IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: 18/11

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of MILES DAVID COLMAN

Delivered On:	3 April 2012
Delivered At:	Coroner's Court of Victoria Level 11, 222 Exhibition Street Melbourne Victoria
Hearing Dates:	3 April 2012
Findings of:	IAIN TRELOAR WEST, DEPUTY STATE CORONER
Representation:	Mr Paul Halley for The Alfred Hospital
Police Coronial Support Unit:	Sergeant D J Dimsey

I, IAIN TRELOAR WEST, Deputy State Coroner having investigated the death of MILES COLMAN

AND having held an inquest in relation to this death on 3 April 2012
at Melbourne

find that the identity of the deceased was MILES DAVID COLMAN

born on 1 July 1989, aged 21 years

and the death occurred on 1 January 2011

at Alfred Hospital, 55 Commercial Road, Melbourne, Victoria 3004

from:

1a. HEAD INJURY SUSTAINED IN FALL FROM HEIGHT

in the following circumstances:

1. Mr Miles Colman was 21 years of age and a university student at the time of his death. He resided with his parents and older brother at 19 Thurso Street, Malvern East. Miles was an intelligent and capable student who had formed strong relationships with friends and teachers at his secondary school, however he seemed to have difficulties meeting the required standards of tertiary study. In 2008, he entered the science faculty at the University of Melbourne but left during the academic year and in 2009, he began a Bachelor of Music at Monash University, again leaving half way through the year. In 2010, Miles returned to his Bachelor of Science studies, however in his last semester he forgot to attend a final crucial test. In family discussions Miles raised concerns about maintaining good relationships with friends and the fact that he did not seem to feel empathy towards other people, however when his mother suggested he see a psychologist, he said he would think about it, but showed no further interest. He appeared to have lost some social confidence, spending less time going out with friends and staying home during the evenings. In addition, he appeared to no longer take pride in his appearance. In December 2010 there was a significant decline, with Miles stating that he could share consciousness with people by entering their thought processes.

2. These matters were raised by Miles with his parents on the evening of 21 December 2010 and the next morning, they organized for him to see the triage psychiatric nurse at the Alfred Hospital. An appointment was made and on attending the hospital, a Crisis Assessment Treatment Team (CAT team) attendance was arranged for him at home, later that afternoon. Miles was becoming increasingly fearful and oppressed by the voices he could hear in his head and after the CAT team attended, he readily agreed to go back to the hospital as he believed he would be safer there.

3. Miles was admitted to the psychiatric unit on the evening of 22 December, under the care of Consultant Psychiatrist, Dr Jianyi Zhang. He presented with a first episode of schizophreniform disorder characterized by paranormal delusions and auditory hallucinations, with a history given of gradual deterioration of mental state and function for one year, after his return from holiday in Vietnam. In addition he gave a circumspect history of drug use that involved past use of LSD and Magic Mushroom and regular use of cannabis. A formal assessment was undertaken on the 23rd and Miles was placed in

the High Dependency Unit (HDU), after stating that he had suicidal thoughts, with voices talking about him in a derogatory manner and telling him to commit suicide. Miles was commenced on Risperidone and Lorazepam, with dispensing doses of 1mg twice a day. Upon review the next day he appeared less distressed, however, whilst he was compliant with Risperidone, he refused to take Lorazepam due to the sedation side-effect and accordingly, the dose was changed to 0.5mg twice a day. Miles had the support of a loving family who attended the hospital to visit him twice daily, noting a marked improvement in his condition over the first few days. His mental state varied from visit to visit, sometimes withdrawn and depressed, sometimes more responsive. Miles was noted to socialize well with other patients, with his affect being warmer and reactive and with him consistently denying any suicidal ideation, or plan.

4. When reviewed by Dr Zhang on the 29 December, Miles presented with a significant decrease in his auditory hallucinations, appearing more logical and coherent and no longer bothered, or disturbed by voices. He denied any suicidal ideation and given the improvement in his condition, he was discharged from the secure section to the Low Dependency Unit (LDU), on 15 minute observations. A further review the following day noted that Miles was future orientated and that he appeared calm and relaxed, resulting in Dr Zhang allowing escorted leave with his parents and a reduction in his level of observations, to general observations. On the morning of 31 December, Miles was taken out by his parents for a short walk in Fawkner Park, during which time he appeared depressed, explaining to his parents that he had hurt his friends very badly. He was reviewed later in the day by the Psychiatric Registrar and denied hearing any voices or having any suicidal ideation and following the review he attended the music therapy session. When visited during the evening by his father he seemed more positive than he had been since his admission, with him talking of his plans and appearing to be looking forward to the future, which included the possibility of studying music therapy. There was no indication of self harming intent.

5. On 1 January 2011 at approximately 8.45am, Miles was observed by a staff member from a first floor window of the hospital, to be shuffling sideways along a three metre high wall that enclosed a courtyard. It appears that he had climbed an exposed drain pipe attached to the courtyard wall in order to get on top of the wall. The staff member activated a personal alarm device before observing Miles to stand and jump, landing on his head when he struck the ground. Shortly thereafter a medical emergency team arrived and Miles was intubated at the scene before being transferred to the emergency department where further trauma resuscitation was performed. A CT scan of the brain showed extensive head injuries, with unsurvivable brain injury. Following discussions between Intensive Care Unit consultants and family members the decision was made to withdraw therapy and the family's wish for organ donation was arranged. Miles Colman subsequently died on 2 January 2011.

6. No autopsy was performed in this case as the coroner, on advice from Dr Matthew Lynch, Senior Pathologist with the Victorian Institute of Forensic Medicine, directed that no autopsy was required. Dr Lynch performed an external examination of Miles at the mortuary, reviewed the circumstances of his death, the medical deposition and clinical notes, the post mortem CT scan and provided a written report of his findings. Dr Lynch reported that examination revealed evidence of head injury consistent with the history and concluded that in all the circumstances a reasonable cause of death was head injury sustained in a fall from height. Toxicological analysis of post mortem body fluid was

positive for hydroxyrisperidone within the therapeutic range. Risperidone is an antipsychotic medication prescribed for schizophrenia and some behavioural disorders, including delusions.

Comments

7. This tragedy highlights the dilemma facing health professionals who manage and treat patients with mental illness and their difficulty in predicting when a patient is at risk of crossing the suicide threshold. Prior indication of intent maybe well documented, however such material can rapidly go out of date and thus be less helpful as an indication of future behaviour. There is a significant mortality rate of individuals suffering mental illness, with the patient's actions frequently being impulsive. I am satisfied that there is no evidence in this case to suggest that Miles' medication regime, or treatment plan, was other than appropriate. I am further satisfied that it was reasonable to move him from the HDU to the LDU, consistent with the requirements of the *Mental Health Act* to treat involuntary patients in the least restrictive environment, consistent with good psychiatric care. In addition, the reduction in observations from 15 minutes to general observations was reasonable, given his level of improvement. In these circumstances it is unrealistic to expect patients to be under constant surveillance. Sadly, despite the continuous support of his family and the availability of appropriate therapeutic care, the tragic outcome could not be prevented.

8. On the evidence before me, I am satisfied that appropriate modifications have been made to the outer casing of the courtyard down pipe, in order to prevent it's use as a climbing aid. I also note that an adjoining fence has been increased in height in order to reduce the risk of climbing.

9. I find that Miles Colman intentionally took his life by jumping from a height.

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

The family of Miles Colman;
The Alfred Hospital;
Investigating Member, Victoria Police;
Interested Parties.

Coroners Court of Victoria

Signature:

IAIN WEST
DEPUTY STATE CORONER

3 April 2012