short admissions to Blue Mountains Hospital Emergency Department (**ED**) for acute alcohol intoxication.[88]

15. **2009:** in August and September 2009 Julian presented several times to Blue Mountains Hospital ED for acute alcohol intoxication.[89] This included on 24 August 2009 when Julian was brought by ambulance, twice, to the Blue Mountains Hospital. On that occasion he was referred for involuntary detoxification treatment and transferred to the Hope Cottage, Nepean Hospital. The Discharge Summary made by the Drug and Alcohol Unit noted that:

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[87] https://grow.org.au/learn-more-about-grows-residential-rehabilitation-program/
[88] Autopsy Report pg 3.
[89] Autopsy Report, pg 3.

(1) Julian had been "on ETOH detox program in this unit for 25-30 times";

(2) he had become homeless since his divorce in 2005 and resided for about 10 months in a rehabilitation program in Liverpool [possibly a reference to the GROW Community facility based in Hoxton Park];

(3) he had resided in Foster House in Parramatta between 2008-2009 [Salvation Army Men's Crisis Accommodation Service];

(4) he had attended the William Booth Program twice for a total of 10 months and the Hadleigh Lodge program in December 2008 [Salvation Army Recovery Services Centre that operated in the Blue Mountains until 2014].

(5) Initially Julian had refused rehabilitation but while in the detoxification unit had agreed to reside at the Hope Cottage [short-term accommodation facility at Nepean Hospital].

16. On 10 November 2009 Julian completed a consent form for Involuntary Drug and Alcohol treatment with the Nepean Blue Mountains Local Health District (**NBMLHD**).

17. **2010:** during 2010 Julian presented at least once to Blue Mountains Hospital ED (September) for acute alcohol intoxication.[90] On 1 October 2010, a Nurse Manager (NBMLHD Drug and Alcohol Services) noted Julian had been referred to the Sydney West Area Health Service Involuntary Treatment Program. Julian was reviewed by an Addiction Specialist and advised he was not suitable for the involuntary plan and recommended a voluntary treatment plan.

18. **2011:** during 2011 Julian presented at least once (January) to hospital ED for acute alcohol intoxication.[91] Julian was brought to the Blue Mountains Hospital on 26 January 2011, where it was documented that he had been drinking alcohol heavily over the preceding 3 days after having been abstinent for about 6 months. The possible trigger was thought to be his father's death about 2 weeks earlier. On 12 May 2011 Dr Walker (psychiatrist Julian consulted in the community) reviewed Julian and noted Julian had been sober for 3 months.

2013

19. In 2013 a Drug and Alcohol social worker contacts Rick Turner, Drug and Alcohol Councillor, who advises that Horne can be assessed by the Involuntary Treatment Team at Herbert Street, Orange (Bloomfield Hospital).[92]

[90] Autopsy Report pg 3.
[91] Autopsy Report pg 3.
[92] Nepean Hospital, progress notes, Vol 3.

20. On 15 January 2013 Julian was brought by ambulance, intoxicated, to Nepean Hospital. Between 16 and 18 January 2013, Julian underwent detoxification at Nepean Hospital before self-charging stating, "I just have to get out of here". A doctor requested an alert be placed on intake data base for Horne, for a Mental Health Plan to be put in place before any further admission. [93]

21. On 26 January 2013, Julian was sentenced by the Katoomba Local Court with a condition requiring Julian to reside at the Bridge Program, Surry Hills, and the Probation and Parole Service to oversee Julian's attendance in that residential rehabilitation drug and alcohol program.[94]

22. On 27 January 2013, Julian presented to the Blue Mountains Hospital ED for acute alcohol intoxication.[95]

23. On 29 January 2013, a Nepean Hospital social worker was notified by a family member that Julian had drunk after self-discharging from detoxification.

24. On 6 February 2013, Julian agreed to engage with (NBMLHD) Drug and Alcohol Services. The following day a family member advised Drug and Alcohol Services that Julian was heavily intoxicated and unable to come to the phone. Documented to be awaiting a detoxification bed.

25. On 18 February 2013, Julian presented to the Blue Mountains Hospital ED for acute alcohol intoxication.[96]

26. On 28 September 2013, Julian presented to Hornsby Hospital for acute alcohol intoxication and absconded the following day.[97]

27. In October 2013 Dr Walker notified Julian's GP that Julian was medicated with Fluoxetine and Seroquel, his depressive and anxiety symptoms were in remission, he remained in the Bridge program and was continuing with his abstinence[98].

2014 to 2015: Abstinence

28. During 2014 and 2015 Julian abstained from alcohol.

29. On 20 April 2015, during a consultation with his general practitioner (**GP**), it was noted Julian was abstinent from alcohol (Julian stated he had not used alcohol in the preceding

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93 Nepean Hospital, progress notes, Vol 3.
94 Criminal History p.7.
95 Autopsy Report, pg 3
96 Blue Mountains Hospital, emergency documents, p 10.
97 Hornsby Hospital, progress notes.
98 Walker letter to Keevill 2.10.13, Walker records.

2 ½ years) and was requesting a referral to see a psychiatrist (having been seen by a psychiatrist Dr Mark Walker previously).[99]

October 2015: Relapse

30. On 20 October 2015, Julian's GP noted Julian wanted to see a psychiatrist who specialises in alcohol misuse disorder. A referral was made to a psychiatrist based in Burwood.[100]

31. On 26 October 2015, an ambulance was called to attend Julian's home at Hawkesbury Road, Winmalee. It recorded Julian had reportedly been "*consuming alcohol for a few days."*[101]

32. On 3 November 2015, Julian presented to Nepean Hospital ED requesting detoxification.[102] He was admitted as a voluntary patient to CAM Nepean for detoxification (this was on referral from his GP). During that admission it was noted Julian had presented "*with an alcoholic relapse after 3 years"* and wanted to be admitted as a voluntary patient.[103] A letter of referral was sent by Dr Ian Carr-Boyd to Nepean Hospital for "*consideration of admission for acute (on recurring) alcohol intoxication"*. Julian was admitted to the Nepean Hospital's detoxification unit. It was recorded that Julian had been "*…drinking 5L wine a day for 12 days, states trigger [was] relationship of 7 years breaking down…denies thoughts of self-harm"*.[104] Julian was transferred to a detoxification bed where he remained for a week until 10 November 2015.[105]

33. On 10 November 2015, Julian was discharged from Nepean Hospital after detoxifying and was referred to Drug and Alcohol Community Counselling Service by the Nepean Hospital[106]. On discharge Julian stated he would follow up with AA meetings. Julian is allocated Rick Turner (psychologist) for treatment.

34. On 18 November 2015, Julian commenced counselling with a Drug and Alcohol psychologist (Rick Turner). He attended sessions every 2 to 4 weeks on average and as late as 16 February 2016 reported ongoing abstinence. Attends counselling sessions with Rick Turner on 18.11.2015, 15.12.2015, 5.1.2016, 19.1.2016 and 16.2.2016. Also attending weekly AA meetings. [107]

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[99] Balance Springwood, letter dated 2 Oct 13.
[100] Balance Springwood.
[101] Ambulance Case #10154, p 2.
[102] Nepean Hospital, discharge documents.
[103] Balance Springwood, patient history.
[104] Nepean Hospital, discharge documents Vol 1.
[105] Nepean Hospital, progress notes, Vol 3.
[106] Nepean Hospital, discharge documents Vol 1.
[107] Drug and Alcohol Community pages 21-36.

March to August 2016: Admissions for intoxication

35. On 2 March 2016, Julian was removed from a train at Blackheath Railway Station in an intoxicated state and taken to Nepean Blue Mountains Hospital where he was admitted for a short time.[108]

36. On 4 March 2016, Julian attends the Nepean Hospital with Wendy Horne and is admitted to the CAM Nepean for alcohol detoxification.[109] It was recorded: "*nil current thoughts of self-harm…but reports hallucinations when withdrawing…wants to stop drinking, keen to go to AA meetings".*[110] On 7 March 2016, Julian reported to nursing staff he was "*sick of relapsing again and again…he knows where to get help but every time he starts drinking again he stops seeking help".*[111] Julian was discharged on 9 March 2016 with a plan for follow up with his GP, Drug and Alcohol counselling and to attend AA meetings.

37. On 18 March 2016, Julian spoke to Rick Turner after a counselling session and reported he was attending daily AA meetings. Julian requested counselling around intimate relationship issues. Recommended he see his GP. Julian agreed to attend the Drug and Alcohol Drop In Clinic in Penrith.

38. On 24 March 2016, Julian was seen by a Drug and Alcohol Service clinical psychologist at the Drop In Clinic. Julian sought help with his alcohol abuse and mental health. He reported a relapse on 15 March 2016 and that he was '*seeing psychiatrist Dr Walker on and off since 2008*' and regularly attending '*SMART recovery group and AA meetings*'. He reported drinking "*5 litres of wine*" daily (on the days he drank).

39. Between April and May 2016, Julian attended AA meetings and counselling sessions with a counsellor (Venetia Demou). He attended counselling sessions on 4.4.2016, 2.5.2016, 5.5.2016, 12.5.2016, and 17.5.2016[112]

40. On 8 June 2016, Julian was found in bed with a bottle of vodka and taken to Nepean Hospital. He absconded the following day (4:20 am).[113] At 9 am Ambulance services were called to Blackheath for Julian. It had been reported that a male (Julian) was "*staggering along the street, grabbing the wall and intoxicated*". Julian was taken by ambulance to Blue Mountains Hospital ED[114]. After discharge nursing staff asked police to conduct a welfare check on Julian at his home (2/27 Ridge Street, Lawson)[115]. On

[108] Ambulance Case #10674, p 2; Blue Mountains Hospital, emergency notes, p 23.
[109] Nepean Hospital, progress notes, Vol 1.
[110] Ibid.
[111] Ibid.
[112] D&A Community, p 25.
[113] Nepean Hospital, ED Patient transfer form, Vol 1.
[114] Ambulance Case #10674
[115] Blue Mountains Hospital, emergency notes.

attendance police found the rear window smashed and Julian in his bed covered with vomit with a vodka bottle (3/4s empty) beside his bed. Julian was taken by ambulance to the Blue Mountains Hospital (9 June 2016) for treatment.[116] Julian is offered Drug and Alcohol and Social Work referral but declines. He discharged himself. The Nursing Unit Manager recorded there was to be Drug and Alcohol and "CNC" follow up in the community.

41. On 10 June 2016, an ambulance was called to Adelaide Street, Lawson for a male (Julian) found lying in a garden intoxicated. Julian was taken to Blue Mountains Hospital for treatment. Noted on admission to be his third presentation to hospital for intoxication in about "2 days". During admission the Nursing Unit Manager spoke with Drug and Alcohol Services at CAM Nepean about patient detoxification at Nepean Hospital, but Julian declined that option.

42. On 11 June 2016, Julian self-discharged from hospital the following day. Later that morning he was found unconscious on a train at Central Railway Station (Sydney).[117] Ambulance paramedics noted Julian had a "wine cask" and smelled strongly of alcohol.[118] He was taken by ambulance to St Vincent's Hospital for treatment.[119]

43. On 13 June 2016, Julian fell over, intoxicated, behind shops at Lawson. Ambulance attended. He was found with numerous lacerations all over his body. He was taken to Blue Mountains ED for treatment. Nursing staff noted Julian had "*climbed out of bed, wanting to go home to pay bills and requesting Valium"*. Julian self-discharged.[120]

44. That same day, 13 June 2016, between 8-11 am, Julian boarded a train at Penrith Railway Station and pressed the emergency help button. He was removed at Blacktown Railway Station due to intoxication. Ambulance services attended and saw he was wearing a Blue Mountains Hospital wristband. Julian was assessed and conveyed by ambulance to Blacktown Hospital.[121]

45. On 16 June 2016, Julian was taken by ambulance to Blue Mountains Hospital. He was acutely intoxicated. Noted to have a low Glasgow Coma Scale (**GCS**) and alcoholism after being found at home by a friend, comatose after ingesting methylated spirits. Julian was wearing a Blacktown Hospital wrist band when admitted. His regular medication noted to be Quetiapine (antipsychotic medication used in the treatment of depression) and

[116] Event Ref No E61471418, p 2.
[117] Ambulance Event Ref No E62075869, p 2.
[118] Ambulance Case #10546, p 2
[119] Ambulance Case #10546, p 2
[120] Blue Mountains Hospital, emergency notes
[121] Ambulance Case #10488, p 2

Lovan (SSRI anti-depressant). A history of depression/anxiety and alcohol abuse was also documented.[122]

46. On 17 June 2016, Julian requested voluntary admission to a detoxification bed at the Nepean Drug and Alcohol Service. A bed was expected to become available in that unit the coming Monday. Julian reported to staff ongoing issues with anxiety.[123]

47. On 19 June 2016, nursing staff found Julian wandering around the ward complaining of high levels of anxiety and agitation. He "*denies hallucinations but states lots going on in his head"*. Julian was also found drinking from alcohol wipe tub after he filled it with water. Julian was issued with a dose of Valium[124]. Nursing staff recorded Julian was "*agitated and states that he is wanting to run"*. He subsequently attempts to leave the ward and security were called.

48. On 20 June 2016, Julian left via a fire escape. Nursing staff alerted by the fire alarm. Security attended and Julian administered Seroquel. Later that morning Julian transferred to Nepean Hospital for detoxification but discharges himself against medical advice.[125]

49. On 6 July 2016, Julian attended on a Drug and Alcohol counsellor (NBMLHD) at the Springwood Community Health Centre (**CHC**). Julian advises he had relapsed in the context of continued relationship issues.[126] In counselling sessions on 6 and 28 July, and 18 August 2016, Julian reports his relationship had ended but he was receiving abusive messages from his ex-partner.

50. On 28 July 2016, Julian attends an appointment with a counsellor at the Springwood CHC. He reported abstinence but ongoing relationship issues acted as emotional triggers for him.[127]

51. On 10 August 2016, Julian attends on a counsellor at Springwood CHC.

52. On 18 August 2016, Julian attends on a counsellor at the Springwood CHC. Julian reported still being abstinent but having nearly relapsed owing to relationship issues.[128]

53. It appears by 26 August 2016 the difficulties in his relationship with partner had intensified (Julian reported to Lydia Irving he had to cease contact with her as his partner believed he was being unfaithful).[129]

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[122] Ambulance Case #10941, p2; Autopsy Report.
[123] Blue Mountains Hospital, progress notes, volume 2
[124] Blue Mountains Hospital, progress notes, admission
[125] Nepean Hospital, Alcohol and Drug documents, volume 1.
[126] Springwood CHC records.
[127] Springwood CHC, p 17.
[128] Springwood CHC, p 15.

54. On 30 August 2016, Julian is referred by his GP to Dr Mark Walker (psychiatrist who assessed Julian previously) for Dr Walker's "*opinion and management of psychiatric issues"*.[130]

2 to 6 September 2016: Coffs Harbour and Macksville Hospital admissions

55. On 2 September 2016, Julian was found intoxicated, walking up and down a street in Sawtell (NSW) yelling abuse. He was taken by police to a motel[131] (Julian later told his friend, Lydia Irving, that his partner had left him in Coffs Harbour[132]).

56. On 4 September 2016, Julian was found at the motel unconscious in bed. Ambulances paramedics attended and found Julian intoxicated with a one litre bottle of methylated spirits in the bin. Julian was taken to Coffs Harbour Hospital for treatment[133]. Julian self-discharged from Coffs Harbour Hospital ED about midday. Later that same day he was found intoxicated in public and returned to Coffs Harbour Hospital by ambulance.[134]

57. On 5 September 2016, Coffs Harbour Hospital ED noted Julian had presented there for the second time following an "*Alcohol and Methylated Spirit Binge…situational crisis and patient tells me...[this] binge is attempt at self-harm"*.

58. Later that day Julian was removed from a train at Nambucca Heads Railway Station (after leaving hospital) due to intoxication. Ambulance conveyed him to the Macksville Hospital ED.[135] Julian absconded that same day and took a taxi to Macksville Railway Station before returning to the hospital to collect his belongings. Julian was located later at Macksville Railway Station, unconscious, with an empty methylated spirits bottle next to him.[136] He was then taken by ambulance back to Macksville Hospital.[137]

59. On 6 September 2019, arrangements were made for Julian to take a train to Sydney.[138]

7 to 9 September 2016: Kempsey Hospital admission

60. On 7 September 2016, Julian was removed the train at Kempsey Railway Station and taken to the Kempsey Hospital ED. Julian was admitted overnight before self-discharging but is returned soon after by police[139]. A counsellor from Nepean Drug and Alcohol

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[129] OIC WS [22]; Irving [6].
[130] Balance Springwood Practice, patient history.
[131] Event Ref No E63042716, p 3
[132] OIC WS [23]; Irving [8].
[133] Ambulance Incident #40335
[134] Ambulance Case #40754, p 2
[135] Event Ref No E61925627, p 2
[136] Event Ref No E61925627
[137] Ambulance Case #40890
[138] Macksville Hospital, nursing progress notes, p 8
[139] Kempsey Hospital, nursing progress notes, p 7

contacted Kempsey Hospital and advised that Julian has an appointment at Nepean Drug and Alcohol Service that afternoon[140]. Julian was assessed by the Kempsey Drug and Alcohol Service which noted it was "*unable to assist at this time as he is refusing detox".* Julian stated he wished to return to Penrith[141]. Julian's sister, Kirsten Campbell, reports speaking to Kempsey Hospital and recommending it speak with the Nepean Drug and Alcohol Service[142].

61. Julian left Kempsey Hospital around midday.[143] Later that day he was found by staff at a motel in Kempsey unresponsive in his bed covered in vomit. He was taken by ambulance to Kempsey Hospital for acute alcohol intoxication[144].

62. Julian was then transferred to Port Macquarie Base Hospital for CT brain scan due to his low Glasgow Coma Scale (GCS) and for further detoxification treatment.

10 to 13 September 2016: Port Macquarie Base Hospital

63. At the Port Macquarie Base Hospital, Nursing staff noted Julian's "*general condition remains very weak"* and that he continued to refuse all meals and general nursing care.[145]

64. Additional, unsuccessful, attempts were made by Mental Health clinicians to assess Julian (an Intensive Care Unit (**ICU**) Registrar noted that "*Julian did not wish to engage…except when [he] wants Diazepam; and becomes disruptive and attempts to leave the unit until he is given same"*).

65. On 13 September 2019, Julian attempted to leave the hospital. Nursing staff, assisted by security staff, returned him to the ward. Julian was recorded as saying "you can't keep me here". Julian was assessed noted by an ICU Registrar not to be *"suicidal…[patient notes] he has detoxed to many times…he is over the worst…intends not to drink until he gets home to the Blue Mountains…I believe he has capacity and can be discharged at his own risk*".

66. Julian then self-discharged from Port Macquarie Hospital[146].

14 to 30 September 2016

67. On 14 September 2016, Julian was removed from a train in Taree in an intoxicated state.

68. Julian was later found heavily intoxicated on a train at Hornsby Railway Station, "*unable to ambulate or talk properly"*[147] He was taken to Hornsby Hospital for treatment due to acute alcohol

[140] Kempsey Hospital, CLIN DOC – Drug Alcohol, p 8
[141] Kempsey Hospital, nursing progress notes, p 4
[142] OIC WS [33].
[143] Kempsey Hospital, nursing progress notes, p 5
[144] Ambulance incident #40237
[145] Port Macquarie Hospital, progress notes.
[146] Port Macquarie Hospital, progress notes.
[147] Ambulance Case #11199, p2

intoxication.[148] A treating doctor had contact with the Nepean Drug and Alcohol Service and requests an assessment by the Hornsby Hospital's Mental Health and Drug and Alcohol Services.

69. Julian's Springwood CHC Counsellor advises the Hornsby Hospital doctor that Julian has had multiple admissions to hospital for both intoxication and self-harm and provides contact details for Julian's family.[149] The treating doctor also requests additional information from Dr Browning at Springwood Medical Practice[150].

70. By about 11:30 am Julian absconded from Hornsby Hospital. His clothing and belongings were also missing.[151] Julian called Hornsby Hospital and advised he had got home, had taken out his cannula and was "*going to get drunk"*.[152]

71. On 16 September 2016, Dr Esther Phelps (Hornsby Hospital) contacts the NBMLHD Drug and Alcohol Services and speaks to a Social Worker who noted:

> "…Julian was taken to Hornsby Hospital intoxicated. Dr Phelps was enquiring with regards to recent history, GP details and medication. On review of CHOC the author was unable to ascertain medication; however, Julian's recent admissions to Coffs Harbour and Kempsey hospitals and inpatient withdrawal unit treatment at Nepean and Ed presentations to Nepean were informed. The GP details as per this encounter registration and "person lo contact" (his mother) details were provided, Dr Phelps informed Julian would likely remain an inpatient and the D&A clinician can make contact with her on Monday 19th September via the Hornsby Hospital pager system."[153]

72. On 19 September 2016, Ms Demou (NBMLHD Drug and Alcohol counsellor/clinician) attempted to call Dr Phelps at Hornsby Hospital. Dr Phelps could not be reached and the operator did not how to locate Dr Phelps. Ms Demou noted a plan to attempt calling Dr Phelps the next or following days.[154]

73. On 22 September 2016, Ms Demou (NBMLHD Drug and Alcohol counsellor/clinician) spoke to Julian by phone at about 3:50 pm. Julian sounded intoxicated but coherent enough to speak sensibly. Said he was on his way home. Ms Demou encouraged him to go home to get some sleep and self-care. Julian stated he would call for an appointment when he felt better and indicating he appreciated the call and concern. Ms Demou planned to make a follow up call the following week.[155] At about 7:30 pm that same day Julian was found by train staff intoxicated at the Penrith Railway Station. An ambulance attends. Julian noted to have a small laceration on his forehead, "*slurred speech",* and a radical pulse. He is conveyed to Nepean Hospital for treatment.

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[148] Event Ref No E61851615, p 2
[149] Springwood CHC, p 12
[150] Hornsby Hospital Progress Notes, p 60
[151] Hornsby Hospital Progress Notes, p 61
[152] Hornsby Hospital Progress Notes, p 61
[153] NBM Drug & Alcohol Clinical note 16.9.2016 (9:15 am) (saved file name "Item 52").
[154] NBM Drug & Alcohol Clinical note 19.9.2016 (2:22 pm) (saved file name "Item 52").
[155] NBM Drug & Alcohol Clinical note 22.9.2016 (3:49 pm) (saved file name "Item 53").

74. On 23 September 2016, Julian self-discharged from Nepean Hospital at about 1:45 am.[156] Julian later seen wearing a hospital gown and drinking methylated spirits on a train at Lawson Railway Station (Police CAD 63798653: *"CBF (check bona fides) of a male wearing hospital gown and drinking metho from bottle on train…"*).[157]

75. On 24 September 2016, Lydia Irving (friend) spoke to Julian and gave him money to buy a cask of wine hoping to stop him drinking methylated spirits.[158] From this day onwards she had daily phone contact with him and tried to support and convince him to stop drinking.[159]

76. On 26 September 2016, Julian's mother requested an ambulance attend Julian's home to conduct a welfare check. The ambulance service noted it was reported Julian had been "*suicidal over the last couple of days but has not stated to her any plans"* [160] Ambulance paramedics attended 2/27 Ridge Street, Lawson at about 6 pm and found Julian unresponsive and smelling of methylated spirits.[161] Ambulance takes Julian to the Blue Mountains Hospital and admitted there about 6:40 pm for acute alcohol intoxication.[162]

77. During admission it was noted during admission that Julian had drunk "1L methylated spirts earlier today", had been found "slumped in couch with reduced level of consciousness" with a "GCS 7? on arrival". In ED his GCS was initially scored at 11 (not obeying commands and incomprehensible sounds) but this improved during admission. His medications were noted to be Quetiapine 100mg mane. Julian was given Diazepam and IV fluids, and it was later determined he was not to be discharged from ED until he was sufficiently sober to walk unaided. He was discharged about 1 am on 27 September 2016.[163]

78. That same day Julian's mother calls an NBMLHD Drug and Alcohol Services counsellor (Lesley Hohnen) and advises Julian was at home drinking methylated spirits and, "*wanted Julian to be held somewhere so he could be detoxed".* The counsellor advised there were difficulties doing so under present laws. Julian's mother advised she had attended AA and this group had been supportive of her. The counsellor advises she would ring Julian's "present counsellor" (Ms Demou).[164]

79. On 29 September 2016, Julian's mother called ambulance to his home. Julian was reported to be drinking methylated spirits and to become agitated if he didn't. Julian was taken to Blue Mountains Hospital.

80. On 30 September 2016, Julian had a scheduled appointment with Dr Mark Walker.[165]

October 2016

[156] Nepean Hospital, Drug and Alcohol documents, volume 1
[157] COPS Event Ref No E62335950, p 2
[158] Irving WS [10].
[159] Irving WS [10].
[160] Ambulance Case #11134, p 2
[161] Ambulance Case #11134, p 2
[162] Ambulance Case #11134, p 2
[163] Blue Mountains Hospital, ED notes, p 17; see extract of records annexed to Fan WS.
[164] Springwood CHC, p 10; NBM Drug & Alcohol Clinical note 28.9.2016 (saved file name "Item 54").
[165] Hornsby Hospital Progress Notes, p 71].

81. On 4 October 2016, Julian spoke by phone to his sister. Julian said he was trying to self-detoxify with his mother.[166]

82. On 5 October 2016, Julian attended an appointment with his GP (arranged by his family).[167] Julian noted to have become "*completely intoxicated overnight*". His GP noted, "*patient unresponsive in mothers car…drinking [including] metho…been in hospitals up the coast last weeks but no known definitive action…no control".*[168] Julian was then taken by his mother to the Blue Mountains Hospital. Julian sobered up and then absconded from hospital (Julian's mother called police when he absconded concerned for his welfare).[169]

83. That same day, 5 October 2016, shortly after 12:15 pm, Constable Morgan and Senior Constable Matthew Bambrick at Katoomba found Julian at Edge Cinema (Katoomba). Senior Constable Bambrick assessed Julian to be *well affected by alcohol, smelling strongly of alcohol and having trouble maintaining his balance.*[170] Julian was slurring his speech and the officers found it difficult to comprehend what he was saying. Paramedics attended at 12:55 pm and observed Julian heavily intoxicated with cuts on his arms which he claimed were self-inflicted.[171] Julian was taken back to Blue Mountains Hospital by ambulance under s 22 of the *Mental Health Act 2007*.[172]

84. Julian arrived at the Blue Mountains Hospital at about 2:52 pm and given a breath analysis using an Alcoliser. It returned a reading of 0.283. Senior Constable Bambrick completed a Police Request for assessment of a detained person under Section 22 of the *Mental Health Act*. Handed the form to the triage nurse in the emergency ward.[173] While at the hospital Senior Constable Bambrick spoke to Julian's mother who advised that Julian had recently drunk methylated spirits.[174]

85. A nurse noted Julian wanted "*his diazepam…[he] became impatient, climbed out of bed despite bed rails being up and chewed his infusion line…leaving blood on the floor…security guard involved and needed to confine him"*.[175]

86. At 6.15 pm Julian absconded from the Blue Mountains Hospital. He attended a BWS in Leura stole a bottle of wine.[176] Ambulance paramedics and police attended. He was found lying on a park bench heavily intoxicated and treated for intoxication from drinking methylated spirits. At 8.15 pm Julian was taken to the Blue Mountains Hospital for treatment.[177]

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[166] Campbell statement [10].
[167] Campbell statement, p 10
[168] Balance Springwood Practice, patient history
[169] Campbell statement, p 10; OIC WS [43].
[170] Bambrick statement, p 5
[171] Ambulance Case #10713
[172] Event Ref No: E61851615, p 2
[173] Bambrick statement, p 6; Morgan statement, p 13
[174] Bambrick statement, p 6
[175] Blue Mountains Hospital, emergency notes, p 24
[176] Ambulance Case #11219, p 2; Blue Mountains Hospital, emergency notes, p 24
[177] Ambulance Case #11219, p 2

87. On 6 October 2016, Julian was noted to be settled and awaiting transfer to the Nepean Drug and Alcohol Service.[178]

88. Julian was discharged from the Blue Mountains Hospital about 12.15pm and admitted to Nepean Hospital for Drug and Alcohol detoxification. It was noted on the Intake form that Julian had been: *"drinking very heavily since relapsing to alcohol use…. wishes to undergo a safe medicated alcohol withdrawal…Julian is at risk of harm through careless and reckless behaviour…or through alcohol poisoning"*.[179] It was also documented that Julian had been drinking a bottle of spirits (700 ml) or 4 to 5 litres of wine daily for the preceding 6 weeks and that he had had numerous detoxifications attempts with 2 to 3 rehabilitation admissions in the preceding 10 years.

89. On 7 October 2016, nursing staff were told Julian had jumped the fence and absconded. About 2:30 pm Julian returned to the unit. At 4:30 pm he again absconded and did not return (noted to have "*self-discharged against medical advice"*)[180]. Julian met a friend at Emu Plains Station.

90. On 8 October 2016, Julian presented to Blue Mountains Hospital ED and reported he had been drinking methylated spirts and had hit his head on the corner of a coffee table after falling.[181]

91. On 9 October 2016, Julian was discharged from the Blue Mountains Hospital ED during the afternoon.[182]

92. On 11 October 2016, Julian called Lydia Irving (friend) and said he was hallucinating.[183] Ms Irving attended Julian's home about 4:30 pm.[184] Ms Irving had entered the unit shortly before police arrived, using her set of keys, and found Julian lying on his bed surrounded by vomit. Shortly after her arrival Constables Prestage and New attended Julian's home after police received a call from Maree Badgery-Parker (Julian's ex-wife – not his recently separated partner), requesting police check on Julian's welfare as he had been on an "8-week bender (much longer than normal" and she was aware he was drinking "metho".

93. Constable New attempted talking to Julian but Julian could not respond coherently and went in and out of consciousness. Ms Irving advised Constables New and Prestage that Julian's mother had bought him a 5-litre cask of wine the previous day, which he had finished within a 24-hour period, and he was known to drink methylated spirits if he had no other alcohol to drink (Ms Irving reported her belief that Julian was not drinking methylated spirits to end his life). An empty 5 litre cask wine was found along with a 1-litre bottle of methylated spirts (half to ¾ full) was found in his cupboard. The attending police could not ascertain if Julian had consumed methylated spirits on this occasion or not.[185] An ambulance attended and took Julian to Blue Mountains Hospital.[186]

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[178] Blue Mountains Hospital, emergency notes, p 6
[179] Nepean Hospital, discharge documents, volume 1
[180] Nepean Hospital, discharge documents, volume 1
[181] Blue Mountains Hospital, emergency notes, p 1
[182] Blue Mountains Hospital, emergency notes, p 1
[183] Irving statement, p 14
[184] New statement, p 8
[185] Statements of New and Prestage.
[186] Ambulance Case #10947

94. Julian was admitted to Blue Mountains Hospital ED about 6 pm on 11 October 2016.[187] Constable New and Constable Prestage considered that Julian did not meet the criteria to be detained by police under section 22 of the *Mental Health Act*.[188] On admission he was noted to be "rousable to painful stimuli only" and to have old bruising to his eyes from a fall 3 days earlier.[189]

95. At 7.30 pm, Nursing staff noted Julian was awake and "*trying to climb out of bed…requesting Diazepam."*[190]

96. On 12 October 2016, the treating ED team discuss request the Drug and Alcohol team to review Julian. The treating team learns that the Drug and Alcohol Clinic Nurse Consultant is not at the Blue Mounts Hospital that day. Julian advised of that fact and that a call can be made to the Drug and Alcohol team at Nepean Hospital to check if a bed is available there for voluntary admission. Julian said he wanted to go home and did not wish to see the Drug and Alcohol team that day.[191] Julian given the contact number for detoxification at the Nepean Hospital. Julian self-discharged from the Blue Mountains Hospital ED on 12 October 2016 at about 8.50 am.[192]

13 October 2016: Deceased

97. On the morning of 13 October 2016, Lydia Irving called the Blue Mountains Hospital about 7:15 am to check on Julian and was told he had been discharged. Ms Irving contacted Julian's mother about 8:30 am advising she had learnt of Julian's discharged from hospital. Julian's mother attended his unit about 11 am and used her keys to enter his unit[193]. Julian was found deceased by his mother.[194] Police and ambulance attended thereafter followed by Ms Irving. A half empty methylated spirits bottle (Coles Smart Buy label with alcohol concentration of 95% with less than 5% water[195]) and an empty orange juice bottle was found on his kitchen table.

98. Julian's mother advised police she believed Julian would drink methylated spirits to become intoxicated and or if he had no money to purchase alcohol. About one week prior she had bought him a cask of wine in the hope he would not drink methylated spirits if other alcohol was available to him.

99. Post-mortem toxicology revealed[196]:

    a. a blood alcohol level of 0.379 g/100mL (vitreous alcohol level was 0.477 g/100mL).

    b. Diazepam, Nordiazepam (Diazepam metabolite), Fluoxetine, Oxazepam and Temazepam detected in non-toxic range.

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[187] Russell statement, p 48
[188] Prestage statement, p 17
[189] See extract of ED records annexed to Fan WS.
[190] Blue Mountains Hospital, discharge transfer documents, p 5
[191] Fan statement [21]
[192] Campbell statement, p 12; Blue Mountains Hospital, emergency documents, volume 2
[193] Irving WS [15].
[194] Russell statement, p 8
[195] Supplementary Pharmacology Expert Certificate.
[196] Limited Pathologist Report dated 08.11.16 p.3

100. External examination revealed no injuries on the body (superficial abrasions and some bruising were observed). In the opinion of Dr Du Toit-Prinsloo (pathologist), Horne died as a result of acute alcohol intoxication[197].

[197] Limited Pathologist Report dated 08.11.16 p.3

Annexure B

On behalf of the family of Julian Horne, I would like to thank the court for the opportunity to submit this Family Statement.

We would like to start by genuinely thanking all involved in contributing and bringing together this long and complex body of work. In particular we would like to thank Janet de Castro, and before her Katie Llewelyn, and Chris McGorey for keeping us informed, explaining the process, and managing the process with dignity and flexibility. Julian's children are now young adults, and although it is 4.5 years since his death, understandably they have not yet been able to fully engage with the manner of his death. You may not realise it, but this brief of evidence you have collected may actually be invaluable in their piecing together the story of their father in the future.

In approaching this statement, the family had three goals.

Firstly, we wish to contribute something more to the record of who Julian was. As Mr McGorey said on Monday, these proceedings are not intentionally light on establishing the full picture of who Julian was, but necessarily so in order to concentrate on the manner of his death. As the family, we are not so bound, and we believe that there is value in intentionally capturing a fuller picture of the remarkable multidimensional man that Julian was, and in particular his ceaseless efforts to make the system work for him so he could be well.

Secondly, we wish to add to the story a small amount of our lived experience as the family. Our hope in doing so is that the value held in family knowledge can eventually contribute to the broader knowledge and add something of use. We believe that the voice of the lived experience, including family knowledge, is key to better program design and therefore more positive outcomes for patients like Julian.

Finally, we wish to respond as lay persons, to a few key points raised in proceedings. We see two critical but separate issues; crisis management and treatment management.

Firstly, standing back from the detail, we have observed a system that is excellent at zooming in to think deeply about details (and we understand the need for that), however, if the goal is to meet the needs of complex cases like Julian's, then somebody needs to take a big step back and away from siloed thinking. We need to see that what was intended to have been the design for a race horse, may in fact have be becoming a struggling nag.

Julian, where to begin?

Well for a start, despite what we have focused on today, Julian spent most of his life NOT intoxicated. Most of his life was spent in the love of learning, the love of and engagement in literature (especially poetry), the love of music and debate and philosophy, and ceaselessly working on himself and his relationships. To illustrate this……despite everything you see in his records today, he died with every major relationship in his life still intact!! How many addicts can say that? For me personally, he made the world a richer, more meaningful place.

He excelled at tertiary level at literature and humanities, he was a talented professional writer who worked in policy for two NSW Govt departments, and he was a competitive bike rider. He was never happier than when he was in the bush; it clearly brought him solace. But as Dr Fisher so accurately described, he lived with deep existential anxiety which brought unbearable pain….. and alcohol was the off-ramp for that pain when it got too much.

Our journey with Julian (but not Julian himself) was defined by his inability to find a way to manage that pain. He sought every imaginable way to calm that beast. CBT didn't touch the sides, pharmacology made it worse or just took the edge off; he tried multiple residentials, group programs, self-help, explored various psychiatric diagnosis (he knew the DSM inside out), constantly in search of a way to understand himself and release himself. Despite all of the relapses and damage, more than anything he wanted to be a good dad and be 'normal' and able to provide for his family.

Personally, I believe Julian was just neuro-atypical. His craving to be 'normal' was driven by a deep sense that he wasn't, (because he probably wasn't) but that this somehow represented failure. The

harder he tried to be normal, the more he fell short, under scoring the narrative of failure. Above all he wanted relationships and connection, and hence the immeasurable pain at their failing. But that's just my theory.

The family's lived experience was one of despair, because too often we could not feed potentially lifesaving information effectively into the system. Being alcohol related, it was already complicated by the 'do not enable the addict' vs 'keep your loved one alive' equation. It was a recurring nightmare.

Interestingly, what I have heard at this inquest is a bit of a microcosm of that experience. Firstly, it impossible to navigate this 'connected-up' system from the outside. It is a sea of new and evolving acronyms, with very little actual change underneath. Then there is the mystery of community vs hospital vs somewhere in between. Add to that the he-said/ shed-said, and lack of adjudicator or a person-centred system. Imagine for example, how a family might navigate the diametrically opposing views of Dr Nixon "Julian exemplified a particular IDAT criteria" to Dr Fisher's adamant stance that Julian would not fit the criteria.

As long as the system is process-centred, rather than person-centred, there will be no effective connecting-up for vulnerable patients like Julian. So long as the great new product is time limited for 12 weeks (in chronic health?), severe crisis triggered patients like Julian will access D&A services when they are stable, but be missed at the very time they need them the most because EDs insist on only being 'acute'.

Then there is the invisibility of the family. Mum, his ex-wife Maree, and I, personally called every hospital where Julian presented during his final binge. I very much doubt that many, if any, of those calls even made the notes. We tried to connect Nepean and whatever LHD he was in, because even then we just knew that within the NSW Health e-systems was that 'tab' that nobody knew to look at. And even if you looked at it, there was probably nothing there, because it hadn't come through the 'right' referral pathway. It's like shouting into outer space.

This brings us to the discussion of crisis management during bingeing, and the concept of the 'last resort'. If not IDAT, then what?

Judging by the reports and the testimony of witnesses, there seems to be little debate that when Julian binged, he was a danger to himself. Dr Nixon reports that 'it is precisely because addiction impairs an individual's ability to make decisions in his/her best interests, that the Drug & Alcohol Treatment Act was written."

This impairment was our experience of Julian's illness, and was the driver in our attempts to have him involuntarily treated. When Julian was binging, he was in life a threatening crisis. As Dr Gill said, 'he had lost control'. While within the grips of a binge, even when he not actually intoxicated, his ACTIONS evidenced impaired judgement to act in his own best interests. He said the right things to treating professionals, but his actions demonstrated the exact opposite. With the greatest respect, we reject the assessment of Dr Fisher that you could not predict that the behaviour would be highly likely to continue. It is true that every other binge in his life did end, but this was just luck, and a philosophical and not a practical approach, and eventually Julian did die during a binge.

When Julian is within a binge, he is addicted. Splitting hairs about whether that definition extends to his periods of sobriety does nothing to guide us in responding to his being a danger to himself. If a patient had over dosed on pills, but then said they felt better and were not intending to self-harm, and then immediately went out and over-dosed, not one but a dozen times, do we really imagine that we would not call into question their actual intention to self-harm?

Where then was Julian's option to protection from being a danger to himself? No access to the Mental Health Act, no access to IDAT. What then was Julian's last resort?

On the matter of treatment management, our view is as follows.

Dr Gills report tells us that 36% of people seeking D&A treatment services at EDs were seeking treatment for alcohol related reasons. The College of Emergency Medicine states that alcohol is behind 1 in 7 (14%) of ALL ED presentation.

We felt, that if WE were responsible for the outcomes of a business where 14% of our customers were from one patient segment, we would become EXPERTS in that area. We would bring that customer segment close…. very close. If our business was acute and their needs were chronic, we would create very strong immediate bridges to the intense services they needed, because to do less, would be to not meet their needs OR our outcomes, and it would put more pressure on the rest of our business. We would provide services when THEY needed services, and where THEY needed services. Person-centred systems would track patients moving across geographical areas.

As Dr Ezard remarked, we are moving towards not using terms like absconding and leaving against medical advice, because what we are really being told by these actions, is that we are not meeting our patient's needs. This was very much the case for Julian. He knew what was about to happen, and how un-useful it would be, because he had done it dozens of times and most of it did not meet his needs.

The story told to us by NSW Health was the glossy high level brochure of what that building and those bridges could be. "Joined up services", ACMs, Community liaisons, all with broad promising but vague descriptions …….Meanwhile, The story from the LHD on the ground was the actualization of that brochure, and like most brochures, the reality is it delivered falls short of the promise:

- Inconsistent services across LHDs, treatment hours, modes of treatment (phone vs face to face)
- Communication systems across LHDs with potentially critical areas not practically accessible
- Time, ie resourcing issues preventing access to the full connected-up data even when it was there.
- Rigid referral/ communication pathways that could only accept information along certain pathways.

From our perspective, an economic lens was predominant in planning, and not a person-centred lens.

In finishing, we asked ourselves what do we think success could look like?

Firstly, with respect to crisis management, there needs to be an agreed crisis process for binge drinkers like Julian. It is not enough to hold our breath and hope for luck. We are agnostic about whether it is under the Mental Health Act, IDAT, or another vehicle. It just needs to exist.

Certainly, the IDAT process we have seen this week seems too technical and drawn out. Consider instead a broader reading of the Mental Health Act to allow for severe binge drinking to be included in the definition of self-harm?

Secondly, but perhaps more importantly, we imagine the realization of connected-up treatment services that are matched with resources to meet demand, to the right places at the right times when patients do engage. We imagine some useful form of D&A units inside EDs, 24/7 with resources that matches the 14% demand….but with goal of reducing this alarming statistic. We imagine family liaison would be an integral part of those units.

Finally, in order to harness the enormous body of knowledge held by patients and families, we imagine that the lived experience could be a part of the design of improvements. Mechanisms for doing this may already exist? I remember discussing something similar with Julian's casework Mary many years ago. From memory, Julian was too sick to assist and the family could not because we lived outside the LHD!! We imagine a pre-administered state-wide panel of patients and families willing to contribute to LHD planning. And we imagine the LHD and NSW Govt actually using it effectively by including consultation from early stages.

If Julian were here, he could reimagine this success. In our minds, he will always be a part of that.

Thank you for hearing the views of our family.

Kirsten Campbell