IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2010 2389

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)

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

(Amended pursuant to s76 of the *Coroners Act 2008*
on 25 February 2013)

Inquest into the Death of: JOY APOSTOLOPOULOS

Delivered On:	25 February 2013
Delivered At:	Level 11, 222 Exhibition Street Melbourne 3000
Hearing Dates:	8 July 2011 and 15 November 2012
Findings of:	IAIN TRELOAR WEST, DEPUTY STATE CORONER
Representation:	Mr P. Halley appeared for the family on 8 July 2011 and Ms J Piggott appeared on the 15 November 2012 Mr B Ihle appeared for Dr Jeanes Mr B O'Shea appeared for Alfred Health on the 8 July 2011 and Ms S Cash appeared on the 15 November 2012
Police Coronial Support Unit	Sergeant Tracy Weir

I, IAIN TRELOAR WEST, Deputy State Coroner having investigated the death of JOY APOSTOLOPOULOS

AND having held an inquest in relation to this death on 8 July 2011 and 15 November 2012

at MELBOURNE

find that the identity of the deceased was JOY APOSTOLOPOULOS

born on 14 September 1968

and the death occurred on 24 June 2010

at Mordialloc Railway Station

from:

1 (a) MULTIPLE INJURIES DUE TO IMPACT BY TRAIN

in the following circumstances:

1. Joy Apostolopoulos, aged 41 years, was a single woman who resided with her father at 1/8 Shepparson Avenue, Carnegie. She had a past medical history of depression since 1991, together with a diagnosis of schizophrenia in 2003, when she was first admitted to Alfred Psychiatry Unit. In addition, Ms Apostolopoulos had a history of suicide attempts, with the attempts including overdose of medication and attempted electrocution. Whilst living with her father she had the support of Ms Vacouftsis, her loving sister who lived next door. Her past management was undertaken by the Mobile Support and Treatment Service, with more recent management being undertaken by the Waiora Clinic. At her last medical review at the clinic on the 16 June 2010 it was noted that her mental state was stable, as she had been taking her usual dose of Clozapine and Venlafaxine medication.

2. On 19 June, Ms Apostolopoulos was admitted to the Alfred psychiatric ward after she was seen acting erratically near the Carnegie railway station, with concerned bystanders contacting police. She was subsequently ambulance transferred and admitted to the hospital, where she remained for involuntary treatment in the low dependency area. Her family reported an increase in her level of anxiety over several days leading up to her admission and she stated to doctors that she was depressed and suicidal, with ongoing ideas of suicidal ideation. A medication review following her reporting ongoing headaches led to her agreeing to trial an increase dose of venlafaxine medication. On the 24th, a plan for escorted leave with staff or family was discussed and Ms Apostolopoulos was agreeable to the plan. This plan was

formulated following a mental state assessment, during which time she was observed to be settled and relaxed and not expressing any suicidal ideation.

3. During the course of the three-hour leave period Ms Apostolopoulos, attended a chiropractor, however after returning home and whilst preparing to leave for the hospital at 4.30pm, she became extremely agitated and ran out of the house towards Carnegie train station. Family chased and contained her pending ambulance attendance which occurred at 6.45pm and transferred her back to the Alfred Hospital. During the ambulance transfer, she remained distressed, trying to unclip her safety belt to leave the vehicle. Upon arrival, she was escorted, in company with her sister, by the ambulance officers to the first floor of the psychiatric ward after prior arrangement that she be returned directly to the ward. This occurred at 7.31pm. There was no 'handover' to nursing staff at the time the ambulance officers returned her to the ward.

4. Following entry into the locked ward, Ms Apostolopoulos was placed on 15-minute observations. She was provided with something to eat, whilst her sister accompanied the Charge Nurse to an office in order for a history to be taken of the events that had occurred. Ms Apostolopoulos was observed eating in the dining room at 7.45pm, however, after the recounting of the history was completed, she could not be located on the ward. This resulted in her sister leaving the hospital to search for her and staff making formal notification of her absence, to police.

5. On 24 June 2010 at approximately 11.30pm, Ms Apostolopoulos sustained fatal injuries when she walked into the path of a city bound train, in the vicinity of the northern pedestrian crossing, at Mordialloc Station. She died at the scene.

6. The evidence satisfies me that Ms Apostolopoulos intentionally stepped into the path of the oncoming train and that the train driver could do nothing to prevent the tragic outcome.

7. No autopsy was performed in this case, as the coroner in consultation with Dr Melissa Baker, Forensic Pathologist with the Victorian Institute of Forensic Medicine, directed that no autopsy was required. Dr Baker performed an external examination of Ms Apostolopoulos at the mortuary, reviewed the circumstances of her death, the post mortem CT scan and provided a written report of her findings. Dr Baker reported that in all the circumstances, a reasonable cause of death was multiple injuries due to impact by train. Toxicological examination of post mortem body tissue was positive for Clozapine, Venlafaxine, (both indicated for the treatment

of schizophrenia) and Olanzapine (indicated for the treatment of depression) all within therapeutic concentrations.

COMMENTS

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

8. A number of issues of concern arise from the investigation and inquest, with the matter of greatest concern relating to how Ms Apostolopoulos was able to abscond from the locked psychiatric ward. It is clear from the evidence that entry to and exit from the ward required a staff member to use a key to open the door, with the door then self-locking, after being closed. Each nursing staff member (2 in the High Dependency Unit and 5 in the Low Dependency Unit) had a key to the door and when visitors wanted to leave, they had to locate a nurse in order to have the door unlock. There is no known witness to Ms Apostolopoulos leaving the ward, despite the weight of evidence satisfying me that she must have left via the locked front door, as I do not believe she would have had the capacity to abscond by climbing over the courtyard wall. This would have necessitated a staff member opening the door, presumably unaware of Ms Apostolopoulos being a patient.

9. The identity of the staff member who admitted Ms Apostolopoulos and her sister into the ward upon their return cannot be determined, however, it would appear that it was someone who had not been specifically allocated to Ms Apostolopoulos' care. The staff member was not recognized by Ms Vacouftsis. Nothing was said at the time, with the staff member simply opening the door to allow access. As there was no handover by ambulance personnel, nor conversation between the parties, the status of either or both women may not have been understood by the staff member. This may account for the later reopening of the door to allow one to leave. It is of concern that no ambulance handover took place upon return to the ward, nevertheless, it can't be concluded that had it occurred, the absconding would have been prevented.

10. Of further concern is the fact that the ward appears not to have been aware that Ms Apostolopoulos was returning. This conclusion is based on the evidence of Dr Jeanes (Psychiatrist, Alfred Psychiatry) who stated that had the ambulance officers forewarned that she was being returned, ward staff could have made preparations, such as considering making room available for her in the High Dependency Unit. However, the ambulance officers had made contact with the hospital (via their communications room), as they were directed to

return Ms Apostolopoulos directly to the ward, rather then take her to the Emergency Department. The evidence does not permit a finding as to the point of contact at the hospital, with it being either to the ward, or some communication centre within the hospital. If it was the former, it is clear that the contact was not acted on, as no preparations were put in place. If it was not directly with the ward, it appears there was a breakdown in failing to communicate the information to the ward. Whilst it would seem unlikely that the direction to transfer directly to the ward would be made without ward input, either way, the opportunity was lost to prepare for her arrival and prompt reassessment.

11. The evidence satisfies me that it was appropriate for medical staff to permit day leave for Ms Apostolopoulos. A medical assessment had taken place prior to the decision being made and leave was on the basis that she would be in the care of her sister, who had been known to staff for many years and whom doctors trusted as a carer. Medical staff should not be criticized in the circumstances, especially in the light of legislative requirements mandating involuntary patients be treated in the least restrictive environment.

12. Ms Vacouftsis appropriately expressed concern during the course of her evidence, that if nursing staff were not familiar with patients, then a patient may inadvertently be released from the ward. She suggested a visitors sign in/sign out book. Dr Jeanes was of the view, however, that this would place a significant imposition on the staff, in that it would require ongoing monitoring at a time when limited nursing resources were required to be directed to nursing responsibilities. I do not accept that this is sufficient reason for not implementing such a policy. When the general ward is in 'locked mode', the nursing staff are directed away from nursing duties in order to answer the doorbell, or to open the door for visitors leaving. I do not believe the requirement to check a person in or out via a book entry, would significantly add to their time away from other duties,

RECOMMENDATIONS

Pursuant to section 72(2) of the **Coroners Act 2008**, I make the following recommendations connected with the death:

1. That the Alfred Psychiatry Unit implement a plan ensuring the recording of persons (other than hospital staff) entering and leaving the Unit's general ward, when the ward is in 'locked mode'.

2. That hospital staff and ambulance officers ensure an appropriate handover takes place, whenever a patient is delivered directly to the Alfred Psychiatry Unit ward.

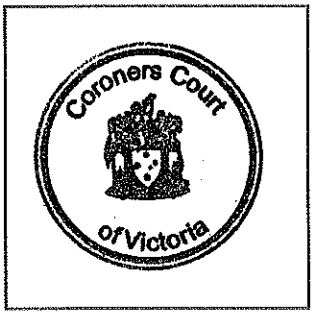
I direct that a copy of this finding be provided to the following:

Family of Joy Apostolopoulos

Medical Director, Alfred Health

Chief Executive Officer, Ambulance Victoria

Signature:



IAIN WEST
DEPUTY STATE CORONER
Date: 25 February 2013