IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2015 2066

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the Coroners Act 2008

Findings of:	Paresa Antoniadis Spanos, Coroner
Deceased:	Craig Michael Akerblom
Date of birth:	22 September 1983
Date of death:	29 April 2015
Cause of death:	Hypoxic ischaemic brain injury secondary to hanging
Place of death:	Dandenong

I, PARESA ANTONIADIS SPANOS, Coroner,

having investigated the death of CRAIG MICHAEL AKERBLOM without holding an inquest:

find that the identity of the deceased was CRAIG MICHAEL AKERBLOM

born on 22 September 1983

and that the death occurred on 29 April 2015

at Dandenong Hospital, 135 David Street, Dandenong, Victoria 3175

from:

I (a) HYPOXIC ISCHAEMIC BRAIN INJURY

II HANGING

Pursuant to section 67(1) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances**:

BACKGROUND AND PERSONAL CIRCUMSTANCES

1. Mr Akerblom was a 31-year-old unemployed man who was living with his parents, Laurie and Lennart, in Narre Warren South at the time of his death. He had a medical history that included depression, anxiety, a selective eating disorder, asthma and substance abuse. His health had been managed and treated by general practitioner Dr Ronald Ling of Stud Park Medical Centre since 2000.

2. According to Mr Akerblom's parents, their son's primary school education was largely uneventful, and he excelled at sports including gymnastics and football, although he did not like playing in a team environment. He was passionate about computers and roller blading. In his early teenage years, Mr Akerblom fell in with a bad crowd, was introduced to marijuana and went through a relationship breakup which affected him greatly. He began to show symptoms of anxiety and depression at this time, but was not formally diagnosed until a number of years later.

3. As an adult, Mr Akerblom largely kept to himself, spent lengthy periods in his bedroom playing video games and would only leave the house to attend medical appointments with his mother. He had short periods of employment organised by his parents, but ceased working after suffering a pneumothorax (collapsed lung) in 2011.

4. On 11 August 2012, Mr Akerblom consulted Dr Ling complaining of feelings of hopelessness, worthlessness, mood swings, poor sleep and suicidal ideation without plan or intent which had been present for many years. He admitted to self-medicating with cannabis since about 16 years of age. Dr Ling diagnosed Mr Akerblom with depression, prepared a

mental health care plan, and provided him with a prescription for venlafaxine.[1] At a subsequent appointment on 10 September 2012, Dr Ling referred Mr Akerblom to psychiatrist Dr Kwee Keat Lim for opinion and management.

5. On 20 November 2012, Mr Akerblom consulted Dr Lim at his rooms in Pinelodge Clinic, Dandenong, accompanied by his mother. He reported a history of anxiety since childhood and problems with insomnia, hyper-vigilance, panic attacks, nausea, appetite disturbance and poor concentration. He disclosed that he had previously self-harmed by cutting and burning himself, used marijuana heavily, and had attempted suicide by prescription medication overdose after breaking up with his girlfriend. Dr Lim formed the opinion that Mr Akerblom was suffering from a major depressive disorder with generalized anxiety and social anxiety, reduced the venlafaxine and provided him with a prescription for mirtazapine[2] 15mg. He subsequently wrote to Dr Ling recommending that Mr Akerblom be referred to a psychologist so as his long-term personality problems could be addressed in psychotherapy.

6. Mr Akerblom consulted Dr Ling and Dr Lim regularly throughout 2013, with occasional adjustments being made to his medication regime. He was referred to MIND Australia with the intention of rebuilding his social skills and integrating him into the community to help reduce his anxiety, however he ultimately cancelled his appointment and declined further referral.

7. On 25 July 2013, Mr Akerblom attended the Wellness and Recovery Centre [WRC] at Dandenong Hospital for treatment of his selective eating disorder. He underwent a comprehensive mental health assessment with WRC clinicians, who concluded that he did not meet the criteria for an eating disorder, but rather had a mood disorder on the background of extensive substance abuse, complicated by antisocial and borderline personality traits. They recommended that Mr Akerblom undergo rehabilitation and detoxification to enable further diagnostic testing in the absence of marijuana. This information was reported to Dr Lim.

8. On 19 March 2014, Dr Lim referred Mr Akerblom to psychologist Nadine Stephenson for psychotherapy. He attended seven sessions between 25 March 2014 and 2 July 2014. According to Ms Stephenson, by the time of his final session, Mr Akerblom had increased his social contact and reported improvements in his eating behaviours. There was some reduction in suicidal ideation during the course of his treatment, however it remained present.[3]

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[1] Often marketed as Effexor, this is an antidepressant of the selective serotonin and norepinephrine reuptake inhibitor class used to treat major depressive disorder, anxiety and panic disorder.
[2] Marketed as Remeron, this is an atypical antidepressant used to treat major depressive disorder.
[3] Coronial Brief of Evidence, Statement of Nadine Stephenson.

9. On 3 September 2014, Mr Akerblom consulted dietician Sherry Hsieh, accompanied by his mother. He reported experiencing loss of appetite for over 10 years due to depression, and consuming only take-away or processed foods. On assessment, Ms Hsieh noted that Mr Akerblom was moderately malnourished and showed some psychological and behavioural symptoms of an eating disorder, including preoccupation and increased sensitivity with foods. Ms Hsieh advised Mr Akerblom to commence a daily oral nutritional supplement, and wrote to Dr Ling recommending a team approach to assist Mr Akerblom in managing his depression and weight.

10. On 24 September 2014, Mr Akerblom attended a review appointment with Ms Hsieh. They discussed the impact that irregular sleeping was having on Mr Akerblom's nutritional status and eating habits, and the importance of taking his antidepressants at the correct time. During the consultation, Mr Akerblom told Ms Hsieh that he continued to have thoughts of suicide. She recommended that he return to Ms Stephenson for ongoing management, however he appeared reluctant to do so. Ms Hsieh subsequently wrote to Dr Ling, copying in Dr Lim and Ms Stephenson, updating them on the consultation and expressing her concern for Mr Akerblom's welfare.

11. On 16 October 2014, Mr Akerblom consulted Dr Lim, accompanied by his mother. Dr Lim informed them that he was relocating his consulting suites to Heatherton, Camberwell and Glen Iris. Mrs Akerblom told him that it would be difficult to get her son to these locations as she could not drive long distances. Dr Lim suggested that Mr Akerblom see Dr Ling and request a referral to another psychiatrist at Pinelodge if he could not attend the new practice locations. He also noted that Mr Akerblom should continue to see Ms Stephenson and that he was regularly consulting Dr Lim and Ms Hsieh. There was no note as to whether Ms Hsieh's letter was received. At this time, Mr Akerblom was taking mirtazapine 90mg and olanzapine 25mg.

12. On 22 October 2014, Dr Lim wrote to Dr Ling and Mr Akerblom advising of the relocation of his practice from Pinelodge, and providing the addresses and contact numbers of his new consulting rooms. In the letter to Mr Akerblom, Dr Lim also noted the process for continuing at Pinelodge under a new psychiatrist and advised him to contact his GP if he had any issues.

13. From late October 2014 to March 2015, Mr Akerblom had six consultation with Dr Ling. On each occasion, Dr Ling noted that Mr Akerblom was experiencing poor sleep, feelings of hopelessness and loss of interest in activities he usually enjoyed. Mr Akerblom did not report any suicidal ideation. During this period, Mr Akerblom did not consult Dr Lim or Ms Stephenson.

CIRCUMSTANCES PROXIMATE TO DEATH

14. On 20 April 2015, Mr Akerblom consulted Dr Ling, accompanied by his mother, complaining of low mood and suicidal ideation. Mrs Akerblom said that her son had recently become paranoid after seeing a media release on impending prosecutions for the downloading of illegal movies. He believed that he would be tracked down and his parents would be fined. During the consultation, Mrs Akerblom suggested that her son be admitted to a psychiatric inpatient unit for treatment. Mr Akerblom rejected the suggestion, and declined a further offer from Dr Ling.[4] Dr Ling counselled Mr Akerblom, arranged for him to return for review in a week and told him to make an appointment to see Dr Lim as soon as possible. He also provided prescriptions for mirtazapine 45mg and olanzapine 10mg.

15. On 23 April 2015 at about 7:15am, Mrs Akerblom was preparing to leave the house. She popped in to see her son first, who said that he was okay and accepted her offer to bring some food home after her shift. She then left for work. At about 9:45am, Mr Akerblom Snr told his son that he needed to go out for a few hours to quote a job, and asked him if he needed anything first. When Mr Akerblom confirmed that he did not, Mr Akerblom Snr left for work.

16. At about 1:45pm, Mr Akerblom Snr returned home from work. He made himself a cup of tea and let the dog outside. He then heard a thumping noise coming from his son's bedroom and went to check what it was. When Mr Akerblom Snr entered the bedroom, it was very dark. He noticed that his son was sitting in a small space between his bed and the wall, and that his arm was banging against the wall. He initially thought that Mr Akerblom was having a stroke, and so he contacted emergency services, however while attempting to move his son to a clear space to render assistance, he felt a cord around his neck which was attached to a venetian blind covering the bedroom window. Mr Akerblom Snr removed the cord and commenced cardiopulmonary resuscitation [CPR].

17. Ambulance paramedics arrived a short time later and took over CPR. Mr Akerblom was resuscitated, intubated and taken to Dandenong Hospital in a critical condition.

18. On arrival at Dandenong Hospital, Mr Akerblom was unresponsive and had a Glasgow Coma Score [GCS][5] of three, indicating profound unconsciousness. He was admitted to the Intensive Care Unit [ICU] for ventilation, circulatory support and neurological assessment. Despite receiving six days of maximal care in ICU, Mr Akerblom's neurological condition did not improve and he developed myoclonus (muscle jerking) in his face, arms and legs. A brain

[4] Coronial Brief of Evidence, Statement of Dr Ronald Ling dated 29 March 2017.

[5] The Glasgow Coma Scale is a neurological scoring system which is used to assess conscious level after a head injury. It categorises severity of a brain injury into mild (13-15), moderate (9-12) and severe (8 or less).

MRI was conducted which showed bilateral basal ganglia and hippocampal ischaemic changes, indicating a severe hypoxic brain injury. In consultation with Mr Akerblom's family, the decision was made to withdraw active treatment and provide comfort care only. Mr Akerblom was kept comfortable until he passed away at 3:00pm on 29 April 2015.

CORONIAL INVESTIGATION

19. Senior forensic pathologist, Dr Michael Burke of the Victorian Institute of Forensic Medicine, reviewed the circumstances of the death as reported by police to the coroner, post-mortem computer assisted tomography [PMCT] scans of the whole body and performed an external examination. Among Dr Burke's anatomical findings were an abraded injury around the neck, in addition to evidence of organ donation.

20. Routine toxicology conducted on ante-mortem samples obtained by Dandenong Hospital on 29 April 2015 detected acetone, midazolam,[6] fentanyl,[7] levetiracetam,[8] and trace amounts of paracetamol, in addition to olanzapine,[9] mirtazapine[10] and cannabis.

21. Dr Burke concluded that it was reasonable to attribute Mr Akerblom's death to *hypoxic ischaemic brain injury secondary to hanging*, without the need for autopsy.

22. At my request, a Mental Health Investigator [MHI][11] from the Coroners Prevention Unit reviewed the circumstances of Mr Akerblom's death and his medical records, requested additional statements from Dr Lim and Dr Ling and assessed the clinical management and care provided to Mr Akerblom. The MHI advised that:

    Communication between Dr Lim and Dr Ling

    a. In his statement to the Coroner, Dr Ling reported being unaware at the time of his final appointment with Mr Akerblom on 20 April 2015, that he had not attended an appointment with Dr Lim since 14 October 2014. He had provided a continuing referral to Dr Lim on 2 February 2015 and given it to Mr Akerblom. Dr Ling reported that during the 2 February 2015 appointment, neither Mr Akerblom nor his

[6] This is a short acting benzodiazepine used intravenously in intensive care patients.
[7] This is a narcotic used as a perioperative analgesic and as an adjunct to surgical anaesthesia.
[8] This is an antiepileptic used for the control of partial onset seizures.
[9] Often marketed as Zyprexa, this is used in the treatment of schizophrenia and related psychoses.
[10] Often marketed as Remeron, this is an antidepressant used to treat major depressive disorder.
[11] Mental Health Investigators [MHI] are part of the Coroners Prevention Unit [CPU] established in 2008 to strengthen the prevention role of the Coroner. CPU assists the Coroner to formulate prevention recommendations and comments, and monitors and evaluates their effectiveness once published. MHI is staffed by appropriately qualified clinicians who are independent of the health professionals or institutions involved. They assist the Coroner's investigation of deaths occurring in the mental healthcare setting by evaluating the clinical management and care provided and identifying areas of improvement so that similar deaths may be avoided in the future.

mother mentioned that Mr Akerblom had not attended an appointment with Dr Lim since 14 October 2014.

b. Dr Lim's original statement dated 27 November 2015 indicated that Mr Akerblom generally attended appointments with him approximately every 4-6 weeks in the year prior to his death. Dr Lim wrote a letter informing Dr Ling of his practice relocation on 22 October 2014. This letter did not specifically refer to Mr Akerblom but was a generic letter sent to all GPs who had referred patients to Dr Lim.

c. Dr Lim reported his usual practice of communication with referring GPs was to provide an update if there was a significant change to the patient's clinical presentation or if he was facilitating a referral. Dr Lim sent a letter to Dr Ling on 7 March 2013 stating that he was facilitating referral for Mr Akerblom to attend the Wellness and Recovery Centre Eating Disorders Service (WRC) and Mind Australia.

d. No significant changes to Mr Akerblom's clinical presentation were noted and no direct referrals were made by Dr Lim from 7 March 2013 until Mr Akerblom's death.[12] Dr Lim encouraged Mr Akerblom to self-refer to South East Alcohol and Drug Service (SEADS)[13] on 7 August 2013, however he did not make the referral directly as advised by the Monash Health Crisis Assessment and Treatment Team (CATT) and Dr Lim therefore did not write to inform Dr Ling. Similarly, Dr Lim made a re-referral to private psychologist Nadine Stephenson on 18 June 2014 to continue his sessions, however as this was not a new referral, it was not communicated to Dr Ling.

e. Dr Lim does not appear to have communicated with Dr Ling between his letter sent on 7 March 2013 and the incident leading to Mr Akerblom's death on 23 April 2015. While communication from Dr Lim to Dr Ling seems to have been suboptimal and contrary to Royal Australian and New Zealand College of Psychiatrists [RANZCP] expectations,[14] the available evidence does not enable me to make a causal connection between this shortfall and Mr Akerblom's death.

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[12] Coronial Brief of Evidence, Statement of Dr Kwee Keat Lim dated 27 November 2015.

[13] South East Alcohol and Drug Services (SEADS) is now known as Monash Health Drug and Alcohol Service.

[14] The Royal Australian & New Zealand College of Psychiatrists, 'Professional Practice Guideline: Best practice referral, communication and shared care arrangements between psychiatrists, general practitioners and psychologists' (2014) <https://www.ranzcp.org/Files/Resources/College_Statements/Practice_Guidelines/PSBest-Practice-Referral-Communication-between-ps.aspx> [RANZCP Guidelines].

Dr Lim's continuing management and discharge planning

f. Dr Lim's usual practice for managing patients who fail to continue to attend for consultations was to send a letter to the patient informing of their missed appointment and ask that they contact Dr Lim's office to reschedule. If no response was received, Dr Lim would write to the patient's GP alerting them to the missed appointment.

g. When Mr Akerblom attended his final appointment with Dr Lim on 16 October 2014, he and his mother opted not to make a subsequent appointment due to concerns about attending the new practice some distance away. Dr Lim sent a letter to Mr Akerblom on 22 October 2014 to inform of his new practice locations and the process for obtaining a referral to another psychiatrist at his previous practice if that was the patient's preferred option. At some time between 22 October 2014 and Mr Akerblom's death, Mrs Akerblom made an appointment for Mr Akerblom to see Dr Ling at his new practice on 4 May 2015. As such, Mr Akerblom was not considered discharged from Dr Lim's care.

h. Dr Lim did not communicate Mr Akerblom's non-attendance between 14 October 2014 and his death in April 2015 to Dr Ling. This is consistent with Dr Lim's usual practice for managing a patient who fails to continue to attend consultations outlined above.

Dr Ling's decision not to refer Mr Akerblom for psychiatric assessment on 20 April 2015

i. During Mr Akerblom's appointment with Dr Ling on 20 April 2015, a psychiatric inpatient admission was suggested by both Mrs Akerblom and Dr Ling, which Mr Akerblom declined. According to Dr Ling, if during the appointment Mr Akerblom had requested hospital admission himself or agreed when he and Mrs Akerblom suggested hospital admission, he would have referred Mr Akerblom to Pinelodge Clinic or the Dandenong Hospital emergency department.

j. Furthermore, Dr Ling would have arranged inpatient admission regardless of whether Mr Akerblom remained engaged with Dr Lim. Dr Ling reported advising Mr Akerblom and his mother to make an appointment with Dr Lim as soon as possible, and arranging a follow-up appointment with himself for a weeks' time. However, Dr Ling conceded that with hindsight, it may have been prudent to seek further psychiatric assessment that day.

23. The MHI concluded that while Dr Lim had not communicated with Dr Ling in the 19 months prior to Mr Akerblom's death, there were no significant changes in Mr Akerblom's clinical presentation requiring Dr Ling's consideration or indicating the possibility of an increased suicide risk. Therefore, the level of communication between Dr Lim and Dr Ling did not contribute to Mr Akerblom's death.

24. I find that Mr Akerblom, late of Berwick Springs Promenade in Narre Warren South, died at the Dandenong Hospital on 29 April 2015 and that the cause of his death was hypoxic ischaemic brain injury secondary to hanging.

COMMENTS

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

1. Although not causally related to Mr Akerblom's death, this case highlights the need for effective coordination of care among clinicians to ensure that opportunities to prevent harm are not missed.
2. While in practice Mr Akerblom's care was shared by a general practitioner, psychologist, psychiatrist, dietician, and allied health services, there was no clear plan in place between them to ensure that treatment decisions were optimal and holistic or that Mr Akerblom's disengagement from psychological and psychiatric assistance was identified I a timely way and addressed.
3. I note that the RANZCP Guidelines recommend a formal shared care agreement be created where multiple clinicians are involved with a patient, to delineate roles and areas of clinical focus, increase communication and assist clinicians to work collaboratively to optimise treatment in the patient's best interests. Triggers for communication under the Guidelines include a patient's level of cooperation with the treatment plan or if the patient has ceased to attend treatment.

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

Lennart & Laurie Akerblom

Monash Health

Dr Kwee Keat Lim c/o Avant Law

Dr Ronald Ling

Constable Brett Whyte, Dandenong Police

Signature:

PARESA ANTONIADIS SPANOS
CORONER
Date: 14 December 2017