IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: 675 / 2007

REDACTED FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
Section 67 of the ***Coroners Act 2008***

Inquest into the Death of: K

Delivered On:	March 1, 2012
Delivered At:	Coroners Court of Victoria Level 11, 222 Exhibition Street Melbourne 3000
Hearing Dates:	September 16 and 17, 2010 January 24, 2011
Findings of:	JUDGE JENNIFER COATE State Coroner
Representation:	Mr Paul Halley for Eastern Health instructed by DLA Phillips Fox
Police Coronial Support Unit	Leading Senior Constable King Taylor

I, JUDGE JENNIFER COATE, State Coroner having investigated the death of K

AND having held an inquest in relation to this death on September 16 and 17, 2010 and January 24, 2011

at the Coroners Court of Victoria at Melbourne

find that the identity of the deceased was K of Seville East

born on August 12, 1973, aged 33 years

and the death occurred on February 20, 2007

at The Alfred Hospital, Commercial Road, Melbourne 3004

from:

1 (a) COMPLICATIONS FROM BLUNT FORCE TRAUMA TO HIS HEAD CONSEQUENT UPON BEING STRUCK BY A MOTOR VEHICLE AS A PEDESTRIAN[1].

in the following circumstances:

Background

1. K was born on August 12, 1973 and was 33 years old at the time of his death. He lived with his parents, Mr and Mrs K, at Seville East.

2. K had a long history of struggling with substance abuse which appears to have dated back to his early teens. His brother also had a history of substance abuse and mental health problems and at the time of K's death his brother was in Dandenong Psychiatric Hospital as a result of his drug induced psychosis. K's parents supported their two sons over many years with their drug and mental health problems.

3. K had a long history of addiction to multiple drugs and attempts to control his drug use.[2] As at February 2007, he was undergoing methadone treatment. His "methadone" doctor was Dr Malcolm McRae who last saw K on February 8, 2007 at which time he gave him a script for

[1] Dr Malcolm Dodd, the forensic pathologist who performed the post mortem examination upon K found cerebral contusion, global cerebral oedema and diffuse axonal injury.

[2] Statement of Mrs K 6.5.2007 states that K had been using drugs including "speed" as early as 13 years old. He was also using heroin. Mrs K described a number of years wherein both of her sons grappled with their drug problems.

methadone and "upped" the dose from 45 to 50 milligrams[3]. He stated that K had spoken to him during that appointment about not taking his methadone but then decided he would continue. Dr McRae had left some instructions with the pharmacist dispensing methadone to K about what to watch for with K, as it was Dr McRae's opinion that K had some history of "doctor shopping".

4. On 9 February 2007 K presented to Dr Andrew Kirwan stating that he had been using multiple drugs of addiction and that he was suffering withdrawal symptoms.[4] Dr Kirwan made some referrals to drug and alcohol services for him to pursue.

5. On the weekend of February 10 and 11, 2007 Mrs K became aware that K had not had his methadone since 8 February. His father offered to take him to get his methadone but K stated to his mother and father that he would be fine.

6. On Sunday 11 February, it was K's brother's birthday and he was at home for the weekend on release to the family. On that morning of 11 February 2007 at about 7.30am, K rang Lilydale police station and spoke to L/S/C Westmore. He identified himself and told her he was going to kill himself. L/S/C Westmore knew K from previous dealings. L/S/C Westmore did an admirable job of engaging K in a discussion[5] and endeavouring to assist him and understand his concerns. K discontinued the call and L/S/C Westmore called back and spoke to K's mother, Mrs K, and alerted her to K's condition and requested she check on her son.

7. Mrs K requested L/S/C Westmore speak to K again and put her back onto the telephone with K wherein L/S/C Westmore advised K that the police and ambulance were on the way. She re-assured him that he may need to go to hospital to have his current methadone status addressed and she stated that K seemed calm and thankful for this advice.

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[3] Statement of Malcolm McRae 23.10.08

[4] See letter from Dr Kirwan 20.1.08

[5] Statement of L/S/C Westmore of 10.12.2007

8. Between 9am and 10am the Lilydale police attended at K's home and spoke to him. The police were aware that the Crisis Assessment and Treatment Team ("the CAT Team") had been notified and were going to attend.

9. The CAT Team arrived at about 4.55pm.

10. The time that the CAT Team were at the family house is in issue but it is agreed that they spoke to Mrs K before leaving, advising that K would be alright and that their diagnosis was that it was a "drug issue". Mrs K was given some Diazepam for K's anxiety and the management plan was for K to be linked with drug and alcohol services the following day. It was the assessment of the CAT Team that K was not "suicidal".

11. After the CAT Team left, the family had dinner and then Mr K took K's brother back to Dandenong hospital. Mrs K commenced cleaning up in the kitchen. At about 9.40pm she noticed that Mr K had pulled up in the driveway arriving back from the hospital. K came into the kitchen and spoke to his mother at about 9.55pm. Mrs K noticed that K had changed his clothes and was wearing all dark coloured clothing. Shortly thereafter Mr K came into the kitchen to ask where K was and Mrs K replied that she did not know.

12. Immediately fearing for his safety Mrs K went outside to look for him. She saw lights flashing down on the highway and immediately feared that K may have been involved in an accident. In the meantime, at approximately 10.05pm, K had gone down an embankment onto the Warburton highway behind his parent's place and ran out in front of an oncoming car. As a result, K sustained serious head injuries and was airlifted to the Alfred Hospital. K did not regain consciousness. He remained on life support at the Alfred Hospital until February 20, 2007 when he passed away.

The issues for investigation

13. During the course of the investigation various issues were explored. By the time of the Directions Hearing the issues identified for investigation at inquest were (a) the timeliness and nature and adequacy of the CAT Team assessment and (b) whether or not K's actions were an intentional taking of his own life. No issues arose with respect to the police response, the

emergency services responses, the actions of the driver of the vehicle that collided with K or the medical treatment of K at the hospital.

The timeliness, adequacy and nature of the CAT Team Assessment

14. As noted above, issues did arise touching upon the nature and adequacy of the assessment of the CAT Team that attended upon K that day. To this end, Associate Professor Paul Katz, the Clinical Director of the Adult Mental Health Program at Eastern Health who oversees the Crisis Assessment and Treatment Teams at Eastern Health provided a statement at my request dated 24 December 2010 after the close of the evidence in the inquest. Associate Professor Katz was requested to address the outcome of an internal review of these circumstances, to address the issue of the production of the CAT Team diary, which had been unable to be located throughout this investigation and to also provide information about the changes instituted in the wake of K's death.

15. Associate Professor Newton is the medical director of the Mental Health Clinical Service Unit at Austin Health and has been so since 2009. Prior to this he was the Clinical Director of Psychiatry at Peninsula Health. Through the Australian and New Zealand College of Psychiatrists, he was nominated by the College to provide an independent expert opinion to the Court on the nature and quality of the CAT Team assessment in these circumstances and invited to comment on the circumstances generally using the benefit of his clinical expertise and experience. He provided a report[6] and gave evidence.

Contact with the Crisis Assessment and Treatment Team (CAT Team)

16. The evidence is that the Outer East CAT Team based at Maroondah Hospital were contacted about K by the police in the wake of L/S/C Westmore's contact with K and his mother at or around 8am on 11 February 2007. During the course of the day information was collected by the CAT Team triage nurse who spoke to K's mother several times throughout the day. The triage notes confirm that the CAT Team were advised that K was three days into withdrawing

[6] Exhibit 7

from drugs, was paranoid and suicidal, was not eating or sleeping and had been depressed for a few months. The notes also confirm that Mrs K gave considerable information about the family history of mental illness and hospitalisation. The triage notes record that Mrs K stated that K was stating that he was unhappy with himself and wanted to die. The notes record that Mrs K indicated that K does not make himself clear when he talks to people.

17. The triage notes also record that K was spoken to that morning and that he was attempting to minimise what his mother had said although the notes do record K saying he wanted to be admitted to hospital as he thought he was having a "nervous breakdown". He admitted to being suicidal that morning and the notes record that K was constantly saying "admit me. ....admit me.....admit me...."

18. The triage notes also record that the CAT Team spoke to Mrs K at about 1pm that day very apologetic about how long it was taking and rang back at about 3.30pm to 4pm again apologising for the delay.[7] Mrs K stated that it was during this late afternoon call that she advised that K was getting worse as he was asking his father for a gun.

19. The CAT Team that was dispatched to attend upon K was RPN[8] Ken Payne and RPN Paul Casey. Both members were very experienced clinicians who had worked in crisis assessment for many years. Both RPN Casey and Payne state that when they came on their shift that afternoon, they assessed K's situation as a priority and dealt with it as their first job. RPN Payne stated that he thought K's referral looked "extremely serious" and needed to be dealt with as a priority.[9]

20. Upon their arrival at the family home at about 4.55pm, RPN Payne described K as pleasant and welcoming[10]. It was noted that K described a long history of poly substance abuse and advised that he had recently stopped taking his prescribed methadone and that he wished to recommence a drug detoxification program. RPN Payne noted that K showed no evidence of a psychotic illness during assessment.

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[7] Statement of Mrs K 6.5.2007

[8] Registered psychiatric nurse

[9] Transcript 253

[10] His statement of March 22, 2007

21. RPN Payne stated that K was asked by the CAT Team about his suicidality and his mother's concerns about his statements earlier in the day. It was the evidence of the CAT Team that K told them he had been "edgy" in the morning, possibly because of the abrupt cessation of his methadone, but now felt better and had no suicidal ideation. He told the CAT Team he wanted to get into a detox program and "sort himself out". He was noted to be *warm and reactive, able to smile and acknowledge humour.*

22. He was rated by the CAT Team as a low suicide risk.

23. RPN Payne stated that he did not then, and has not since, been uncomfortable about the assessment he made of K's condition at the time with the information he had.

24. RPN Payne stated that they wished to give assistance to the family and thus agreed to take K as a client until his drug and alcohol services were in place. RPN Payne stated this was discussed with K's parents and that Dr Sebastian, the on call psychiatric registrar, was called to obtain 10mg of Diazepam for K to help minimise his further anxieties arising from his methadone withdrawal.

25. RPN Paul Casey,[11] a psychiatric nurse for 32 years at the time he gave evidence, has worked in crisis assessment teams continuously since 1995.[12] He stated that he was aware when they attended that the referral was from the police and that K had contacted the police requesting that they shoot him. He also noted that the triage nurse had spoken with K's mother who expressed concern that K was suicidal, not making sense and needing to be in hospital. His evidence was that they had both a verbal handover from the triage nurse and the triage notes with them when they went to the assessment.[13]

26. He confirmed that the triage notes had noted that K had a strong family history of mental illness and a personal history of poly substance abuse and had recently ceased his methadone

[11] Statement 8.4.07: Exhibit 4

[12] Transcript 177

[13] Transcript 180

and diazepam which had been assisting him to withdraw from his drugs of addiction. Since withdrawing he had not been sleeping or eating well and was expressing "suicide ideas". In his statement, RPN Casey sets out his notes of the assessment of K. His statement records that K stated he did not want to kill himself and that he had no intention of acting on such ideas.

27. RPN Casey, differed from RPN Payne, in that he described K as experiencing a "fluctuating mental state" and that given his genetic history of mental illness it would be prudent to follow up with him in the short term to ensure he was admitted into a drug withdrawal program. RPN Casey also noted that whilst he and RPN Payne agreed that K's suicide risk was low, a safety plan should be made and this was done.

28. RPN Casey described the safety plan as one in which K agreed to accept that his suicide ideas were fluctuating and he would not act on them but rather call the 24-hour number if these thoughts returned.

29. RPN Casey stated that he discussed the plan with Mrs K and that she agreed with this plan. RPN Casey states that he gave Mrs K 6x5mg Diazepam tablets with instructions on how to give them to K.

30. In evidence, Mr and Mrs K did not agree that they were consenting participants in the management plan. They took issue with the adequacy of the time the CAT Team spent with K and the outcome of the assessment that they reached that K was not suicidial given the information that they had. They also took issue with the lack of communication and support offered to them given that they were anxious to have their son held safely during what they thought was a dangerous crisis period for him.

The duration of the CATT assessment

31. This was a contentious issue. The evidence of Mrs K was that RPN Casey and Payne arrived at about 4.55pm and left at about 5.20pm.[14] The evidence of Mr K is that RPN Payne and

[14] Transcript Pp 46-51

Casey arrived at about 5pm[15] and that they were present for no more than about 20 to 25 minutes.

32. On examination of their evidence as to how sure they could be of the timing of the arrival and departure of the CAT Team, Mrs K agreed that it was a hectic, crazy day that day. She stated in her statement that she had trouble remembering much description about that day.[16] She also conceded that she did not see the CAT Team arrive. Mr K agreed that he was not wearing a watch, but that he was estimating the timing of the CAT Team's arrival and departure based on how long it took him to prepare the BBQ he was cooking for dinner.

33. The evidence of RPN Payne is that he and RPN Casey arrived at or close to 5pm.[17] His evidence was that he thought they were at the house for about 40 to 45 minutes and stated that they could not have done the assessment in 20 or 25 minutes. His evidence was that he thought they left the house at about 6.15pm.

34. RPN Casey agreed that they arrived at about 5pm. He was not able to be certain as to what time they left but based on the assessment that was undertaken he stated it could not have been 15 to 20 minutes.[18] RPN Casey was adamant about this in evidence stating he was absolutely certain that was not so as he had never conducted an interview with a new patient in less than 45 minutes to an hour.[19] RPN Payne was also firm in his evidence that it was not possible to do such an assessment in 15 to 20 minutes and they did not.[20]

35. It was conceded by Eastern Health that if the CAT Team were only there for 20 to 25 minutes that would have been inadequate to do a proper assessment. However, that was not conceded.

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[15] Transcript Pp 104-116

[16] Statement of Mrs K 6.5.2007

[17] Exhibit 9: Statement of Mr Payne and Transcript P 247

[18] Transcript p 247

[19] Transcript Pp 218-9

[20] Transcript 243

36. Unfortunately, according to the statement of Professor Katz, the CAT Team diary has been destroyed and therefore was not available to the court in this inquest. This diary may have been able to assist in confirming times of arrival and departure from the K household.

37. Associate Professor Newton considered the length of the assessment to be an important consideration. In his opinion, an adequate assessment of a new patient in these circumstances would take between 45 minutes to an hour in the hands of highly competent clinicians in ideal circumstances and that such an assessment would involve speaking to available family members to get information about the circumstances and background.[21]

38. He stated that a 15 minute assessment would not be adequate time to establish a rapport with the patient and the family, obtain an adequate history conduct a thorough risk assessment, conduct a mental state examination, elicit the family's concerns and agree upon a management plan with the patient and family.

Conclusion as to duration of the CATT assessment

39. In the end, the state of the evidence does not allow me to form a concluded view on this issue to the necessary Briginshaw standard.[22] I accept without question that the K family are being honest and forthright in their recollections of what they thought happened on this day. I also accept the evidence that this was a "crazy" day as Mrs K says with so much going on and was demanding and confusing for the family and ultimately shocking and traumatic. Both RPN Payne and Casey are adamant that they did not and would not perform an assessment such as this in 15 to 20 minutes. They had given K's case priority when they came onto their shift.

40. It is unfortunate for RPN Payne and Casey that the notes of their attendance and assessment are scant. Whilst inadequate notes cannot lead one to conclude that there was an inadequate assessment, or that the assessment was necessarily too short, it does not assist RPN Casey and Payne. It is clear that inadequate notes are not good practice and this has been agreed by both CAT Team members and the institution which supervises them. Unfortunately for the

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[21] Report of A/Professor Newton P 5

[22] Mr Halley submitted that conclusions could not be reached on inexact proofs in the circumstances given the ramifications for the professional reputations of Payne and Casey and that the Briginshaw standard was required and I agree with this submission.[22]

institution, the diary which may have been able to shed some light on this issue was destroyed (See comments below).

Information available to the CAT Team

41. There are some questions raised in the material about what the CAT Team knew about K's history. It was the view of Associate Professor Newton that the triage nurse had taken good notes of the original referral. He did observe however that the triage notes did not contain an actual triage scale which may have been helpful in determining the urgency of the referral to the Team. (See below: Changes since 2008). The evidence is that the attending CAT Team had these notes with them when they attended upon K. It was Associate Professor Newton's opinion that this was all good clinical practice.

42. Mrs K stated that K had a psychiatric history that needed to be taken into account. Dr Gill, consultant psychiatrist at Maroondah Hospital, provided a statement.[23] Dr Gill had no direct involvement in K's case. However, on the issue of what actual recorded psychiatric history K had, Dr Gill stated that K had a past history of contact with Orygen/Epic years earlier, but no history of psychiatric diagnosis or past admissions. He noted a family history of schizo-affective disorder in K's sister and drug induced psychosis in his brother. (The statement of Dr Gill did not provide an opinion as to the reasonableness or otherwise of the assessment reached or actions of the CAT Team.)

The adequacy of the assessment

43. The assessment made by the CAT Team was that K's diagnosis was a reaction to his withdrawal from his methadone program and thus his issues were not mental health issues. In essence their assessment was that K was not suicidal or suffering from a psychiatric illness but reacting to his drug withdrawal.

44. Dr Malcolm McRae was K's treating General Practitioner (GP) who had first met him in 2003. He was prescribing K's methadone. He considered K to be "a bit of a doctor shopper". As noted above, he last saw K on February 8, 2007. He stated that K told he him he was considering taking himself off methadone. Dr McRae stated he encouraged K to continue with

[23] Statement of Dr Gill March 21, 2007

the methadone and gave him another script for a month's methadone. Dr McRae stated that upon reviewing his notes he had noted that K was looking for work and made no reference to committing suicide and that he would not have considered K to be a suicide risk.

45. Associate Professor Newton was requested to provide an opinion on the adequacy of the assessment made of K by the CAT Team. He stated that if it was found the CAT Team were only present for 20 or 25 minutes, that would not be an adequate time to perform the required assessment.

46. He also noted the inadequacy of the notes made by the attending CAT Team. He stated that whilst the triage notes identified the possibility of a psychotic illness, the possibility of depressive illness, the possibility of a drug withdrawal syndrome and the possibility of a high suicide risk, the notes of the assessment from the attending CAT Team did not include a chronological history of symptom development relevant to the mental health issues contained in the triage notes or evidence of a systematic questioning regarding the relevant symptomatology to rule out these diagnoses.

47. Associate Professor Newton stated that whilst the assessment did include notes about mental state examination, that mental state examination only provided a cross-sectional picture and that it was the history of systematically elicited symptom development that would have provided a better indicator of what the diagnosis might be. Associate Professor Newton identified that the notes fell far short of what would constitute documentation of a thorough examination in these circumstances which in the opinion of Associate Professor Newton should have specifically covered methadone withdrawal, depressive symptoms, psychotic symptoms and longitudinal risk. Associate Professor Newton noted that there was little evidence that the clinicians explored with care K's request for a gun and his request to the police to shoot him. Associate Professor Newton also noted that in his opinion a risk assessment needed to include questions about hope and ruminations about death and that these responses should have been documented in the assessment.

48. Associate Professor Newton considered that K would have been a difficult person to assess with all of his presenting issues and that the environment was a difficult one to work in given the evidence about what a hectic day it was for Mrs K together with the presence of K's brother at the house. In Associate Professor Newton's opinion the assessment of K would

have required a range of very open questions through to close directive questions and a high level of curiosity from the clinician. The evidence from both clinicians is that they concede the notes are poor, but that the assessment itself was thorough and appropriate and the conclusion they reached was one open to them at the time.

Family involvement in the assessment

49. RPN Payne stated that he did not discuss K's situation with his parents in the wake of his interview with K. He stated that he did not do it because of the comprehensive state of the triage notes, but expressed considerable regret in evidence that he did not do that. His evidence was not that he considered the discussion would not have changed his view about K but it would have been of much greater assistance to the K family.[24]

50. As to how much information was gleaned from the family, RPN Payne's evidence is that they did not have a discussion with the family about their perceptions and fears and beliefs, and again his reason for that was that he had very comprehensive triage notes from the handover when they came on shift that afternoon.

51. Associate Professor Newton indicated that in the circumstances where a family are clearly expressing their own concerns and had been involved in considerable interaction with the psychiatric triage nurse, a reasonable expectation of good clinical practice would be that the clinicians would engage with the patient's family to obtain a history from a family member or members.

52. Both Mr and Mrs K were adamant in their evidence that as the CAT Team were leaving they told them that K was "suicidal" and that the response of the CAT Team was to say to K, "You're not suicidal are you K?", to which he made no verbal response, only smiled.[25] Both Mr and Mrs K in closing submissions reiterated their recollection that as the Cat Team left, they said to K "You're not suicidal are you K?" to which he responded with just a "wry grin" but no words. RPN Casey states he does not recollect this but stated he believes he would have sought more information if that had been said.

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[24] Transcript 255

[25] Transcript 295

Conclusion as to adequacy of the assessment

53. The paucity of the notes of the assessment, whilst not conclusive that steps were missed, leave some doubt as to the thoroughness of what was done. The task of a mental health practitioner in assessing whether or not an individual is at risk of intentional self harm is a complex and unenviable task. The sad outcome of a person taking their life in the wake of an assessment that the person was not "suicidal" is not evidence that the assessment was flawed. But it must be understood that a properly documented assessment that systematically goes through what has been found, based on what, and what diagnosis has been reached and treatment plan agreed upon is essential to this complex process.

54. As part of that process, the inclusion of the family who are supporting and caring for a person must be appropriately taken into account. The evidence in this case is that the interaction with K's family was limited to some feedback at the end of the assessment and advice as to a management plan, which included the provision of the Diazepam.

55. The CAT Team members conceded that they did not feel the need to obtain any information from K's family about him as they had thorough notes from the triage nurse. This should have been communicated to K's mother and father to reassure them that they had a great deal of information about K. Further, based on the facts and the opinion of Associate Professor Newton, good clinical practice is to engage with the patient's family to obtain or confirm the history. Had this been done, it would have addressed anything further that had happened since the triage notes were taken given that they were taken in the morning and many hours had passed since then.

56. A service that is set up to be a crisis assessment mental health intervention needs to be capable of a response that is quicker than 8 hours from call to response. The evidence of Associate Professor Newton was that the opportunity for a successful intervention may be lost by losing the co-operation of an "at risk" patient who becomes frustrated and overwhelmed by their feelings of hopelessness.

57. The evidence is that dual diagnosis patients present a range of particular complexities in risk assessment and call for a range of service flexibility and diagnostic awareness to ensure that the symptoms of one condition are not masking the other. This adds to the complexity of the scene that RPN Casey and Payne arrived at on this day.

58. As stated above, ultimately, I am unable to come to a conclusion as to the length of time that the assessment took, but I am able to conclude on the evidence that the delay in arriving may have contributed to K's decision not to cooperate with the assessment. The poor documentation of the assessment, whilst not evidence in and of itself of an assessment lacking in competency, is evidence of practice falling short of what is required of a crisis assessment team.

59. K's case provides a profound reminder of the complexity of a psychiatrically trained team, assessing the risk of self-harm when the patient's condition is compounded by drug use. The need for skilled and systematic assessment and response to dual diagnosis patients has been recognised by the introduction of a number of changes addressed below.

60. Associate Professor Newton also made the point in his evidence that a feature of the complexity of making risk assessments generally is that once a patient has made up their mind to take their own life, they will not tell the truth to those who they perceive are there to try and stop them.[26] This makes crucial the amount of information necessary to obtain from family and other sources to assist in making the assessment.

61. Associate Professor Newton also spoke about the need when making the assessment of someone who was clearly expressing suicidal intent in the hours before the assessment and is then denying those ideas as significant and a factor to consider in the risk assessment. He stated that he would be considering whether in fact the person has resolved whatever issues there were and is now full of hope and an expectation to live and recognition of important things in life that hold him and anchor him to his life. He also stated that part of the clinician's considerations should also be that if the assessment is the patient is not suicidal now, might

[26] Transcript 162

they be suicidal in an hour?[27] Due to the lack of documentation, I am unable to assess objectively whether K was examined in this way.

62. Associate Professor Newton pointed out that there is evidence in the triage notes that K clearly wanted to be admitted in the morning of the day he took his life. The evidence from the CAT Team is that by the time they got to him at 5pm that afternoon, he was denying he had such an intention. Professor Newton agreed in evidence that as the hours went on throughout the day, K's feelings of frustration and sense of helplessness may well have increased.[28] Again, there is not objective documented evidence that this possibility was examined with K.

The management plan

63. The management plan was the provision of 10mg of Diazepam, some follow up visits, liaison with the GP and a referral to Drug and Alcohol services. Associate Professor Newton indicated that in his opinion the management plan was adequate given the conclusions of the assessment, but the assessment itself may not have been adequate to support the conclusions drawn.

Documentation generally

64. **The CAT Team diary**: As noted above, during the investigation into the circumstances surrounding K's death, it emerged that the CAT Team kept a diary which recorded the movements of the Teams on any given day. That diary was called for but not produced. Associate Professor Katz advised that the diary was destroyed as part of the hospital's "confidential document disposal system". I have no further explanation of this process or the rationale behind it.

65. **Assessment notes**: The notes of the CAT Team members were the subject of some negative comment from both Associate Professor Newton and the Hospital's own internal review team. The notes were found to be an inadequate record of the assessment, diagnosis and treatment plan for K. The inadequacy of the documentation was conceded both by the members of the Team in their evidence and in closing submissions for Eastern Health.

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[27] Transcript 166

[28] Transcript 175

66. **Documentation of internal review**: Ironically, the written records of the critical incident review in the wake of K's death were also poor. Associate Professor Katz produced the written record of the critical incident review which constituted a page and a half. The document contains no date or signature. There is no record of who constituted the review panel, who chaired the review and/or wrote this page and a half summary. Both RPN Payne and Casey both recall attending the review process, but were unable to recall details of who else was there.

67. Associate Professor Katz stated that since the time of this incident, the structure and process of the Serious Incident Review Committee (SIRC) has been improved. An Associate Director of the Quality Planning and Innovation Team has now been appointed and better record keeping systems are in place to ensure that

(a) the people present at a critical incident review are recorded;

(b) recommendations are fed back to the appropriate people; and

(c) the required actions are clearly documented.

Did K intend to take his own life?

68. Mrs K in her statement described K's last few hours in the house. She stated that her husband took their other son back to the Dandenong Psychiatric Hospital where he was an inpatient on day release at that time. Mrs K stated that it was K's brother's birthday that day and that it was just a "crazy day" in which she has some trouble remembering "much description about that day". Mrs K stated that K ate dinner quite well and she then engaged in cleaning up after dinner. She described some interaction with K wherein he was talking to her and then minutes later he had left the house after changing his clothes so that he was wearing all black.

69. Mr K stated that he spoke to K when he arrived back home after delivering their other son back to the hospital. He stated that K was in the driveway when he got home and he had a conversation with him in which K asked him what the CAT Team were doing. Mr K stated

that K was not drug affected. He said he told K to sit down and he would talk to him. He said he told him "I am taking you to the hospital myself like I did (your brother)."[29]

70. Shortly thereafter, upon realising that K was missing, from the house Mr and Mrs K commenced an immediate search for him, consistent with their level of concern about his condition.

71. In evidence Mrs K said she first went to his car, expecting he may have tried to kill himself in this way. She stated that she then saw "flashing lights' down at the highway, she was immediately fearful that was involving K. Mr and Mrs K drove to where they could see those flashing lights on the highway beneath their home. It was there that they learned of the grim news that K had been hit by a car.

72. The driver of the vehicle that struck K was Robert Walker. He stated [30]that he was driving his wife's car along the Warburton Highway at about 10pm on that Sunday evening coming home from work. He said he was travelling at about 80kph in the 90kph zone. He stated that as he was driving he saw a male run out onto the road in front of him, turn and face the car and put both hands up into the air. He estimated this male was about 5 feet in front of him when he stepped out. He stated that the male did not look surprised or frightened but almost looked calm. Mr Walker noted that the incident happened so quickly that he hit the brakes as heavily as he could at the same time as he hit the male. Mr Walker stopped and endeavoured to render assistance and obtain assistance for K.

73. Travelling behind Mr Walker was another driver, Richard Lever[31] who made a statement to police consistent with Mr Walker's description of what happened on the road that night. In his statement, Mr Lever stated that he thought that he was in a better position to see what happened than the driver and went on to say "*there was nothing the driver could have done to avoid the male on the roadway. There was no excessive speed, it was dark, it looked to me as if the male ran out in front of the car deliberately.*"

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[29] Transcript p 302

[30] Statement of Robert Walker of 3.3.07

[31] Statement of Richard Lever 11.2.2007

74. Mr Walker was breath tested at the scene by the police who attended and he registered as negative to alcohol. He was noted to be in considerable shock. Indeed when Mr Walker came into the police station some days later to make his statement he was observed to be shaking and teary. He had not yet returned to his work and advised that he had not been sleeping since the accident.

75. A syringe was found in K's front pocket by an attending paramedic at the scene.[32] He was unable to recall whether the syringe was capped or not. His evidence was that he placed the syringe into a sharps container to make the scene safe. Given that K was treated both at the scene and in hospital for 9 days before he passed away, there was no value in any toxicology report as to whether or not K had used that syringe to inject himself prior to the collision. This issue potentially had some significance with respect to K's ability to form the intention to take his own life. [33]

76. In closing submission, Mr Halley for Eastern Health submitted that the evidence of K's possible drug use in the immediate moments before he went out onto the road that night together with K not having expressed a definite wish to die to his mother, raised sufficient doubt about his intention that night, that I should not find that he was making a conscious, deliberate and voluntary decision to take his own life when he went onto the road in front of the car.

77. There is no evidence that K injected himself that night. There is evidence that a syringe was found in K's front pocket and the paramedic who found it cannot recall if it was capped or not. In evidence, he confirmed that his note in his attendance record about recent drug use was only an assumption made by him based on finding the syringe in K's pocket.[34]

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[32] Statement of Craig Munns (Exhibit 2). There was an issue raised about exactly where the syringe was found. Some notes suggest it was in K's arm but that appears unlikely on the evidence. The evidence that it was found in K's front pocket is the more likely scenario given the force with which K was struck, it would be unlikely that the syringe would still be hanging in his arm after being forcefully struck by a vehicle.

[33] See autopsy report of Dr Malcolm Dodd wherein he stated that due to the prolonged stay in hospital no toxicological samples were available.

[34] Transcript 18

78. Mrs K submitted that the syringe found in K's pocket was most likely an old one. She stated that K did not want the valium which had been left for him as he did not want any drugs and in her view that is because he did not want to die a drug addict. She stated he had no drugs, he didn't want any drugs "and that's the reason he is in the ground now". He was undergoing withdrawal.[35].

79. Further Mr K stated that when he saw K come out of the house when he got home, he was not drug affected. He stated he had seen his son drug affected many times over the years and he was not drug affected on this night.

80. Mrs K, in her final oral statement to the court on 24 January 2011 stated that in her view K had the intention to end his own life, when he went out onto the road and stated that in her view he had "been suicidal all day". Mrs K confirmed that she concluded this based on K having called the police in the morning and asked them to shoot him, having asked for a gun twice during the day (once asking the police in the morning and then asking his father in the afternoon), and changing his clothes into all black and putting some identification in his pocket, before leaving the house.

81. Both Mr and Mrs K believed their son to be suicidal on 11 February 2007. Mr K Senior stated that his son changed his white clothing to black that night, even including his runners. He noted that he did this so that the driver of the car that hit him had no chance.

82. At the initial Directions Hearing, Mrs K raised an issue as to whether or not K's actions on the road before he was struck by the car were done with the intention of taking his life. Her legal representative raised an issue about whether or not K's raised arms may have been him signalling the car to stop. However, at the close of the evidence in the inquest, the family submitted that it was "suicide" and that the CAT Team should have known that K was suicidal and should have put him in hospital.

83. In closing submissions, Counsel for Eastern Health submitted that I could not make a finding of suicide based on the evidence before me to the requisite standard. This submission centred

[35] Transcript 298

around it being "plausible" that K had injected himself with some drug and that his wandering on to Warburton Highway was as a result of intoxication rather than an intention to take his own life. Whilst it is so that there was a syringe found in K's pocket, there is not evidence of sufficient weight to conclude K had injected himself prior to his collision with the vehicle. The syringe was not kept and there was no post mortem toxicology analysis for K as he was hospitalised for some days before his death. His father stated he was not drug affected when he saw him what must have been only minutes before he went on to the road.

Conclusion as to intention

84. The evidence on balance is that when K ran out onto Warburton Highway in front of the oncoming vehicle at about 10.06pm on the evening of 11 February 2007, he did so with the intention of taking his own life.

85. I come to this conclusion based on the evidence that he had been expressing a wish to end his life at various times and in various ways throughout the entire day. At 7.30am that morning he had called the police and requested they shoot him. When he spoke to the triage CAT Team nurse he had repeatedly asked to be admitted to hospital. During the day he had asked his father for a gun. Whilst I accept the evidence that he was denying he was feeling "suicidal" when he spoke with the CAT Team in the early evening, by 10pm that evening K had changed his clothes to black, including his runners, ensured he had some identification on himself, when told by his father he was being taken to hospital he left the house and ran into the path of an on-coming car on a road in an area with which he was familiar. He faced the oncoming car, looking neither surprised nor frightened, but almost calm as he was struck and fatally injured.

86. On the issue of whether or not he was drug affected at all, let alone to such a degree that he was unable to form the intention to consciously and deliberately take the actions which caused his death, I do not accept that the evidence allows such a conclusion on balance. K's father saw him in the minutes before his death and gave evidence that he was familiar with his son's demeanour when he was affected by drugs and he was clear K was not drug affected when he saw him. The matter of minutes between K disappearing from the house and the time he was hit on the road leads to the conclusion that he had virtually no opportunity to inject himself.

87. For these reasons, I conclude that he acted with the intention to end his life when he put himself in front of the on-coming vehicle.

Emergency response in the wake of the collision

88. In the immediate wake of the collision, 000 was called. Mr Walker and others who had stopped to render assistance to K got him into the recovery position. The local CFA attended the scene and assisted with K. Upon the paramedics attending the scene, K was intubated but had no signs of response to respiratory effort at the scene. He was initially placed in the back of an attending ambulance until he was transferred to the airwing by which he was transported to the Alfred Hospital.

89. K was admitted into the Alfred Hospital Intensive Care Unit at 11.50pm on the evening of Sunday 11 February 2007 with a grim prognosis. K passed away at 6.15am on 20 February 2007 as a result of the severe injuries he suffered after being struck. No issue arose with any aspect of the emergency response or hospital treatment of K. The evidence was that all who both attended the scene and were involved in the emergency medical management and intensive care treatment of K performed their roles in a competent and timely way.

Findings of the internal review of the hospital

90. As noted above, the hospital conducted its own internal review. That review found that K's symptoms were consistent with withdrawal and that no major psychotic symptoms were present or evident. The review noted that K reported no suicidal ideation and no suicide plan. The review also noted that K was difficult to assess in the family setting but assessed as not requiring admission. The CAT Team accepted the referral to manage K into a drug withdrawal program.

91. The review outcome recorded that whilst the death could not have been predicted, a recommendation was made regarding a documentation format that articulated the expected standard basic minimum information and properly reflected the comprehensive assessment that the review found was made in this case.

92. The internal review also noted that there was no access to direct admission to the drug and alcohol service which is a problem for "dual diagnosis" patients and also noted that K would have been cooperative if a bed had been available. The review also noted that the "in-patient unit" can assist in managing patients with drug and alcohol issues if there is an underlying mental illness. Further, it was noted that this option should be considered during an assessment. The review also concluded that the development of the pathway to utilise this facility should also be considered.

93. The review also noted the delay in responding from the call to the Crisis and Assessment Team service in the morning until 5pm in the afternoon, noting that rostering of staff over the weekend may require reviewing to ensure resources are available.

Changes that have been implemented since K's death

94. Associate Professor Katz's statement provides a list of changes that have been made since K's death. In broad terms Professor Katz summarised the relevant changes as follows:

(i) a centralised triage service has been set up so that all calls are entered on a computerised screening register. All calls are now rated by the triage rating scale to measure the urgency and type of response needed. (This change has been accompanied by a triage guideline, introduced in July 2010, which would have resulted in K's case being required to have been responded to in 2 hours.)[36] Further a dedicated triage team has been instituted.[37]

(ii) All patients deemed to not require a CAT service following assessment are reviewed by the consultant psychiatrist (within the next 24 hours).[38]

(iii) Two new forms have been added to the assessment documentation that must be completed by CAT Team clinicians. The first is the "home visit risk assessment form" (which introduces a checklist to ensure that the assessment is completed and documented in a consistent and comprehensive manner). The second form that has been introduced is "Dual Diagnosis (D and A) substance use history" form.

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[36] Submissions of Mr Halley (24.1.2011)

[37] Evidence of RPN Casey Transcript 228

[38] Ibid

(iv) The keeping of statistics (including time spent with patients) has been given a high profile and it has been emphasised to staff to be important documentation (to ensure that the actual time taken to perform the assessment is documented).

(v) 20 hours of mandatory training has been introduced on a yearly basis for all CAT clinicians which includes modules on clinical documentation and clinical risk and management.

(vi) a comprehensive review of risk assessment has been carried out service wide and a new form has been designed and is being trialled currently.

(vii) several medical and legal documentation in service lectures have been held and more are scheduled.

(viii) monthly audits of clinical documentation and clinical risk and management forms have been implemented.

(ix) performance appraisals for all Team clinicians now include a review of clinical documentation.

(x) the results of these audits and overall standards of clinical documentation are discussed at staff meetings as well as by e-mail.

(xi) ongoing work is being done on best practice in clinical documentation.

(xii) medication that is dispensed is now recorded in the body of a patient's notes and signed on the treatment sheet by the prescribing doctor.

(xiii) whilst there have been no changes to admission pathways to drug and alcohol units, since 2007 the statewide initiative of combining drug and alcohol services with mental health services has taken effect. CATT has appointed a dual diagnosis portfolio holder who attends linkage meetings and has done a reciprocal placement at a drug and alcohol facility resulting in closer liaison and improvement to the referral process for drug and alcohol services.

(xiv) a restructuring of the roster has resulted in one extra staff member available on both AM and PM shifts seven days a week.

Was K's death causally connected to the acts or omissions of RPN Payne and Casey?

95. It was submitted by Mr Halley of Counsel on behalf of Eastern Health that the test in *Keown v Khan* is the appropriate one on the question of causation. That is, it is necessary to consider whether the act or acts of RPN Casey and Payne departed from a norm or standard or the

omission was in breach of the recognised duty imposed upon a psychiatric nurse when attending to a patient in the community.

96. I do not make a finding that the individual acts or omissions of RPN Casey and or Payne caused K's death. However, there are a number of system issues that compounded the complexity of this already difficult situation. The delay in the arrival of the CAT Team, the difficulty of making an assessment of this complexity in what seemed to be a fairly chaotic environment including having to deal with K's brother on day leave at the time, the difficulty of a complex poly substance abusing patient withdrawing from drugs and suffering acute feelings of despair and hopelessness which were assessed as being symptomatic of a reaction to drug withdrawal alone, and working in a system compounded by a difficult pathway for working with "dual diagnosis" people.

Conclusions:

97. Mrs K and her family fought for K both in life and in the wake of his death. Mrs K and her husband impressed as loving and caring parents who had and continue to have drug and alcohol and mental health problems within their family. They have shown admirable dedication to K in life and death. One of the great and complex challenges of self-harm risk assessment is that it is well recognised as often not being a straight line. That is, a patient's mood and intention can move and fluctuate from hour to hour. It is one of the great challenges and dangers of the assessment of risk for self-harm. We as a community must always strive better to help those vulnerable members of our community like K who call for help.

98. I have taken considerable time to compile the facts in K's case, not only because what happened ended in the loss of his life, and a lifelong sadness inflicted on his family, a terrible trauma to Mr Walker who may well be affected for the rest of his life, but also in recognition that those like RPN Payne and Casey who spend years of their lives working in one of the most difficult and demanding of areas of community need and deserve to be assisted and supported by the sorts of system changes set out above.

COMMENTS

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

Dual diagnosis issue

1. The assessment made by the CAT Team was that K's diagnosis was a reaction to his withdrawal from his methadone program and thus his issues were not mental health issues. Mr Halley submitted, that this has been identified as an issue for service provision in Victoria in that psychiatric and drug and alcohol services, though presenting problems frequently occurring together in the one patient, are being dealt with by separate services. In the wake of K's death, the "Dual diagnosis" form has been introduced and referred to below.

2. The evidence is that there is no access to drug and alcohol services after hours and dual diagnosis admissions to psychiatric wards were not available at the time of K's admission.

3. The evidence is that although K was expressing "suicidal" thoughts for much of the day, he expressed a clear wish to be admitted to hospital that day. It was the opinion of Professor Katz and indeed the evidence demonstrates that K would have been compliant with a voluntary placement in hospital, whether it was a mental health placement or a drug and alcohol placement, when he was discussing his situation with the triage nurse in the morning of the day he died.

4. The introduction of the dual diagnosis form is a positive step. It is to be hoped that the use of this form will cause not only a break down in the separate service delivery thinking but also in the way in which diagnostic thinking is performed and risk to safety assessed.

5. The clinicians' assessment on this occasion was that K was not suffering from a psychiatric illness but was having a problem withdrawing from methadone and so what he needed was medication to help him combat the effects of withdrawal and help him sleep and that they would return the next day and help him to liaise with a drug and alcohol service to take him in to hospital to withdraw safely.[39] Mrs K is firmly of the view that she would have persuaded them otherwise had she been spoken to.

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[39] Transcript 212 Evidence of RPN Casey

6. Further, the conclusion appeared to be reached that K was not showing signs of psychosis or any recognisable mental health condition, and that his distress was related to his withdrawal from drugs. RPN Casey stated that he did not feel that K was being guarded or reserved when answering their questions.

7. Mr Halley submitted that Eastern Health did not have a drug and alcohol in-patient treatment facility available to it, meaning that had such a facility been available to admit K based on his condition being drug related rather than a mental health problem, K would have co-operated as he was seeking assistance and his death may have been avoided.

8. Significantly, I was advised that there is now an ability to admit people directly into a psychiatric facility who have issues around suicide ideation to keep them safe whilst withdrawing from drugs.

Document destruction

9. It was not possible to establish the rationale behind the apparent destruction of the hospital kept diary referred to above. However, whatever the rationale was for the hospital to destroy any documents which are likely to be required by a coroner investigating the death of a patient in contact with the hospital's services, it is a most unwise practice and should not be repeated.

The changes since K's death

10. Given the thoughtful and comprehensive changes since 2008 set out above, I am satisfied these changes address the system issues arising from the circumstances surrounding K's death and obviate the need for me to make any separate or additional recommendations.

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

Mr and Mrs K

Investigating member S/C Wendy Smith

LSC Westmore

RPN Casey

RPN Payne

Associate Professor Newton

Medical Director Eastern Health

Transport Accident Commission

Office of Chief Psychiatrist

Mr Bill O'Shea, Alfred Hospital

Signature:

JUDGE JENNIFER COATE
State Coroner
March 1, 2012