FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

Section 67 of the ***Coroners Act 2008***

Court reference: 2181/06

Inquest into the Death of JASON DAVID JENKINS

Delivered On:	15th October, 2010
Delivered At:	Coroners Court of Victoria at Melbourne
Hearing Dates:	19 and 20 July 2010 at 250 William Street, Melbourne 3000
Findings of:	JUDGE JENNIFER COATE
Representation:	Mr Paul Halley for Alfred Health
Place of death:	Dandenong & Punt Rd, Windsor, Victoria 3181
Coroner's Assistant:	Leading Senior Constable King Taylor (Police Coronial Support Unit)

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Court reference: 2181/06

In the Coroners Court of Victoria at Melbourne

I, JUDGE JENNIFER COATE, State Coroner

having investigated the death of:

Details of deceased:

Surname: JENKINS
First name: JASON

AND having held an inquest in relation to this death on 19 and 20 July, 2010 at 250 William Street, Melbourne

find that the identity of the deceased was JASON DAVID JENKINS[1] and death occurred on 17th June, 2006

at Dandenong and Punt Road, Windsor, Victoria 3181

from
1a. LONG DROP HANGING RESULTING IN COMPLETE DECAPITATION[2]

in the following circumstances:

Introduction:

1. At the time of his death, Jason had a 15 year history of suffering from chronic paranoid schizophrenia, chronic poly-substance abuse and a considerable history of suicidal ideation and actual attempts on his own life. He had a history of both in-patient and out-patient treatment at mental health facilities. He was often non-compliant with the treatment plans for him. He was often homeless and at times committing criminal offences. He was regularly abusing alcohol and non prescription drugs such as marijuana and heroin.[3]

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[1] Jason was identified by using a fingerprint match with his records held by Victoria police.
[2] Post mortem examination was conducted by Forensic pathologist Dr Malcolm Dodd and the results of that examination provided in a report to the Coroner.
[3] Report of Associate Professor Peter Doherty.

2. He was an enormous challenge to his treating team. As a result of his illness and the complexities associated with it, he was very difficult to engage, often abusive and aggressive and non-compliant with requests to attend appointments and services. In the first half of 2006, he had twice been placed involuntarily into Alfred Psychiatric Unit in March and May. He was discharged from his 3 day involuntary in- patient stay on May 5, 2006 on a 6 month Community Treatment Order commencing on May 5, 2006.[4]

3. He was being treated and managed on this order by a team from The Alfred Hospital called the Mobile Support and Treatment Service (MSTS). This service was a multi-disciplinary intensive support aimed at keeping Jason safe and supported in the community.

4. About 6 weeks into his 6 month Community Treatment Order, sometime in the early hours of June 17, 2006, Jason placed a rope around his neck which he had tied to a railing and jumped to his death from an overpass in Queens Road, Windsor.

Background

5. Jason David Jenkins ("Jason")[5] was born on June 15, 1972 in Geelong. He was adopted at birth into the Jenkins' family. His adoptive parents later divorced. At the age of about 10, Jason moved with his mother from Warrnambool to Queensland. During Year 10, still in Queensland, Jason left school and got employment in a local supermarket and then as a labourer for a construction company. When Jason was about 18 or 19 he returned to Warrnambool to live with his grandparents.

6. According to his mother, whilst she was aware that Jason had been smoking marijuana at school, his consumption of alcohol and marijuana increased upon his return to Warrnambool. The evidence is that by the time Jason was 19 in 1991, he was exhibiting symptoms of paranoid schizophrenia and engaging in poly substance abuse.

7. Jason had a criminal history which spanned from 1993 up to 2006 and included offences of violence and drug related offending. There is no evidence that Jason had any dependents or was in any relationship at the time of his death and although he had some work in earlier years, for a number of years he had been in receipt of the disability support pension.

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4 Exhibit 5: Copy Community Treatment Order of 5.5.06 to 02.11.06.

5 Permission to refer to Jason by his first name was obtained from his adoptive mother, who was present in Court at the commencement of the Inquest.

8. Jason was being treated at The Alfred Hospital for a number of years prior to his death. His first in-patient admission to The Alfred was in January 2002. Associate Professor Doherty[6] stated that by the time of that first admission, Jason had had 11 years of treatment for his schizophrenia and was on injectable anti-psychotic medication.[7] Associate Professor Doherty summarized some of the complexity of Jason's history as follows:

> *"He had polysubstance drug abuse with heavy use of marijuana, intravenous amphetamine and heroin. He had been variously treated in recent years with methadone and buprenorphine. Jason was known to the alcohol and substance use clinic known as South City Clinic and had been referred to the Statewide Dual Diagnosis (mental illness and drug abuse) Service. His attendance for medical or other care was always patchy .*
>
> *The Mobile Support and Treatment Service undertook the role of improving his activities of daily living and maintaining independent living, whilst attempting to treat his psychotic disorder. Jason had a history of being homeless and there was an attempt to improve his compliance and hopefully engage in the service with the long term goal of using more efficacious treatment agents and reducing his substance abuse. Jason's commitment to change and his ability to engage with a clinical service were minimal and he continued to use substances."* [8]

Jason's inpatient involuntary admissions in 2006

9. Jason was on a community treatment order (CTO) at the commencement of 2006. As set out above in the introduction, Jason had two in-patient admissions in 2006. In early 2006 Jason had been charged with some dishonesty and violence offences. He was facing eviction from his accommodation. He was abusing a range of illicit drugs. The MSTS were still trying to support and manage and treat him in the community.

March 2006 admission

10. On March 20, 2006 when visited in his home[9] he was observed to have both arms in splints. He would not give any information other than to indicate that he had fallen. Further investigations revealed that he had been treated at Alfred Emergency on March 18, for bilateral fractures of his ulnas after having fallen from a balcony. The fractures required medical intervention but he left the Emergency Department refusing the treatment. At the home visit on March 20 he was still refusing medical treatment for his fractures and refusing psychiatric treatment. His CTO was revoked and he was placed in psychiatric in-patient care until being

6 Associate Professor Doherty was the Director of Psychiatry at the Alfred at the time of Jason's death.
7 Exhibit 1
8 Exhibit 1; Pp1-2
9 According to the report of Associate Professor Doherty of June 26, 2006

discharged on April 11. He continued to refuse surgery for his fractures. He was on a range of anti-psychotic medication upon his discharge.

11. Associate Professor Doherty noted that consideration was given to a placement at Wirringa Secure Extended Care Unit at that time but no bed was available and "unlikely to be available for some months".[10]

May 2006 admission

12. Two months later, on May 2, 2006 Jason again had his Community Treatment Order revoked on the basis that he was found to be in a suicidal state in the context of an impending court hearing for charges against him. Jason was reviewed twice by Dr Louise Dawson during this admission. Jason was released on another Community Treatment Order for 6 months on May 5 2006.

13. Jason continued to remain difficult to treat in the community. The treating team continued to try and negotiate with him to accept his medication. His last few weeks were summarized by Associate Professor Doherty as follows:

> *"On 30 May he was reviewed by two staff of the MSTS and was to have his depot medication then but refused. There were concerns about his mental state on that review. It was decided to wait for 24 hours. On June 1 he accepted the depot medication.*
> *On 8 June he was seen by his case manager from the MSTS. At that meeting he stated he would not attend a planned meeting to further discuss accommodation issues saying he did not want to live in the proposed future residences.*
>
> *Medication was due on 15 June but he was not able to be found. On 16 June when staff attended at Hanover Southbank he was not present though he had been seen that morning for breakfast there. Phone contact was made later that day and he agreed to attend for his depot later in the afternoon of that day. He did not attend. Another attempt was made on June 17 to review him and give him his injectable medication."*

14. As stated above, whilst still on the CTO commencing on May 5, 2006, sometime in the early hours of June 17, 2006, Jason had placed a rope around his neck which he had tied to a railing and jumped to his death from an overpass in Queens Road, Windsor.

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[10] Ibid P 2

Issues arising from the circumstances of Jason's death

15. At the Directions Hearing held on March 25, 2010 several issues were identified as of relevance to the circumstances surrounding the death of Jason.[11]

The appropriateness of the decision to discharge Jason on a Community Treatment Order?

16. Jason was released on a 6 month Community Treatment Order on May 5, 2006 authorised by Dr Louise Dawson. The ability to make such an order is contained in the *Mental Health Act 1986*. In making such an order, an authorized psychiatrist is required to take into account all of the relevant statutory requirements of the *Mental Health Act 1986*. Mr Halley of Counsel on behalf of Alfred Psychiatry submitted that it was necessary to assess the decision to discharge Jason in the context of the statutory requirements that Jason be given the best possible care and treatment appropriate to his needs in the least possible restrictive environment.

17. Mr Halley submitted, non contentiously in my view, that the intent of Parliament is clear in the *Mental Health Act* that treatment of persons with mental illness should be aimed towards integrating those persons back into the community rather than extracting them from the community.[12] That is, treatment and care of people suffering from a mental illness should be designed and aimed at keeping people living and participating in the community rather than an inpatient setting, subject to their safety. That is the backdrop for decision making and assessments.

18. Dr Louise Dawson, the psychiatrist that placed Jason on the Community Treatment Order made a statement[13] and gave evidence at the inquest. Her evidence was that she had assessed Jason's risk of suicide and examined Jason's mental state. She expressed the opinion that in her assessment Jason had sufficiently settled and was safe to be returned to the community on a Community Treatment Order, with the support of the Mobile Support and Treatment Service (MSTS). [14]

19. Her evidence was that at the time of his admission on May 2 2006 he was feeling sad and pressured. He had on-going persecutory beliefs. He had stated he wanted to hang himself from a bridge. It was Dr Dawson's evidence that by the end of Jason's admission on May 5 2006 he was denying any on-going suicidal beliefs or plans and his mental state had improved quite

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11 Section 67(1)(c) *Coroners Act 2008* requires a coroner investigating a death to find, if possible, the circumstances in which the death occurred.
12 Submission of Mr Halley at P 121 Transcript.
13 Exhibit 3 and Pp's 81- 97 Transcript.
14 The Mobile Treatment and Support Service is a multidisciplinary intensive service available to patients with a complex array of needs such as Jason. The evidence was that the service had been very successful supporting a number of patients. Jason was well-known to the service and the practitioners managed to engage with him even though he presented a range of complex challenges to the practitioners.

rapidly during his admission period.[15] Dr Dawson had attributed his abstinence from illicit drugs as the reason why his mental state had rapidly improved. Dr Dawson noted that on discharge, Jason "was pleasant on interactions with no psychotic material expressed and no current suicidal ideation".[16]

20. When asked about consideration of a secure long term in-patient stay for Jason at that time, Dr Dawson stated that there would be "obvious benefits" for Jason in such a facility. She agreed with Dr Coulson that one of the obvious treatment benefits for Jason would be the ability to treat him with the anti-psychotic Clozapine. Both doctors agreed that this anti-psychotic medication was a better treatment option for Jason but not if he was erratic and unco-operative as the medication required repeated medical examinations and blood tests and a high level of compliance.[17] Both agreed that the only environment in which Jason could be treated with Clozapine would be in a secure extended care ward.

21. Dr Brett Coulson was the consultant psychiatrist for the MSTS for the Alfred as at May 2006. He described himself as the "direct medical clinician for Jason's care".[18] He gave evidence as to Jason's treatment regime which included at times, going to Jason's accommodation to try and connect with him, even though this proved unsuccessful at times as Jason was often not present and did not keep appointments. Jason was described by Dr Coulson as not having any insight into his illness or the detriment to his health of his poly substance abuse. Dr Coulson described Jason as "incredibly challenging" which included his high risk of aggression to staff which meant that any attendance upon Jason always required two staff to attend.

22. Dr Coulson's evidence was that Jason had chronically psychotic symptoms which were made worse by his poly substance abuse. He would get more agitated, distressed and disorganized as a result. Dr Coulson made clear in his evidence that Jason's best prospects of improving his health in the long term were to have a long term in-patient stay but that the "resourcing was not there" because of the demand on long term in-patient beds.[19] He stated that to take such a step would have to be a last option for a patient, but that for Jason, the team felt there were very few further options for him. When finally pressed by me on this point, Dr Coulson stated if there had been a long term bed available for Jason, he would have recommended that for him.[20] Dr Dawson, when asked whether she would have chosen a long term secure bed for Jason at the time she was treating him in May 2006, if one had been available, stated as follows:

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15 Transcript p 87
16 Transcript P 95
17 Evidence of Dr Dawson: Transcript P 93
18 Transcript P 45
19 Transcript P 53
20 Transcript P 73

"I think he was the perfect candidate. He had a known psychiatric treatable illness, schizophrenia. Ah...., he was a risk to himself chronically, and he was chronically a risk to others. And that he really did deserve a good long trial of Clozapine in a secure setting, where he would be hopefully free of illicit substances, so that we could really maximize our chances of getting Jason better. [21]

25. This observation from Dr Dawson is amplified by the evidence of Mr Stuart Edge who had been the case manager of the MSTS treating Jason as at June 2006. Mr Edge observed that Jason was very difficult to engage in that he was dismissive, violent a lot of the time, abusive and avoidant. He described him as one of the harder people to engage in treatment.[22] He also gave evidence that it was hard to assess Jason's mental state at times because he could be drug affected. It was hard to find accommodation for Jason because of his chronic drug abuse, treatment resistant psychosis and his rejecting of services. When asked about the appropriateness of a referral to a long term secure in-patient facility, Mr Edge thought such a referral would have been "*extremely appropriate*".[23]

26. Associate Professor Doherty was the Director of Alfred Psychiatry at the time of Jason's death. He gave evidence to the inquest that in his opinion the use of the MSTS, being one which could provide more focused and intensive support was a sensible option for Jason and provided a very caring team for him.[24] He also gave evidence that the team was struggling to manage Jason in the community but that there was a lack of beds in the more secure long term facilities.[25] As to the appropriateness of the discharge on the CTO in May 2006, Associate Professor Doherty seemed to be saying he was unable to give an opinion about that because the documentation in the hospital file was inadequate. I shall return to the issue of adequate documentation in the hospital file.

27. Jason was well known to the MSTS service.[26] All of the evidence was that he was very difficult to keep engaged and had provided a range of challenges. The evidence is that those who were treating Jason were putting considerable expertise and effort into maintaining his engagement with the service in extremely difficult circumstances. It was difficult to support Jason to maintain housing as a result of his poly-substance abuse, poor self care, dishonesty and violence, persistent psychotic symptoms and generally hostile and avoidant behaviour with the treating team. Indeed, Dr Simon Straface, the current Director of Alfred Psychiatry, in a statement provided to the Inquest stated that "Non adherent, insightless or otherwise disinterested

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21 Evidence of Dr Dawson: P 97
22 Transcript P 107
23 Evidence of Mr Edge: Transcript 112
24 Transcript P 9
25 Transcript P 20
26 Dr Simon Straface provided a statement (Exhibit 4) in which he set out the structure of the community program at Alfred Psychiatry which included a description of the Mobile Support and Treatment Teams structure, rationale and purposes.

patients present a significant challenge to services, as does the co-ordination of care when multiple service providers are involved".[27]

Conclusion

28. Having had the benefit of the statements and oral evidence of Drs Coulson and Dawson and Mr Stuart Edge and Associate Professor Doherty, I am satisfied that at the time the decision was made to discharge Jason on a Community Treatment Order on May 5, 2006 with the Mobile Support and Treatment Service multidisciplinary support, that was a reasonable decision in Jason's circumstances and in the circumstances of the reality of what options were available to the treating team. That is, this decision must be seen in the context of the treatment options available to the doctors, Jason's long term history of poly substance abuse and the difficulties, complexities and limits of suicide risk assessment generally in these circumstances. [28]

Was there sufficient ongoing risk assessment of Jason as between May 5, 2006 and his death on the 17th of June 2006?

29. Mr Edge gave evidence of each of the contacts with Jason that he was involved in from the time of his discharge to the time of his death. He also gave evidence about the rationale for trying to keep Jason engaged with the service by striking the balance between not being too demanding with him whilst endeavouring to ensure he was given sufficient treatment and monitoring to keep him functioning adequately in the community.

30. This style of treatment and management of Jason is demonstrated by what took place over the last couple of weeks of Jason's life. On May 30 he was reviewed by the MSTS. There were concerns noted about his mental state at that time. It was decided to wait 24 hours before making a further decision about Jason. The team were able to give him his depot injection on June 1 2006. On June 8 2006 he was seen by his case manager, Stuart Edge. He was being resistant to assistance for accommodation. He was required to move. His medication was due again on June 15 2006. Mr Edge gave evidence of his efforts to engage Jason over the next couple of days to persuade him to come in and have his treatment. Mr Edge had conferred with Dr Coulson about this situation.

31. On June 16 the MSTS went to his accommodation trying to find Jason. He had been seen for breakfast that morning. Telephone contact was made with Jason and he agreed to attend that afternoon for his injection. He did not attend. In the early hours of the morning of June 17 2006, Jason took his life.

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[27] Exhibit 4: Statement of Dr Straface

[28] See "Comments" section of this Finding.

32. In making an assessment as to whether there was sufficient ongoing risk assessment of Jason, the first place to look for evidence of this is in the notes contained in the hospital file. It has been conceded by The Alfred Hospital that the documentation of mental state examinations of Jason was not sufficient to enable an understanding and tracking of his condition and that the documentation fell short of what was acceptable.

33. Mr Edge gave evidence that The Alfred, upon reviewing Jason's death came to that conclusion and he agreed with the conclusion.[29] The evidence was that, given the high turnover of staff in a facility like The Alfred, it was essential to maintain adequate records of a patient's condition to enable proper risk assessment.

34. Despite the lack of documentary corroboration, the evidence was that Mr Edge was making mental state examinations each time he interacted with Jason and, as part of that mental state examination, he was making risk assessments.

35. It was submitted by Mr Halley on behalf of Alfred Psychiatry that although the documentation of the mental state examinations of Jason was not adequate, there was evidence that there were ongoing mental state examinations. Further, it was the submission of Mr Halley that the risk assessments were appropriately undertaken and that there was not evidence to find that Jason's death was linked to a failure to make appropriate ongoing risk assessments.

CONCLUSION

36. Having heard evidence from Mr Stuart Edge I am satisfied that ongoing risk assessments were being made for Jason and thus there is not evidence that a failure to make ongoing risk assessments can be causally linked to Jason's death.

Was it reasonable to undertake the approach that the treating team did which was to allow Jason some latitude before revoking his community treatment order to enforce his medication?

37. Cogent reasons were given by those with vast experience and expertise in this area as to why it was reasonable to undertake the course that was undertaken. It was the evidence of both Dr Coulson and Associate Professor Doherty that it was reasonable to allow a couple of days for Jason to meet with the Mobile Support and Treatment Team, in the way in which this was done in Jason's case. These are clinical judgments that have to be made by experts working in a demanding and imperfect system. The evidence supports the conclusion that it was not

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[29] See Comments section on the issue of documentation

unreasonable, given all of the complexities that Jason presented, to decide to give Jason a day or two to comply with the requests before revoking his CTO.

38. Dr Coulson's evidence was that the service was trying to get Jason to be more engaged with the service and that their assessment was, to be too intrusive with Jason would not be productive of a better relationship with him and reduce his chances of being compliant with treatment. In a similar vein, Dr Coulson stated that one of the problems a treater has in circumstances such as these is that when the team is trying to maintain and build engagement with someone like Jason, that frequently hospitalizing them against their will can be seen as a betrayal and therefore counterproductive to building engagement.[30]

39. Dr Coulson described that as a tension between risk assessment and engagement. He added that he did not believe that the team ever stopped trying to look at ways to engage Jason, no matter what challenges he presented although in the last 6 months of Jason's life the team were frequently considering the possibility of a long term in-patient stay for him to stabilize him with appropriate anti-psychotic medication. Dr Coulson made clear in his evidence that, if faced with the same situation, he would not make a different decision about not revoking Jason's Community Treamtent Order during his last couple of weeks alive.[31]

40. Mr Edge gave evidence that he thought the team were doing everything they could to keep Jason safe.[32]

41. It was the evidence of Associate Professor Doherty and Dr Coulson, neither of whom are working at Alfred Psychiatry any longer, that the Mobile Support and Treatment Team workers were performing at a high standard in very difficult circumstances. It was submitted that I should find that Mr Edge was both a caring and diligent case worker who also accepted that his documentation was less than adequate but that his care and concern for Jason was not, and I do find that to be so.

Conclusions:

42. I find that Jason had a long history of chronic mental illness and poly substance abuse and a history of suicidal ideation and previous suicide attempts. Given his history and the nature of the acts which led to his death, I am satisfied on the evidence to the requisite standard that Jason jumped from the overpass with the intention of taking his own life whilst on a Community Treatment Order.

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30 Transcript P 59
31 Transcript P 70
32 Transcript P 113

43. I find that Jason was at high risk of death throughout 2006. Dr Coulson said so in his meeting with Jason's mother in December 2005. Jason's mother acknowledged being advised of this risk in her statement to police upon learning of Jason's death in 2006.

44. The evidence supports the conclusion that by 2006 Jason was an extremely difficult patient to treat and keep safe in the community. The evidence is that, had the treating team at The Alfred felt they had the option of a secure long term in-patient bed available to them for Jason at the time of his discharge in both March and May 2006, that would have been the best chance of giving Jason a chance at improving his health and potentially saving his life.

COMMENTS:

Pursuant to section 67(3) of the **Coroners Act 2008**, I make the following comment(s) connected with the death (including any notification to the Director of Public Prosecutions under Section 69(2) of that Act):

Adequacy of documentation in the hospital file:

45. The issue of inadequate documentation as to a patient's condition and the dangers of it have been readily conceded by The Alfred. The lack of documentation as to the patient's condition has been accepted as risky practice in mental health work as it creates the ever present possibility that appropriate supervision of the patient and on-going risk assessment is compromised, thereby putting the patient's safety at risk.

46. The evidence was that an internal review of the circumstances of Jason's death was conducted by the Alfred and that the internal review made the following recommendations as to the need to improve record keeping:

1. Documentation for mental state examination to be improved by providing an electronic medical record which contains prompts to ensure that all domains of the mental state examination are considered, reviewed and documented. A regular audit of compliance with feedback to clinical staff was recommended.
2. Risk assessments for self harming behaviour leading to suicide risk to be included in an electronic medical record as part of a clinical prompt and linked to the recovery plan for the patient. This recommendation also recommended that the relapse prevention plan and the crisis plans are available to clinical staff and communicated to patients.

47. Having been provided with this information, I am satisfied that Alfred Psychiatry, have taken appropriate action to address the inadequacy of documentation contained in the files for Jason.

Long term secure in-patient beds

48. Psychiatric services work under the pressure of patients such as Jason on a daily basis. They are required to make decisions to provide the best treatment option with the available services and resources in the framework of the *Mental Health Act* for high risk patients such as Jason.

49. The sad commentary on Jason's life is the evidence from Drs Dawson and Coulson that were there a secure bed available for Jason at the time of discharge, it would have given him the best chance of improving his health and his long term prospects of stable mental health. Both doctors agreed that the ability to have Jason treated with Clozapine for about 18 months, without the deleterious effects of illicit drugs, may have resulted in resolving his fixed delusions. Dr Dawson stated that the short term acute admissions for Jason were to try and treat his aggression and agitation, not his fixed term delusions.[33]

50. It must be made clear that there was not evidence that any of the treating team made a referral for Jason in 2006 into a long term secure facility that failed or was rejected or that his referral was sitting in a queue waiting for a bed, but rather the evidence was that the daily reality of decision making by mental health professionals with patients such as Jason, is done with a knowledge of the scarcity of secure long term beds.

I direct that this Finding be distributed to the following:

1. The Hon. Rob Hulls, Deputy Premier, Attorney General
2. The Hon. Daniel Andrews, Minister for Health
3. Dr Ruth Vine, Chief Psychiatrist
4. Mrs Jenkins, mother of Jason
5. Investigating police member, DSC Scott Dwyer
6. Director of Alfred Psychiatry, Dr Simon Straface

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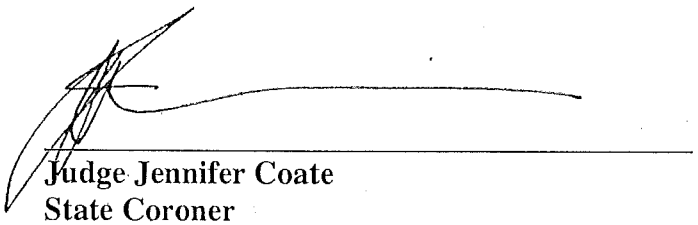
33 Evidence of Dr Dawson :Transcript P 94

7. Mr Stuart Edge
8. Dr Coulson, Consultant Psychiatrist
9. Dr Dawson, Consultant Psychiatrist
10. Associate Professor Doherty
11. Mr Halley of Counsel
12. Mr Bill O'Shea, Corporate Counsel, Alfred Hospital

Signature:



Judge Jennifer Coate
State Coroner
Date: 15th October, 2010