CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of AR
Hearing dates:	21, 22 and 23 March 2017
Date of findings:	6 April 2017
Place of findings:	NSW Coroner Court - Glebe
Findings of:	Magistrate Elizabeth Ryan, Deputy State Coroner
Catchwords:	CORONIAL LAW – cause and manner of death; death in residential care facility; drug toxicity (Fluvoxamine); SUDEP; adequacy of care and treatment.
File number:	2010/436799
Representation:	Advocate Assisting the Coroner: Mr P Bush. Counsel for Ms R: Mr J Brock instructed by Legal Aid Commission. Counsel for Department of Family and Community Services: Mr M Lynch instructed by FACS Legal Coronial. Counsel for Dr Gambrill: Mr E Pike instructed by Avant Law. Counsel for Dr C McDowell: Mr R Sergi instructed by MDA National.

Findings:	**Identity** Mr AR **Date of death**: 30 August 2010 **Place of death**: 78A Market Street Condell Park NSW **Cause of death** Unascertained. **Manner of death** Sudden and unexpected.

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The Coroners Act 2009 (NSW) *in s81 (1) requires that when an inquest is held, the coroner must record in writing his or her findings as to various aspects of the death.*

These are the findings of an inquest into the death of AR.

Introduction

1. On 30 August 2010, twenty-nine year old AR was found unconscious by Disability Support care workers. Due to his health conditions of autism, epilepsy and developmental disability A was living in a residential care home operated by the Department of Ageing, Disability and Home Care. Ambulance paramedics could not revive him and he died at about 5.30 that afternoon.

2. A's mother Ms R attended each day of this inquest, supported by A's sister and family friends. At the close of the evidence Ms R made a very moving statement about her life with A and how much she missed him. She described a close and very loving relationship with her son. Although in his later years A's health problems had sometimes made his behaviour difficult, it was plain that his mother never stopped loving him dearly and that she cared for him throughout with courage and devotion.

3. The circumstances of A's sudden and unexpected death have raised many questions about the cause and manner of his death. Those questions have been the focus of this inquest.

The Inquest

4. An inquest is different to other types of court hearings. It is neither criminal nor civil in nature. It does not determine whether a person is guilty of an offence, and it does not make findings and orders that are binding on parties.

5. A coroner presiding over an inquest is required to confirm that a particular death occurred and make findings as to:-
   - the identity of the person who died
   - the date and place of the death
   - the cause and manner of the death.

   It is not always possible to definitively answer each of these questions.

6. In addition under s 82 of the Act a coroner may make recommendations considered necessary or desirable in relation to any matter connected with the death, including in relation to health and safety.

7. In this inquest, A's identity, where he died and the date of his death are not in issue.

8. As to the cause of A's death, this was identified as multi-drug toxicity in a post mortem report of pathologist Dr Liliana Schwartz. This was based on analysis of A's post mortem blood, which contained what Dr Schwartz considered to be toxic levels of the prescription drug Fluvoxamine.

9. However expert evidence gathered in the course of the coronial investigation raised questions as to whether the coroner could be satisfied on the balance of probabilities that A died as a result of multi-drug toxicity.

10. Accordingly this inquest has focused on providing a greater understanding of the manner and cause of A's death. As the evidence unfolded over the three days of the inquest, the issues which emerged were these:

- Do A's high post mortem levels of Fluvoxamine provide a cause of death?
- Was A's death caused by any failure in his care and treatment?

Background

A's Life

11. The court heard that A was born on 21 August 1981. When he was two years old his mother became concerned that he had not started to develop speech skills. A was tested and ultimately diagnosed with severe developmental disability and autism.

12. Ms R was reluctant to have A placed in a care home. Instead she committed herself to bringing him up in their family home in Rozelle with his sister J-B. Around this time A's father separated from his mother, and since then A has had little to do with him.

13. When A was of school age he started attending a special purposes school, but he was unhappy there. From the age of eight Ms R home-schooled him, teaching him life and social skills, and art and craft.

14. When he was nineteen A had a sudden seizure and was admitted to Royal Prince Alfred Hospital. Describing the seizure, his mother said he suddenly became very still after which his limbs moved in a jerking fashion. He would have fallen had she not managed to support him.

15. On discharge from hospital A was placed in the care of GP Dr John Gambrill and neurologist Professor Alistair Corbett. After a second seizure in January 2001 he was prescribed anti-epileptic medication. Despite trials of different medications over the next two years he continued to suffer weekly seizures.

16. A's medication often made him aggressive and he would sometimes poke at his mother's eyes and strike her chest. As he was non-verbal he could not tell his mother why he was behaving in this way. Over time she began to interpret these assaults as A's way of indicating to her the side effects he was suffering from his medication, being eye pressure and chest pain.

17. By the time he was 23 A was using the anti-epileptic medication Paxam in combination with Chlorpromazine, an antipsychotic drug commonly used to manage aggression in psychiatric patients. These helped stabilise his epilepsy and his behaviour. Ms R obtained some assistance from the Department of Ageing, Disability and Home Care [DADHC], enabling A to attend two days a week at the Sunnyfield Day Options Program. She also took him for a number of sessions with psychiatrist Dr Bernard St George.

18. A had been overweight since at least the age of fifteen and as he got older his mother found it increasingly difficult to manage his desire for extra food. By the time he was 25 years old he weighed about 160 kilograms. A's obesity continued to be a problem, exacerbated by his medication and his reluctance to do physical exercise.

19. Around 2007 A's aggression towards others including his mother re-emerged, to such an extent that she sometimes required the help of police. She made the difficult decision that she could no longer care for A at home.

20. In September 2008 A was placed into full time care at a privately-operated placement, Rainbow Home and Respite Services at Kurmond. Twice a week Ms R made the one and a half hour drive each way to visit him and take him on outings.

21. Ms R was not happy with the care A received at this placement. She did not think he was being provided with recreational activities, and she was worried the carers were not keeping A clean and monitoring his medication as they should.

The Market Street Respite Home

22. With the help of their GP Dr Gambrill, in December 2009 Ms R managed to have A moved into a different placement operated by DADHC at 78A Market St Condell Park, which I will refer to as the Market Street Respite Home. It was intended as a temporary placement until a permanent place for A could be located.

23. The Market St Respite Home is a single storey brick house in a residential street. A shared the home with one other resident. It was staffed on a 24-hour basis by three full time carers, two of whom were assigned for A's care. The carers were not qualified or trained in nursing, medicine or community services. However all had certificates in administering first aid and some had also attained certificates in Disability Care.

24. A lived in his own section at the Market St Respite Home. He had his own bedroom, en suite bathroom, and a small living room furnished with a couch, television and coffee table. A's area was accessed via a door which opened onto the home's communal lounge area.

25. A's carers estimated that when he first came to the residence he was having violent episodes two or three times daily. Over time however he became relatively happy and settled. His aggression gradually receded so that after two months he only required one full time staff member to care for him.

26. A's mother continued to visit him twice weekly. Each evening she spoke on the phone with a staff member who told her how A was and what his activities for the day had been. Ms R was satisfied with his care. She knew A was being sedated more than previously, but she was not concerned because he seemed happier and she knew his medication regimen was authorised by his doctors.

27. In May 2010 DADHC told Ms R there was a permanent placement for A at Smithfield. Ms R visited the home, which was privately-operated, but she was concerned there would be a repeat of their experience at the privately-operated Rainbow House. She told the Department she was not willing for A to be moved there. A was still living at the Market St Respite Home when he died.

A's Medications

28. A's GP since 2003 was Dr John Gambrill. Dr Gambrill reviewed A regularly and provided Ms R with prescriptions for his medication. These were based upon recommendations from his neurologist Professor Corbett and psychiatrist Dr Chris McDowell.

29. At the time of A's death he had not seen Professor Corbett for almost a year. This was probably because since about 2005 his epilepsy had been reasonably well

controlled with the drug Paxam. However the Court heard that in the eight months leading up to his death A suffered four epileptic seizures. It seems these were not made known to Professor Corbett.

30. A was administered other medications on a daily basis to manage his behaviour. Although he had become more settled, he still had violent episodes and it was often not possible to identify what had upset him. When he became aggressive he bit his hands and bashed his head against surfaces. He also sometimes lunged out at carers, hitting or kicking at them. Staff were instructed to follow a behaviour management plan which had been prepared by DADHC psychologists. This involved segregating him in his own living area so he was unable to harm himself, staff members or other residents.

31. The main medications prescribed to manage A's behaviour were Chlorpromazine and the anti- anxiety medication Fluvoxamine. In addition at the time of A's death his psychiatrist Dr McDowell was gradually replacing his daily use of Seroquel with a different medication, Invega.

32. A's dosage at the time of his death was as follows:
    - Fluxoximine 100mg two tablets in the morning, one at night.
    - Paxam 0.5mg one in the morning, two at night.
    - Chlorpromazine 25mg two at night
    - Invega 6mg one in the morning
    - Seroquel one at midday.

33. Doctors had also authorised the use of extra medication for when carers were unable to prevent A's behaviour from escalating to an aggressive level. To administer this medication, which was known as 'PRN medication', carers needed to obtain authorisation from their on call supervisor. A's PRN medication consisted of the drug Ativan, plus a larger dose of his regular drug Chlorpromazine.

34. DADHC records show that PRN medication was required for A on average several days of each month. However on the day of his death A had not been administered any PRN medication as his behaviour was generally manageable that day.

How A's medications were stored and administered

35. The carers at Market St Respite Home were not registered nurses. This meant they were not permitted to give A his medication from manufacturer containers, but only from pre-prepared packages known as Webster packs. These are secure labelled packages which divide medication into dosages on a daily basis. In A's case his daily dosages were further divided into amounts to be administered in the morning, afternoon and evening.

36. A's Webster packs were prepared for him at the Rozelle Village Pharmacy. They were prepared strictly on the basis of the medications and dosages prescribed for him by his treating doctors.

37. Each week Ms R collected A's Webster packs from the Rozelle pharmacy. She checked their contents against A's medication chart, then delivered them to the Market St Respite Home. Here they were again checked against A's medication charts by his carers. Two carers administered A's medication to him, on each occasion signing a Record of Administration sheet.

38. The Court heard that A's Webster packs were stored at Market St Respite Home in a locked medication cupboard inside the staff office. Access to the staff office was obtained through the kitchen. A was not permitted access to either the kitchen or the staff office. Although it was not entirely clear what prevented his access to these areas (evidence was conflicting as to whether they were ordinarily kept locked), there was no evidence that he did in fact go into these areas.

39. According to Ms R and his carers, A was compliant with his medication and did not resist taking it. Nor did he show any particular interest in it. Ms R speculated that since his tablets did not have any taste he was not inclined to try to consume any more than the doses he was given.

40. Ms R and A's carers agreed that A did not have any comprehension of the concept of suicide.

The events of 30 August 2010

41. On the day of A's death the three carers on duty were Liberty Mlotshua, who commenced at 7 that morning, Jane Sultana who commenced at 1pm, and Manroop Singh who commenced at 3pm. Mr Mlotshua and Mr Singh were regularly assigned to care for A.

42. Although all three carers provided police with statements and gave oral evidence at the inquest, obtaining a clear picture of what happened that afternoon was something of a challenge, for reasons which are discussed below. Nevertheless the accounts given by the three carers, although lacking in detail, are generally consistent.

43. It appears A was a little unsettled that afternoon. He spent some time sitting outside with Mr Mlotshua and Ms Sultana, who was caring for the other resident at the home. Afterwards they sat in the communal lounge area where they were joined by Mr Singh when he commenced his shift at 3pm. Sometime later A went into his own area, slamming his door shut behind him.

44. All three carers stated they were aware that when A shut himself in his area they needed to check him every ten to fifteen minutes. The evidence is that A was checked on at least two occasions and perhaps more that afternoon while he was in his rooms; however there is no consensus as to exactly how often and by whom.

45. At about 5.15pm Mr Singh and Mr Mlotshua went into A's area to check on him. They found him in his living room, kneeling against his coffee table. He did not respond when they spoke to him. His chin was on the table and both his arms were hanging down by his sides. In his evidence Mr Singh described seeing A's chest against the edge of the table, but Mr Mlotshua and Ms Sultana were unable to be that specific.

46. Mr Mlotshua and Mr Singh positioned A on the floor and immediately commenced CPR and mouth to mouth resuscitation, while Ms Sultana called an ambulance. The ambulance arrived very shortly afterwards and paramedics took over CPR activities. However they were unable to revive A. He was pronounced dead at 5.50pm.

47. Staff rang A's mother, telling her to come straight to the Market St Respite Home. Ms R was with her daughter at the time and they immediately travelled together to Market St. On the way they were rung once again and told the sad news of A's death.

Lack of contemporaneous statements

48. It will be seen from the above that no one was with A when he lost consciousness. There are thus no eye witnesses available to describe what might have triggered this state. This has contributed to the difficulties in identifying the cause of A's death.

49. The difficulties are compounded by the fact that thirteen months passed before any of the three carers was asked to provide a formal statement about what they saw and heard that afternoon. It is true that their manager Mr Brian Moore prepared an Incident Report the day after A's death in which he recorded:

    '*17:25 approx – staff heard a thud from A's section, A found not breathing between table and wall, with his chin resting on the table and his feet against the wall …. A turning blue (predominantly about the lips)...'*

50. However it is unclear who provided Mr Moore with these details, in particular the information about a thud being heard in A's rooms. None of the three carers made reference to it in their statements or in their oral evidence at the inquest. Mr Moore was unable to recall who had told him about it.

51. Indeed at the inquest the three carers recalled little about what happened that day, or about A's presentation when they found him. This is not surprising given the length of time that elapsed before they were asked to provide a formal account, and the almost seven years that has passed between the day of A's death and the inquest itself.

52. No blame for this state of affairs can attach to the three carers themselves. They co-operated with the coronial investigation and answered questions at the inquest as best they could. However there were significant delays in the police investigation of this matter and, it must be said, within the Coroner's Court itself, given the very lengthy period before the matter came on for hearing.

53. It is an additional concern that the responsible agency DADHC took no steps to carry out an internal inquiry into A's death. This at least may have resulted in contemporaneous accounts being obtained from those who found A.

54. In this regard, since A's death DADHC has developed formal procedures to be followed when a person with a disability dies while living in FACS operated accommodation. These are set out in the FACS document '*Operational Guidelines for the Review of the Death of People with Disability'.* Such deaths are now to be reported to the NSW Ombudsman. An internal independent staff person is appointed to undertake an immediate inquiry into the circumstances surrounding the death. This will include obtaining witnesses' versions of the events in as much detail as possible.

55. This development is welcome. It alleviates a need that would otherwise be present for the Coroner to consider making recommendations in this area.

56. A further source of concern for A's family was the fact that A's unused Webster packs of medication, which were seized by police from the Market St residence, were subsequently destroyed without consultation either with the Officer in Charge or the Coroner's Court. While photographs were taken of the packs, it is a matter of concern that it would not have been possible to make a physical examination of them if the forensic need arose.

Do A's levels of Fluvoxamine provide a cause of death?

57. Much of the evidence heard at the inquest focused on the question whether drug toxicity could be accepted as the cause of A's death. This was the conclusion reached by Dr Liliana Schwartz in the report she prepared following her post mortem examination of A.

58. The post mortem examination included an internal autopsy and a neuropathology examination of A's brain. No abnormalities were found.

59. Dr Schwartz's external examination found bruises on A's upper chest and neck, which she thought may have been caused by A's contact with the edge of the coffee table.

60. Dr Schwartz noted the results of toxicology tests conducted on samples of A's post mortem blood. These contained a concentration of Fluvoxamine of 7.5mg/L, a level which Dr Schwartz described as within the reported fatal range for this drug. The samples also contained therapeutic levels of the drugs Chlorpromazine, Paracetamol and Quetiapine. Dr Schwartz commented that even therapeutic levels of Chlorpromazine could cause serious adverse effects. Further, the adverse effects of the various drugs found in A's blood could be exacerbated by their interaction.

61. On this basis Dr Schwartz concluded the cause of A's death was most likely multi-drug toxicity. She stated she could not entirely exclude the possibility that positional asphyxia and epilepsy had contributed to his death.

Report of Dr Judith Perl

62. In light of the above findings it was decided to seek expert opinion upon A's blood levels of Fluvoxamine and Chlorpromazine. A report was obtained from Dr Judith Perl, a forensic pharmacologist with extensive experience in clinical and behavioural pharmacology.

63. In her report dated 4 March 2015 Dr Perl made findings which may be summarised as follows:

    - A's blood samples were femoral blood samples. Dr Perl expected these to have generally reflected his drug levels at the time of his death.
    - However post mortem distribution may have caused some of the drug concentrations in the samples to increase. Post mortem distribution describes the process whereby after death, drug traces which have accumulated in the body's organs and tissues leak into the body's blood, increasing their concentration of those drugs.
    - The blood concentration of Chlorpromazine found in A's blood was well above the level expected from his prescribed daily dose. However this might be explained by factors such as reduced metabolism due to A's obesity, the competition for metabolism by the various drugs, and post mortem distribution.
    - The levels of Fluvoxamine in A's post mortem blood were well within the reported fatal range for Fluvoxamine of 3.4-11mg/L. They suggested a significant overdose. At these levels it was likely he would have experienced significant toxicity.

64. Dr Perl acknowledged that A's numerous health issues and obesity would have reduced his ability to metabolise some of these drugs. In addition she noted evidence that some patients metabolise Fluvoxamine poorly. Nevertheless she considered it likely A's elevated Fluvoxamine levels would have been a significant factor in his death.

Reports of Professor MacDonald Christie

65. Professor Christie is Professor of Pharmacology, University of Sydney. At the request of the legal representative for DADHC he provided two expert reports dated 1 July 2015 and 14 March 2017.

66. Professor Christie acknowledged the concentration of Fluvoxamine in A's post mortem blood was well within the reported fatal range. However in his opinion there were important reasons to doubt that Fluvoxamine toxicity was the cause of A's death.

67. Professor Christie's reasons may be summarised as follows:
    - It was likely that significant post mortem distribution had contributed to the 7.5mg/L level of Fluvoxamine found in A's blood. This is because Fluvoxamine's physiochemical properties are strongly suggestive of significant post mortem distribution, although the extent of such distribution could not be accurately predicted.
    - In addition drug distribution in morbidly obese people is different from that of healthy individuals and is difficult to predict.
    - For these reasons Professor Christie thought it possible that A's post mortem levels of Fluvoxamine did not accurately reflect the levels present at the time of his death.
    - Even if A's post mortem levels were similar to those at the time of his death, in Professor Christie's opinion it did not necessarily follow that this was the cause of A's death. This was because the number of cases of fatal overdose of Fluvoxamine is so small that limited reliance could be placed on so-called fatal ranges of Fluvoxamine concentration.

68. For these reasons Professor Christie thought it was not possible to conclude that Fluvoxamine toxicity was the cause of A's death, unless there was other evidence that an overdose of this drug had been consumed.

Expert consensus at the inquest

69. Dr Perl and Professor Christie were called to give evidence at the inquest. They gave simultaneous evidence in a conclave, focusing upon whether it was possible to conclude that Fluvoxamine toxicity was the cause of A's death.

70. In their oral evidence both experts agreed that Fluvoxamine is widely used and generally very well tolerated in the management of depression and anxiety. However they emphasised the lack of published data about its post mortem distribution, and what levels may be considered to be fatal.

71. In her oral evidence Dr Perl reiterated that A's post mortem blood levels of Fluvoxamine were very high. However she conceded significant weight should be

given to the possibility that these levels were elevated by post mortem distribution of the drug.

72. This caused Dr Perl to qualify the opinion expressed in her report that it was likely A had experienced significant toxicity at the time of his death. While this possibility could not be discounted, she agreed with Professor Christie that it should not be identified as the cause of A's death.

Was A's death related to SUDEP?

73. During the inquest A's mother raised the possibility that A's death might be considered to be a SUDEP one.

74. SUDEP (Sudden Unexplained Death in Epilepsy) is not a cause of death, but a way of describing sudden and unexpected deaths which occur in people who have been diagnosed with epilepsy. People diagnosed with epilepsy are known to be at greater risk of sudden death than the general population. While much is still unknown about SUDEP, most studies identify the following criteria for the condition:

    - The person had recurrent epilepsy.
    - He or she died unexpectedly while in a reasonable state of health.
    - The death occurred in a matter of minutes or less, during normal activities and benign circumstances.
    - Post mortem examination could not identify an obvious medical cause of death.

75. Due to the evidence in the coronial brief which pointed to drug toxicity as the cause of A's death, no medical evidence was called at the inquest as to whether A's death might be considered to be a SUDEP death.

76. Despite this it does not appear to me that a conclusion of SUDEP is open in this case, due to the existence of the evidence of drug toxicity. It is true Dr Perl and Professor Christie were unwilling to conclude that drug toxicity was a more likely cause of A's death than any other. However the fact remains that there is toxicological evidence of this as a possible cause of death. In these circumstances and having regard to the SUDEP criteria, it appears unlikely that expert opinion could find conclusively in favour of SUDEP in A's case.

Was A's death caused by any failure in his care and treatment?

77. Evidence that A's blood contained unexpectedly high levels of Fluvoxamine led naturally to the question whether an error might have occurred in the way his medications were prescribed, dispensed or administered. Evidence was heard about these matters at the inquest. The evidence supports the following conclusions:

    - There was nothing untoward or unusual in the type or amounts of medication prescribed for A, having regard to his medical and psycho-social needs. This is also the case with regard to his PRN medication regimen.
    - There is no evidence that the type and amounts of medication placed in A's Webster packs did not correspond with the type and amounts prescribed for him. The Court heard the Webster packs were regularly checked against A's medication charts by the Village Pharmacy staff, A's mother, and his carers.

- There is no evidence, oral or documentary, that A's carers at Market St Respite Home did not administer his medication to him strictly in accordance with his prescribed dosages.
- There is no evidence that by his own act A consumed larger amounts of his medication than was prescribed for him. He had neither the means nor the inclination to do this.

78. On the basis of the above, I find that A's death was not caused by any failure on the part of those who prescribed his medication, or those who dispensed and administered it.

79. Regarding the supervision of A that afternoon, the Court heard that his carers made checks on him at regular intervals while he was in his own living area, although they were unable to be precise about how often. The lack of clarity on this point leaves open the possibility that A was not checked at the ten to fifteen minute intervals that the Court heard was policy at the respite home. However there is no evidence that the policy was not adhered to, or that strict adherence to it would necessarily have prevented his death from occurring.

80. The conclusion I have reached is that there was no failure in the care and treatment of A which caused or contributed to his death. The impression I received from the evidence of A's doctors and carers was that they were conscientious and professional in their approach to his care.

Findings as to cause and manner of death

81. Submissions made by the Advocate Assisting the Coroner, and those made on behalf of the interested parties, were unanimous that the evidence did not permit the Court to find a cause of death on the balance of probabilities.

82. Possibilities as to the cause of A's death which emerged from the inquest included drug toxicity, complications of epilepsy, and positional asphyxia (noting the presence of bruises on A's chest and neck which may have been caused by his contact with the coffee table).

83. I accept that on the evidence, drug toxicity is the most likely explanation of all those offered. But, informed by the evidence of the two pharmacological experts, I cannot conclude on the balance of probabilities that it is the cause of death in this case. The effect of the expert evidence is to cast doubt on the two propositions upon which a finding of drug toxicity depends: namely, that A's post mortem levels of Fluvoxamine were similar to those at the time of his death, and that a Fluvoxamine concentration of 7.5mg/L necessarily represents a fatal level of that drug.

84. As a result I am unable to find on the balance of probabilities that A died from drug toxicity.

85. Even if the Court could be comfortably satisfied that A's post mortem blood levels were similar to those at the time of his death, what could be concluded about how this happened? There is no evidence he was deliberately or inadvertently administered an overdose, either at his own hand or that of his carers. Invited to consider the possibility that A's Fluvoxamine levels were elevated at the time of his death, both experts at inquest thought it possible they had been increased by his complex health conditions and the combination of drugs he was using. They agreed however that there was no way to determine if this had really been the case.

86. In these circumstances I consider a finding of sudden unexpected death to be the only responsible finding I can make on the evidence. The overall conclusion as to cause of death must be that it is unascertained.

Question of recommendations

87. In submissions on behalf of Ms R Mr Brock spoke of inadequacies in the investigation of this matter which, he submitted, warranted comment. Mr Brock cited the investigative delays and the consequent lost opportunity to obtain contemporaneous accounts of important matters, including detailed description of A's presentation when he was found.

88. The absence of such evidence did not assist in the task of determining the cause of A's death. However I am satisfied that for such cases in the future, this issue has been addressed with DADHC's new procedures for prompt evidence-gathering. There is therefore no necessity to make any recommendations on this issue.

89. Mr Brock also spoke of the length of time it has taken for this matter to come to inquest, compounding the witnesses' difficulties of recollection. In addition to long delays in the preparation of the coronial brief there were delays within the Coroner's Court in obtaining a hearing date. Six and half years is indeed a very long time for A's family to wait in the hope of finding out what happened to him. I acknowledge these delays have not assisted in finding answers at this inquest, and regret the hardships and frustrations that have been involved for those who loved him.

90. In his submissions Mr Brock also urged the Court to consider making a particular recommendation: namely that regular blood testing be considered for those who, like A, were subject to a medication regime but whose developmental challenges make it difficult for their health carers to monitor them for symptoms of adverse side-effects. In her evidence at the inquest Ms R spoke with real sadness about the possibility that, unbeknownst to herself and A's doctors, over time his medications may have been building up to harmful levels. She thought regular blood testing could have provided a means of detecting this and prompting review of his medication before it was too late.

91. The experts in conclave were asked about the feasibility and efficacy of such a measure. Both expressed that it would be ideal to be able to monitor blood levels for such patients. However there were practical difficulties involved, in addition to the likely expense. These included that many pathology laboratories do not possess the equipment needed to test blood samples for a drug such as Fluvoxamine, due in part to the fact that complications from its use occur so infrequently. There would also be difficulties in interpreting the results of such tests for patients like A, because of the drug's concurrent use with other medications.

92. I sympathise with Ms R and her feelings of regret at the possibility that a measure like this might have helped prevent her son's death. However I have also taken account of the reservations expressed by the pharmacological experts about the usefulness of such a measure. In addition I acknowledge a further matter raised by the Advocate Assisting, Mr Bush: namely whether it is open to the Court to make such a recommendation in circumstances where it has not been possible to find positively that drug toxicity was the cause of A's death.

93. For these reasons I think it would not be appropriate to make the recommendation that Ms R seeks.

94. I would like to thank the Advocate Assisting and everyone who has participated in and assisted with this inquest, including A's mother. I hope that A's mother and sister will accept the sincere condolences of the Coroner's Court for the loss of their much-loved son and brother.

Findings required by s81(1)

As a result of considering all of the documentary evidence and the oral evidence heard at the inquest, I am able to confirm that the death occurred and make the following findings in relation to it.

The identity of the deceased

The person who died was AR

Date of death

He died on 30 August 2010

Place of death

He died at 78A Market Street Condell Park NSW

Cause of death

The cause of death is unascertained

Manner of death

The manner of death was sudden and unexpected.

I close this inquest.

Magistrate E Ryan

Deputy State Coroner
Glebe

Date