IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2016 5912

**FINDING INTO DEATH WITH INQUEST**

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

**Inquest into the Death of LUCAS RICHARD TOWNDROW**

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| Delivered On: | 17 MAY 2018 |
| Delivered At: | THE CORONERS COURT OF VICTORIA<br>65 KAVANAGH STREET, SOUTHBANK |
| Hearing Dates: | 27 APRIL 2018<br>16 MAY 2018 |
| Findings of: | PHILLIP BYRNE, CORONER |
| Representation: | MS CATHRYN HOPPNER ON BEHALF OF LATROBE REGIONAL HOSPITAL |
| Counsel Assisting the Coroner | MR DARREN MCGEE |

I, PHILLIP BYRNE, Coroner, having investigated the death of Lucas Richard Towndrow
AND having held an inquest in relation to this death on 27 April 2018 and 16 May 2018
at The Coroners Court of Victoria
find that the identity of the deceased was Lucas Richard Towndrow
born on 14 April 1965
and the death occurred 13 December 2016
at the train line between Traralgon and Morwell, Traralgon, Victoria 3844

**from:**

1(a) INJURIES SUSTAINED IN A TRAIN INCIDENT

**in the following circumstances:**

1. In this finding I do not propose to focus upon what I will call historical issues, save to say Mr Towndrow, a much troubled man, had a long-standing history of mental health issues. My focus is upon issues proximate to his untimely death.

2. Lucas Richard Towndrow, 51 years of age at the time of his death, was an involuntary patient in the acute psychiatric unit at Latrobe Regional Hospital (**Latrobe**) in Traralgon.

3. On 19 November 2016 Mr Towndrow was arrested by police under section 351 of the *Mental Health Act 2014* and conveyed to the West Gippsland Hospital in Warragul where, after initial assessment, he was transferred to the Latrobe Regional Hospital in Traralgon. He was reviewed by Dr Jayani Wickrematunga and admitted to the Flynn Ward under an Inpatient Temporary Treatment Order (**ITTO**).

4. The ITTO was revoked on 5 December but due to a deterioration in his mental condition on 8 December Mr Towndrow was again placed under an ITTO.

5. Shortly after 10:30am on 13 December Dr Wickrematunga reviewed Mr Towndrow where concerns were raised that after periods of authorised unescorted leave Mr Towndrow returned apparently substance affected. Dr Wickrematunga reminded Mr Towndrow that he was a compulsory patient and would no longer be granted unescorted leave in the afternoons.

6. Mr Towndrow took this news badly and abruptly terminated the consultation. Shortly after, he approached staff requesting leave to have a cigarette. A nurse authorised a short period of unescorted leave to return by 11am. I note that Mr Towndrow had previously been given short periods of leave to go outside for a cigarette.

7. Unfortunately on this occasion Mr Towndrow did not return as required. He left the hospital and walked to the nearby railway track where, as the train approached at speed, he lay on the track and was struck by a V-line train travelling towards Morwell. He died instantly. I add that the unfortunate driver of the train had absolutely no chance of avoiding impact.

8. The matter was appropriately reported to the Coroner. In the circumstances I directed a Coronial Brief be prepared. Subsequently a comprehensive brief was provided to the Court by the Coroner's Investigator Detective Senior Constable Lauren Swan of Latrobe Crime Investigation Unit. I commend Detective Senior Constable Swan on the quality of her investigation and brief.

9. Very early in my investigation I had serious concerns about the management of Mr Towndrow, a compulsory patient, on the morning of 13 December 2016. On its face I queried the appropriateness of Mr Towndrow being given even a short period of leave in light of the events during the consultation with Dr Wickrematunga shortly before leave was authorised.

My concern primarily related to whether an adequate risk assessment had been undertaken prior to leave being approved.

10. Statements were provided to the Coroner's Investigator by psychiatrist Dr Wickrematunga, and Mr Sebastiano Romano, General Manager of Acute Based Services Mental Health at Latrobe Regional Hospital. Having examined that material and becoming aware that an extensive internal review of the circumstances leading to Mr Towndrow's death had been undertaken I asked that Latrobe advise what, if any, refinements had been made to practices and procedures relating to risk assessment, particularly in regard to leave.

11. Subsequently, Mr Romano provided a supplementary statement dated 18 January 2018, in which, in quite short compass, he advised that a Mental Health Escalation of Care Protocol had been developed and approved. He also advised that the Mental Health – Safety Awareness, Assessment and Planning (SAAP) for Inpatient Services Protocol and Patients on temporary leave from hospital protocol had been amended to reflect, in broad terms, that granting leave would now only be at the discretion of the patient's consultant psychiatrist.

12. It became clear that, in spite of Mr Towndrow presenting quite a challenge to clinicians, there was a real prospect I would be required to make adverse findings, or at least comments, about the adequacy of Latrobe's management of Mr Towndrow on the morning of 13 December 2016 in relation to the granting of leave, and record keeping in relation to leave.

13. As Mr Towndrow was a compulsory patient at the time of his death, and his death was not due to natural cause, the *Coroners Act 2008* mandated that mandatory inquest was necessary. I concluded however that I could, in the circumstances, proceed by way of summary inquest; that is finalise the matter "on the papers" without hearing *viva voce* evidence.

14. I listed the matter for summary inquest for 27 April 2018 anticipating that Latrobe would either be legally represented, or at least have someone, with authority to speak on behalf of the hospital, in attendance. I had proposed to enquire of that representative, legal or lay, as to whether adverse findings or comments would be resisted, and/or challenged. Somewhat to my surprise no one attended, neither Latrobe nor family.

15. As a matter of procedural fairness, I could not proceed to finalisation without providing Latrobe with the opportunity to resist the adverse finding I felt obliged to make. Consequently, I relisted the matter for 16 May 2018 and advised Latrobe I anticipated a representative would attend on that day.

16. On 16 May 2018 I held an open court summary inquest at which Ms Cathryn Hoppner, Executive Director Mental Health at Latrobe was present. Ms Hoppner advised she was

authorised to speak on behalf of Latrobe and indicated that an adverse finding in relation to the management/care of Mr Towndrow on 13 December 2016 would not be resisted.

17. I add that in the interim period between April and 14 May 2018 Latrobe provided, under the hand of Ms Hoppner, a much more fulsome statement, with attachments in relation to the revised practices/procedures in relation to their temporary leave and risk assessment policies and practices. In her statement Ms Hoppner also advised that all consultant psychiatrist and staff had been educated/trained in relation to the "new" policies and processes.

18. I am satisfied that the revised policies, now implemented in accord with recently released Chief Psychiatrist's guidelines, will ensure, as best as they can, that the prospect of self-harm by both voluntary and compulsory patients whilst on temporary leave, is minimised.

19. Being entirely satisfied with the adequacy/efficacy of the new policies/practices/guidelines I am relieved of the necessity of making formal recommendations.

**FINDING**

20. I formally find Lucas Richard Towndrow, a much troubled man suffering long term mental illness, died on the morning of 13 December 2016 on the railway tracks adjacent to the Latrobe Regional Hospital when, having been given a short period of unescorted leave to have a cigarette, left Flynn ward, intending to take his own life, walked to the railway line, lay upon the tracks and was struck by a train. While I accept that risk assessment is indeed a "complex, dynamic process", I conclude that prior to temporary leave being authorised the risk assessment undertaken was somewhat cursory and deficient.

**COMMENT**

21. Many years ago my colleague, Deputy State Coroner West, made a pertinent comment with which I concur; he wrote:

> "*This tragedy highlights the dilemma facing health professionals who manage and treat individuals with mental illness and their difficulty in predicting when a patient is at risk of crossing the suicide threshold. The patients' actions are frequently impulsive. Prior attempts and risk factors may be well documented, however, such material can rapidly go out of date and thus be less helpful as an indication of future behaviour. While the difficulties associated with fluctuating risk behaviour are well recognised; it is imperative that health professions remains vigilant in their attempts to identify indicators of anxiety, depressed mood and self harm*".[1]

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

Mr Jack Henderson, Senior Next of Kin;

Latrobe Regional Hospital;

Office of Chief Psychiatrist; and

Detective Senior Constable Lauren Swan, Coroner's Investigator, Victoria Police.

Signature:

PHILLIP BYRNE
CORONER

Date: 17.5.18


[1] Case COR 2001 3310