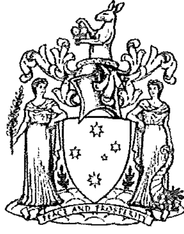

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2015 5061

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the Coroners Act 2008

Findings of:	**GREGORY MCNAMARA, CORONER**
Deceased:	**PETER GRAHAM CHAUCER**
Date of birth:	5 November 1966
Date of death:	5 October 2015
Cause of death:	Injuries sustained when struck by a train
Place of death:	Railway crossing at Overton Road, Frankston, Victoria

BACKGROUND

1. Peter Graham Chaucer was a 48-year-old man who had no fixed address at the time of his death.

2. Mr Chaucer had a history of psychiatric illness dating from 2007 and had been under the care of a number of mental health services and clinicians in the years preceding his death.

3. On 5 October 2015 Mr Chaucer was struck by a train at the railway crossing on Overton Road in Frankston.

THE PURPOSE OF A CORONIAL INVESTIGATION

4. Mr Chaucer's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008.*

5. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

6. The Coroner's Investigator prepared a coronial brief in this matter. The brief includes statements from witnesses, including family members, the forensic pathologist who examined Mr Chaucer, treating clinicians and investigating officers.

7. I have based this finding on the evidence contained in the coronial brief. In the coronial jurisdiction facts must be established to the standard of proof of the balance of probabilities.[1]

PERSONAL HISTORY

8. At the time of his death, Mr Chaucer had been separated from Giovanna Chaucer for approximately one year. The two were married around seventeen years earlier and had two children.

9. Giovanna Chaucer states that Mr Chaucer first began to show signs of depression around late 2006, but that he received mental health support and appeared to recover. Peninsula Health

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[1] This is subject to the principles enunciated in *Briginshaw* v *Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

records show that in 2007 Mr Chaucer "*sought psychology for issues with low mood, poor self-esteem, explosive anger and lying*".

10. Mr Chaucer had been employed as an accounts clerk, but in the last years of his life was unable to maintain employment.

11. Mr Chaucer was involved with public mental health services in the latter half of 2012, beginning with an inpatient admission to Casey Adult Mental Health Service from 21 June 2012 to 27 June 2012. Mr Chaucer was then in the care of the Casey Services Crisis and Treatment Team from 27 June 2012 to 2 July 2012. These presentations occurred in the context of reported suicidal ideation, including specific mention of jumping in front of a train.

12. From 12 August 2012 to 28 August 2012, and from 20 September 2012 to 28 September 2012, Mr Chaucer was in the care of the Mid-West Mental Health Service CATT.

13. Mr Chaucer was under the care of a number of mental health practitioners during this time, eventually engaging with private psychiatrist Dr Peter Graf. Dr Graf's initial diagnosis of Mr Chaucer was that he suffered for severe unipolar depression. Dr Graf later revised his diagnosis to Bipolar Mood Disorder and commenced Mr Chaucer on treatment with lithium as well as the antipsychotic quetiapine.

14. Mr Chaucer had an inpatient admission to Frankston Hospital from 13 January 2014 to 23 January 2014.

EVENTS PROXIMATE TO DEATH

15. In the second half of 2015, Mr Chaucer was admitted to inpatient psychiatric units on multiple occasions, and was under the care of other public mental health services when not an inpatient.

16. He also had recurring presentations to the Frankston Hospital Emergency Department as well as a pattern of inconclusive involvement with the Adult Prevention and Recovery Centre.

17. Mr Chaucer was throughout this time engaged with a private psychologist as well as his private psychiatrist Dr Graf. General Practitioner Dr Sujeewa Fernando also treated Mr Chaucer.

Inpatient Admission to Maroondah Hospital – 29 July 2015 to 3 August 2015

18. In late July 2015 Mr Chaucer began spending excess amounts of money, increasing his alcohol consumption and hearing voices.

19. On 28 July 2015 Giovanna brought him to the Frankston Hospital Emergency Department, where he stayed overnight. After a review on the following day, he was transferred to Maroondah Hospital for a voluntary admission.

20. While in hospital Mr Chaucer stated that although he was prescribed the antidepressant duloxetine as well as lithium and the antipsychotic quetiapine, he had ceased taking the lithium and duloxetine four weeks earlier. After this he reported entering a "*heightened state*".

21. Mr Chaucer was discharged on 3 August 2015. His discharge correspondence from Eastern Health states "*Diagnosis: BPAD [Bipolar Affective Disorder] – manic episode*".

Frankston Acute Psychiatry Team (Peninsula Health) – 4 August 2015 to 19 August 2015

22. Following his discharge from Maroondah Hospital, Mr Chaucer was referred to the Frankston Acute Psychiatry Team (**Acute Team**) at Peninsula Health. Consultant Psychiatrist Dr Lucinda Joy Thurley states:

> *I was concerned on reviewing Mr Chaucer's discharge paperwork that Mr Chaucer had only a brief admission and that the continuation of antidepressant was inconsistent with a diagnosis of mania as antidepressant is generally considered contraindicated in the context of a manic episode. Furthermore I was concerned that he was not on a therapeutic level of lithium. He was also only on a low dosage of antipsychotic. I asked that Mr Chaucer have a medical review to look at his mental state and review his response to his prescribed medications.*

23. Peninsula Health medical records dated 4 August 2015 note that Mr Chaucer was "*linked with private [psychiatrist] Dr Graf*".

24. On 5 August 2015 Psychiatry Registrar Dr Danmei Lin reviewed Mr Chaucer. Mr Chaucer displayed no psychosis or suicidal ideation, but it was felt that he was at risk of deterioration in mental state and in particular mood elevation related to his antidepressant. Mr Chaucer was asked to decrease the dosage of his antidepressant, to increase his dosage of the antipsychotic quetiapine and to attend his General Practitioner for a lithium level.

25. Mr Chaucer initially seemed agreeable, and on 11 August 2015 informed the Acute Team that he believed "*phone calls from Peninsula Health were delusional thoughts and were not reality*", and that he had not reduced his antidepressant or increased his antipsychotic. Mr Chaucer was then given written instructions for his medication changes. Dr Thurley states that "*I was concerned that Mr Chaucer was presenting in an atypical way for someone with*

bipolar disorder and requested that Mr Chaucer have an appointment for review with a consultant".

26. On 14 August 2015, according to medical records, Mr Chaucer requested that the Acute Team "*have no further contact with Giovanna and change his NOK to his [mother]*". On 17 August 2015, after Dr Hodgson reviewed Mr Chaucer, part of the plan formed relating to possible discharge was to "*contact ex-wife for colateral & d/c planning*".

27. On 17 August 2015 Consultant Psychiatrist Jennifer Hodgson reviewed Mr Chaucer. Dr Hodgson's impression was of a guarded man with settling mania and Cluster B (antisocial/narcissistic and borderline) personality traits.

28. Mr Chaucer requested to be discharged from the Acute Team's care as he wished to be managed by his private psychiatrist and psychologist. A plan was made for Mr Chaucer to remain on current levels of lithium and quetiapine and for the Acute Team to consult with Dr Graf once he returned from leave as well as consulting with Giovanna Chaucer before Mr Chaucer's discharge from the service.

29. On this day Acute Clinician Steve Ryan contacted Mr Chaucer's private psychologist and discussed his case. It was arranged that Mr Chaucer's psychologist would contact the Acute Team if he had any concerns.

30. Later on 17 August 2015, after leaving a note at his share house indicating possible suicidal intent, Mr Chaucer attended Dr Graf's rooms and arranged an emergency appointment for 4.30pm that afternoon. After this appointment Dr Graf contacted the Acute Team and informed them that Mr Chaucer's "*mood was labile and fluctuating, not psychotic, but remains quite fragile*" and that Dr Graf would be seeing Mr Chaucer twice per week.

31. Dr Graf increased Mr Chaucer's dosage of quetiapine and requested that the Acute Team continue follow-up until Mr Chaucer's mood settled. A plan was made for Mr Chaucer to present to the Acute Team on the following day for review.

32. Later on 17 August 2015 Giovanna contacted the Acute Team and reported that Mr Chaucer was behaving unpredictably around her and their children, including "*smashing passenger car window for no reason*". According to medical records, Giovanna was "*given time to vent*" and was "*advised if concerned about her safety and children's safety to contact Police in future*". Giovanna then "*requested she be contacted when [Mr Chaucer] is [discharged] from*

[Peninsula Health Mental Health Services]". Medical records do not indicate how the Acute Team responded to this request.

33. On the morning of 18 August 2015 Giovanna again contacted the Acute Team describing Mr Chaucer's erratic moods and behaviour, as well as that "*he has been stating that nobody will sit him down and help him and [he] plans to go away and not answer his phone*".

34. Later on 18 August 2015 Mr Chaucer called staff and accused them of "*lying to him*" and not helping him; he later called again and apologised. Mr Chaucer requested a home visit on the following day as "*his private [psychiatrist] Dr Graf said to him that he was to stay @ home*". There is no indication in medical records of any attempt to contact Dr Graf at this time.

35. On 19 August 2015 Mr Chaucer and Giovanna attended the Acute Team at the Davey Street Clinic together, reporting that on that morning Mr Chaucer had attended Giovanna's workplace after withdrawing $1,000 from his bank with ideas of '*running away*', after which she reported she took him to the hospital. Although Mr Chaucer had previously been reviewed by Dr Hodgson, as Dr Hodgson was not available that day Dr Thurley saw Mr Chaucer and Giovanna due to the apparent urgency of the matter.

36. During this visit, Dr Thurley discussed the events leading up to Mr Chaucer's recent inpatient admission. Dr Thurley states "*I did not find the description of events particularly convincing as a manic episode*".

37. Mr Chaucer at this point again expressed that he "*felt rejected by [mental health services]*" and that he "*can't trust Drs*". He related his inability to distrust doctors to having always felt that he couldn't trust people, which he related to childhood experiences.

38. Dr Thurley developed the impression that "*the current presentation seemed to be in the context of Personality Disorder (Borderline/Paranoid) rather than a manic/bipolar affective disorder presentation*", and noted that Mr Chaucer had previously been diagnosed with obsessional and paranoid personality.

39. According to Dr Thurley:

> *Mr Chaucer was concerned that the diagnosis of personality disorder meant that he did not have bipolar disorder. I encouraged him to continue with his medications and discuss his diagnosis with Dr Graf, his long-term treating psychiatrist. I acknowledged that psychiatrists sometimes have different opinions and that Dr Graf may have a different view of events. It was acknowledged that even if the present behaviour was attributed to personality disorder*

that did not preclude a comorbid bipolar disorder and I listed this as a differential of Mr Chaucer's diagnosis.

40. Dr Thurley asked Mr Chaucer to increase his dosage of lithium. She "*was not convinced that lithium was likely to benefit Mr Chaucer but thought that if he was to be prescribed this medication it should be trialled at a therapeutic level*". Dr Thurley also asked Mr Chaucer to increase his dosage of quetiapine.

41. Giovanna informed Dr Thurley that if Mr Chaucer were to continue attending her workplace she would seek an intervention order.

42. Later that day Giovanna called the Acute Team to inform them that Mr Chaucer had been evicted from his property and that Mr Chaucer had thrown away his mobile phone. The plan at this time, according to medical records, included "*attempt same acute clinician for reviews for continuity of care, Dr Graf to continue medication management and treatment*".

43. On the following day the Acute Team was informed that Mr Chaucer had presented to Frankston Emergency, was seen by the Consultation Liaison Inpatient Psychiatry Service (CLIPS) and was due to be admitted to the inpatient psychiatric unit. A progress note in Mr Chaucer's medical records from the Acute Team states "*discussed liaison with Dr Graf with [CLIPS] -> currently liaison not indicated as Peter is an inpatient*".

Frankston Hospital – 19 August 2015 to 27 August 2015

44. At around 11.00pm on 19 August 2015 Mr Chaucer was brought to the Frankston Hospital Emergency Department by ambulance requesting a review. Giovanna called shortly after to inform staff that Mr Chaucer had sent her multiple messages and made calls and that he seemed confused, noncompliant with medications and suspicious of staff. She was informed of a planned admission.

45. Mr Chaucer was reviewed the following day by Consultant Psychiatrist Dr Geeta Rudra of Consultation Liaison and Inpatient Services (CLIPS). According to a statement from Dr Rudra:

> *Mr Chaucer reported that he was getting mixed messages from his private psychiatrist and the Frankston acute team. He stated that he and Dr Graf both believe he has bipolar while the acute team felt he had a personality disorder. Mr Chaucer reported frustration at his diagnosis and the fact the he was getting differing information.*

46. Mr Chaucer reported a history of poor anger management, but refused an admission and denied suicidal ideation. However, shortly after this assessment Mr Chaucer called Dr Graf and informed Dr Graf that he was suicidal, after which point CLIPS staff contacted Dr Graf to follow-up on Mr Chaucer's review and Dr Graf reported Mr Chaucer's statements.

47. CLIPS had a further discussion with Mr Chaucer and he agreed to an inpatient admission, which commenced on 20 August 2015. On 21 August 2015 Giovanna contacted Peninsula Health to inform them of Mr Chaucer's recent behaviour and condition.

48. Progress notes from Mr Chaucer's admission indicate that clinicians formed the impression that he suffered from "*Borderline PD/Cluster B*" and this was "*certainly not 'manic episode' of Bipolar I*" but rather a "*situational crisis*".

49. Over the course of his admission Mr Chaucer began to request discharge, and it was eventually determined that he did not meet the criteria for involuntary treatment under the *Mental Health Act 2014* (Vic). He was discharged on 26 August 2015 and referred back to the Acute Team.

Frankston Acute Psychiatry Team (Peninsula Health) – 26 August 2015 to 23 September 2015

50. On 26 August 2015 the Acute Team received the referral and proceeded to attempt to arrange a further referral to the Adult Prevention and Recovery Centre due to Mr Chaucer's housing situation.

51. Dr Thurley states that on this day she received a letter from Dr Graf expressing his opinion that Mr Chaucer's proper diagnosis was Bipolar Affective Disorder, and requesting that Mr Chaucer be managed by public psychiatry, and that "*I asked that a member of the Acute Team contact Dr Graf to ascertain whether he planned to continue to see Mr Chaucer and if so, to determine how he wished us to share the care of Mr Chaucer, including who was to be responsible for prescribing medications*".

52. Mr Chaucer's APARC engagement was inconclusive. On 28 August 2015 Dr Thurley discussed Mr Chaucer's presentations with Acute Team Manager Kelly Burroughs and Senior Acute Clinician Zoe Francis. In view of Mr Chaucer's chaotic presentations to different areas of Peninsula Health, Dr Thurley determined that "*it would be beneficial to engage Mr Chaucer in a structured recovery plan*".

53. After consideration of Mr Chaucer's situation, Dr Thurley developed a management plan whereby Mr Chaucer would have a daily appointment with the Acute Team at the Davey Street Clinic for 30 minutes.

54. Dr Thurley states she felt this plan "*would assist Mr Chaucer in providing structure to his day, assist him in developing trust in the service and to work towards assisting him to manage stress and problem solve as well as allowing monitoring of his mental state*".

55. She further states:

> *I felt that it was important to try to redirect his chaotic contacts with different parts of Peninsula Health to the Acute Team; to provide consistency and that there should be boundaries in place regarding his contacts to reinforce the need for appropriate behaviour. If Mr Chaucer was able to be engaged in treatment he was then to be considered for longer term recovery work.*

56. Mr Chaucer attended Frankston Hospital on 28 August 2015 and was redirected to the Davey Street Clinic, which he attended. Later that day, Mr Chaucer informed Acute Team staff that he wished to be discharged from the Acute Team's care. On 30 August 2015 Mr Chaucer again attended Frankston Hospital and was again referred to the Davey Street Clinic, but he did not attend.

57. On 31 August 2015 Mr Chaucer attended the Davey Street Clinic for his scheduled appointment on that day. He stated that he was within the following day attending appointments with Dr Graf and with two different counsellors. Later that day Giovanna attended and informed the Acute Team that Mr Chaucer was erratic and paranoid and had deliberately crashed a rental car out of frustration.

58. Mr Chaucer was reviewed by the Acute Team on 1 September 2015. He reported that he had crashed the car "*for attention from Giovanna*", and this behaviour of seeking negative attention was discussed.

59. After that review, Dr Thurley states:

> *A letter was sent to Dr Graf, private psychiatrist, outlining the plan for Mr Chaucer to have a regular appointment, weekdays, at Davey Street Clinic. The letter also outlined the agreement, as per Dr Graf's request, that Dr Graf was to be in charge of*

prescribing medications for Mr Chaucer, so as to prevent confusion or conflicts in prescribing.

60. Attempts were also made to liaise with Mr Chaucer's psychologist and counsellor.

61. On the following day Mr Chaucer attended again, made a plan for future attendances, and then returned soon after his appointment to state that he no longer wished to have involvement with Peninsula Health. Mr Chaucer continued to attend appointments with the Acute Team irregularly while often requesting to be discharged from their care.

62. On 8 September 2015 Giovanna informed the Acute Team that Mr Chaucer had attended her work behaving aggressively and that an Intervention Order (**IVO**) had been taken out against Mr Chaucer. On 9 September 2015 she informed them that Mr Chaucer had attended her workplace in breach of the IVO and was in police custody. Mr Chaucer was released from police custody on 10 September 2015.

63. On 11 September 2015 Giovanna reported to the Acute Team that Mr Chaucer had been granted bail to attend an appointment with Dr Graf which did not exist, and that she and the children were staying with friends to avoid him.

64. On 14 September 2015 Mr Chaucer attended the Davey Street Clinic for review. Later that day Giovanna contacted the Acute Team and was informed that Mr Chaucer had been cooperative at review. She expressed an ongoing fear for her safety and was encouraged to contact police if she felt unsafe.

65. On 15 September 2015 Mr Chaucer's General Practitioner Dr Fernando contacted the Acute Team with concerns that Mr Chaucer may be suicidal. On the same day Dr Graf contacted the Acute Team to report that Mr Chaucer had not attended his most recent appointments.

66. On the following day Mr Chaucer attended the Acute Team for review, and phone calls were made to Dr Graf to organise prescriptions. A plan was made for Mr Chaucer to attend the Acute Team again on the next day, which he did not do.

67. On 18 September 2015 Dr Graf contacted the Acute Team to inform them that Mr Chaucer had missed further appointments and had not collected his scripts for medication. On the same day police contacted the Acute Team to inform them that Mr Chaucer had been found behaving erratically in Sorrento and had been taken to the Emergency Department by ambulance.

68. Mr Chaucer was again brought to the Emergency Department by police on 20 September 2015. On this date Mr Chaucer was offered a voluntary admission to the inpatient psychiatric unit to which he initially agreed, but then twenty minutes later decided to refuse and was discharged.

69. On 22 September 2015 Giovanna reported a breach of Mr Chaucer's intervention order at the Frankston Police Station. Giovanna reports that she was encouraged to consider finding alternative accommodation, and that she did so. Later on that day Mr Chaucer was found walking along train tracks and was assessed by the Alfred Hospital's Police Ambulance and Clinician Early Response (**PACER**) team. He was assessed to be at a low risk to himself or others.

Presentations to the Frankston Hospital Emergency Department

70. Throughout the last months of his life, Mr Chaucer frequently presented to the Frankston Hospital Emergency Department in states of distress, often reporting suicidal thoughts. Presentations include 12 March 2015, 22 July 2015, 13 August 2015, 15 August 2015, 25 August 2015, 7 September 2015, 10 September 2015, 18 September 2015, 19 September 2015, 20 September 2015 and 28 September 2015. On many of these presentations Mr Chaucer was eventually discharged at his own risk, but at several of them he requested a psychiatric admission and was refused (for example, on 7 September 2015).

71. While Mr Chaucer was under the care of the Acute Team, staff at the Emergency Department frequently redirected him to attend the Acute Team at the Davey Street Clinic.

Acute Team care and engagement with MHARP – 23 September 2015 to 6 October 2015

72. After Mr Chaucer failed to attend a medical review on 23 September 2015, Dr Thurley reviewed Mr Chaucer's medical records. In conjunction with Acute Clinician Paul Bedward, Dr Thurley formulated a Risk Management Plan, and determined that "*a more assertive approach, which would require police to assist to facilitate a home visit due to the safety issues at Mr Chaucer's accommodation, was [not] currently warranted, and in view of Mr Chaucer's forensic issues this approach might do more harm than good*".

73. Dr Thurley formed the opinion that Mr Chaucer would be better managed by the Mental Health Hospital Admission Risk Program (**MHARP**) due to his frequent attendances at the emergency department. On 24 September 2015 the Acute Team liaised with MHARP about Mr Chaucer's suitability, and was informed that MHARP had a waiting list and that

Mr Chaucer would have to agree to the program. A screening register was created to inform staff at the Emergency Department to ask Mr Chaucer if he would accept MHARP referral if he attended.

74. On 25 September 2015 Mr Chaucer was brought to the Emergency Department after he was found sleeping near the Frankston Pier. A bystander claimed that Mr Chaucer had expressed a desire to suicide, but Mr Chaucer later denied this. He was eventually discharged for community follow-up.

75. On 28 September 2015 the Acute Team received a call from 'Dads in Distress' concerned about Mr Chaucer's behaviour and current homelessness. Dr Hodgson of the Acute Team recorded a plan of continuing to offer daily appointments to Mr Chaucer.

76. Later on 28 September 2015 Mr Chaucer was brought to the Emergency Department after friends contacted Ambulance with concerns of auditory hallucinations and suicidal ideation. Mr Chaucer informed staff that he had not been taking his medication.

77. Mr Chaucer denied any immediate suicidal intent, and he was discharged into the care of his friends. There is no indication as to whether Mr Chaucer was offered MHARP referral at this time.

78. Mr Chaucer attended the Acute Team at the Davey Street Clinic on 29 September 2015. Mr Chaucer did not exhibit any suicidal ideation, and denied paranoia or elevated mood. He agreed to MHARP involvement, and agreed to re-attend the Davey Street Clinic on 1 October 2015 for a consultant psychiatrist review. His General Practitioner Dr Fernando and his private psychologist were updated about the presentation, and MHARP was also contacted.

79. A plan was made for a joint review with the Acute Team and MHARP on 7 October 2015.

80. Mr Chaucer attended his appointment on 1 October 2015 for review by Consultant Psychiatrist Dr Hodgson. Mr Chaucer displayed no suicidal ideation and no psychotic symptoms, and Dr Hodgson recorded her impression of Borderline Personality Disorder.

81. A plan was made to discharge Mr Chaucer into the care of MHARP on 7 October 2015 and for Mr Chaucer's General Practitioner Dr Fernando or his Psychiatrist Dr Graf to continue to prescribe and monitor his medications. Dr Hodgson was to liaise with Dr Graf.

82. On 2 October 2015 Mr Chaucer was arrested and interviewed at the Frankston Police Station in relation to alleged contraventions of a Family Violence Intervention Order. He was remanded and remained in custody until 5 October 2015.

Adult Prevention and Recovery Centre and housing

83. Mr Chaucer's housing situation was unstable. He often resided in boarding houses, but was on at least one occasion evicted after punching holes in walls, and was reported to be homeless in the last days of his life.

84. Mr Chaucer frequently requested assistance with a referral to the Adult Prevention and Recovery Centre (**APARC**) and then informed clinicians he no longer wished for a referral. This pattern of interaction reached the point of an intake assessment on 27 August 2015, but on 28 August 2015 Mr Chaucer attended APARC to inform them that APARC "*wasn't for him*", that he needed to "*get everything sorted ... in hospital*" and that he was going to the Emergency Department for help. Later that same day Mr Chaucer returned to APARC again to inform them that he had changed his mind and wished for admission.

85. APARC then clearly communicated to Mr Chaucer and to Giovanna Chaucer that Mr Chaucer was not under the care of APARC, that they did not consider him suitable for APARC at that time but that he might be reassessed again in the future.

MATTERS IN RELATION TO WHICH THE CORONER MUST, IF POSSIBLE, MAKE A FINDING PURSUANT TO SECTION 67(1) OF THE ACT

Circumstances in which the death occurred

86. On 5 October 2015, while still in police custody, Mr Chaucer was brought to the Frankston Magistrates' Court in relation to his alleged interventions. He was convicted of several charges and was made subject to a Community Correction Order for a period of 12 months. He was released from police custody at 3.16pm.

87. A level crossing is located directly to the east of the intersection of Overton Road and Wells Road in Frankston. The railway tracks run parallel to Wells Road in a North-South direction.

88. At approximately 5.00pm on 5 October 2015 the boom gates at this railway crossing lowered, and shortly after this a Pacific National freight train headed north began to cross.

89. While this train was crossing, there was a break in traffic along Wells Road and Mr Chaucer emerged from the northwest corner of the intersection and ran directly toward the railway tracks.

90. Mr Chaucer then ducked under the lowered boom gates and dove underneath the train where he was fatally struck.

Identity of the deceased

91. On 6 October 2015 the Fingerprint Branch of the Victoria Police Forensic Services Department matched the right index finger impression from Mr Chaucer's body to that held on record under the name of Peter Chaucer, born 5 November 1966.

92. I am satisfied that the fingerprint comparison confirms that Mr Chaucer's body was that of Peter Graham Chaucer, born 5 November 1966.

Medical cause of death

93. On 7 October 2015, Dr Matthew Lynch, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an examination upon Mr Chaucer's body and provided a written report, dated 9 October 2015. In that report, Dr Lynch concluded that a reasonable cause of death was '*injuries sustained when struck by train*'.

94. Toxicological analysis of the post mortem samples taken from Mr Chaucer identified the presence of nordiazepam (a metabolite of the benzodiazepine diazepam) and the antipsychotic quetiapine.

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

95. I am satisfied on the evidence provided that Mr Chaucer deliberately took his own life. I am also satisfied that there was nothing that the drivers of the train which struck Mr Chaucer could have done to prevent his death.

96. Following Mr Chaucer's death, Giovanna Chaucer and Dr Peter Graf raised a number of concerns about Peninsula Health's involvement with Mr Chaucer. In order to address these concerns, the Coroners Prevention Unit (**CPU**)[2] conducted a review of Mr Chaucer's treatment.

[2] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations, as well as assisting in

97. I note that Peninsula Health also conducted an internal Multidisciplinary In-depth Case Review following Mr Chaucer's death which resulted in the recommendation of a Risk Reduction Strategy addressing several of the issues also identified by the CPU.

Diagnosis and treatment of Bipolar Affective Disorder and Borderline Personality Disorder

98. Mr Chaucer's clinicians were divided on whether to diagnose him as suffering from Bipolar Affective Disorder or from Borderline Personality Disorder. Dr Graf and clinicians at Maroondah Health supported the diagnosis of Bipolar Affective Disorder, while Dr Thurley and Dr Rudra of Peninsula Health supported Borderline Personality Disorder.

99. The CPU review found that, based on Mr Chaucer's medical records, there is no evidence that either of these diagnoses was incorrect. Bipolar Affective Disorder and Borderline Personality Disorder can share symptoms and often co-occur.

100. However, the CPU went on to note that:

> *Peter Chaucer articulated on many occasions his confusion regarding his diagnoses and what it was he was suffering from. The medical records suggest there was some undermining of the opinions of opposing psychiatrists directly to Peter that did not result in any coordinated or planned approach between the services/clinicians to address Peter's concerns, other than noting them.*

101. Regarding Mr Chaucer's treatment, the CPU concluded that:

> *the treatment offered and available to Peter Chaucer from the services and clinicians across both private and public mental health services was appropriate at the stages of illness and co-existing diagnoses. The monitoring of therapeutic level of lithium [was] undertaken by Peninsula Health in the early stages of contact following his discharge from Maroondah Hospital who recorded his diagnosis as [Bipolar Affective Disorder].*

102. Mr Chaucer was prescribed a variety of medications at the time of his death, but none of them are contraindicated in the treatment of co-existing Bipolar Affective Disorder and Borderline Personality Disorder. When Mr Chaucer took his prescribed medications, the CPU finds that "*his mental state stabilised with an associated decrease in his risks*".

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monitoring and evaluating the effectiveness of the recommendations. The CPU comprises a team with training in medicine, nursing, law, public health and the social sciences.

103. However, Mr Chaucer was not compliant in taking his medications when he was not in hospital. It is clear that part of the reason for this was distrust of his clinicians, and this distrust was increased by his clinicians' mutual undermining and lack of cooperation. However, Mr Chaucer's distrust of clinicians had other sources as well, and on at least one occasion he himself identified it as arising from a general distrust of all people which arose from childhood issues.

104. It should be noted that Dr Thurley had identified the importance of developing trust between Mr Chaucer and his clinicians, and explicitly considered it in formulating a management plan on 28 August 2015.

Coordination between private and public services

105. It cannot be determined whether better coordination between private and public services could have had a significant effect on Mr Chaucer's relationship with mental health services, and whether this could have prevented his death.

106. Nonetheless, the events leading up to Mr Chaucer's death highlight the importance of better cooperation between services and clinicians in treating shared clients. The CPU concluded that:

> *it is reasonable to expect that in the event of a patient being treated by a private psychiatrist and engaged for a reasonable length of time (example two weeks) with the public mental health service, that efforts are made by both parties to consult (with consent) prior to non-urgent decisions regarding treatment being made and that where conflict remains, the patient is informed and involved. Included in this is the documented delegation of responsibilities both clinical and psychosocial, and agreed communication forms and frequency. This is particularly relevant to a patient, regardless of diagnosis, who is presenting as Peter Chaucer did, disorganised and chaotic.*

Peninsula Health internal review

107. Peninsula Health's Multidisciplinary In-depth Case Review resulted in the following recommendation regarding the issue of coordination between private and public services:

> *Establish and implement formal process to support shared care arrangements between [Peninsula Health Mental Health] services and other private practitioners including private psychologists, general practitioners, psychiatric support services and private psychiatrists.*

ED presentations and response to deterioration

108. The CPU was asked to review whether Mr Chaucer should have been involuntarily admitted to an inpatient psychiatric unit at any point, and concluded that:

> *based on the medical records, it is not evidence[d] that Peter Chaucer met all the required criteria for Section 5 involuntary treatment under the* Mental Health Act 2014 *(Vic) in the weeks proximate to his death. His presentation in ED, willingness for admission and denial of any suicidal plans or intent at the time of assessment contributed to the assessment of him as not meeting all the criteria. However, it is unreasonable to claim he did not meet any clinical threshold in place for a voluntary admission which he had requested.*

109. Further to this, the CPU examined the medical records of Emergency Department/CLIPS reviews in the last weeks of Mr Chaucer's life, and found:

> *a reluctance to admit Peter Chaucer to the inpatient unit, which in his early presentations may have been appropriate, but given his continued Police contact, acts of violence, suicidal threats and actions, ... his diagnoses [of Bipolar Affective Disorder and Borderline Personality Disorder], his recent admissions and that he was not taking any medications, it is not unreasonable to expect consideration having been given, following consecutive presentations and his requests for admission, to admit him for an assessment and to plan what to do, for instance, re-establish his medications, liaise with Dr Peter Graf and make the referral and link him to HARP.*

110. The CPU also identified further issues involving Peninsula Health's recognition of Mr Chaucer's deteriorating condition in the time preceding his death, and in their response to that deterioration.

Peninsula Health internal review

111. Peninsula Health's Multidisciplinary In-depth Case Review resulted in the following recommendation regarding the recognition of deterioration:

> *Review and redevelop a service wide system to be implemented across the whole service that supports the recognition and identification of the deteriorating client (clinical, social and behavioural markers) and incorporated a process of review and escalation.*
>
> *Review current escalation processes to ensure clear reporting and monitoring expectations of:*
>
> - *Clinical Risk Committee*
> - *Clinical Handover*
> - *Clinical Review*

- *Case Conferencing*
- *Carer Led Escalation*

Review relevant Clinical Practice Guidelines and processes in both ED and Mental Health Service to incorporate explicit guidelines relating to objective assessment and management of alcohol or other drug use including the application of Blood Alcohol Concentration, Urine Drug Screening and Breathalyser.

Review the process and criteria for development of Risk management plans including timeliness and interim plans.

112. The internal review also resulted in the following recommendation regarding the response to clinical deterioration:

> *Review relevant [Clinical Practice Guidelines] to clarify expectations regarding the service requirements for Identification, Management and Communication of clinical deterioration.*

Communication with and involvement of Giovanna Chaucer

113. Through the last months of Mr Chaucer's life, Giovanna Chaucer communicated with his mental health services continually, including attending the Acute Team at Davey Street Clinic in the company of Mr Chaucer.

114. Despite Mr Chaucer requesting on 14 August 2015 that the Acute Team have no further contact with Giovanna and communicate with his mother instead, the Acute Team continued to treat Giovanna as his carer, and on 17 August 2015 plans were made to contact her in regard to possible discharge planning. There is no indication that any attempt was ever made to contact Mr Chaucer's mother instead of Giovanna.

115. On 17 August 2015, Giovanna reported frightening behaviour, and on 19 August 2015 informed Dr Thurley that she was considering an intervention order against Mr Chaucer. In early September 2015 Giovanna informed the Acute Team that she had taken out an intervention order, that Mr Chaucer had attended her workplace in breach of that order, and that later she and her children were staying with friends due to fear for their safety.

116. The CPU report noted that:

> *leaving aside the over-riding of Peter Chaucer's documented request that staff not discuss his case with his ex-wife, it is unclear why clinicians who [were] aware of his increased violence*

and threats to his family ... and existence of a family violence intervention order still expected Giovanna Chaucer to act as his carer.

Responses to violence in the community and contravention/breaches of IVOs are the domain of Victoria Police, however as the affected family member on an IVO Giovanna Chaucer is not best placed to contribute to decision-making regarding her ex-husband's care. This is not to say that she should not be involved if Peter Chaucer wanted her to be, or that she had valuable support and advice that would inform care planning, but if placed in this situation, regardless of willingness and positive intent, a victim/carer of family violence has to balance the safety of herself/himself and their children against the wish to help the patient/perpetrator. This places the victim/carer in a position of possible reprisal and her/his decisions and contributions to the perpetrator's care cannot be guaranteed to be unaffected by this. As a result, [neither] the best interests of the victim who is also a nominated carer [nor the best interests] of the patient/perpetrator of violence [are] guaranteed.

117. The CPU's review of available literature in the area found nothing addressing the issue of carers who are also affected family members in intervention orders.

Conclusions

118. I am satisfied that, viewed separately, each of Dr Graf, Dr Fernando and the Frankston Acute Psychiatry Team acted reasonably and appropriately in their diagnosis and treatment of Mr Chaucer.

119. I am satisfied that APARC acted reasonably and appropriately in regard to Mr Chaucer's referral, and communicated clearly with all parties involved.

120. Concerns are raised by the reluctance on the part of Peninsula Health Emergency Department staff and CLIPS to admit Mr Chaucer to an inpatient unit when admission was requested as well as Peninsula Health's recognition of and response to Mr Chaucer's deterioration. However, I am satisfied that Peninsula Health has undertaken an appropriate internal review which has addressed these issues. The review also resulted in specific recommendations regarding staff development to better implement its other recommendations.

121. Peninsula Health's internal review also appropriately addressed the issue of shared care arrangements with private practitioners. However, upon consideration of the advice of the CPU, I am of the opinion that Mr Chaucer's case highlights a broader issue which is not restricted to Peninsula Health. I therefore make the recommendation below.

122. I make no specific recommendations regarding the matter of carers who are also affected family members in intervention orders, but I am of the opinion that consideration of this issue could be fruitful for the Victorian Government in responding to Recommendations 97, 98, 99 and 100 of the 2016 Royal Commission into Family Violence.[3]

RECOMMENDATION

123. I recommend to the Office of the Chief Psychiatrist and to the Royal Australian and New Zealand College of Psychiatrists that they develop a shared protocol or guidelines to provide guidance for clinicians who share the responsibility for the care of patients across the public and private sectors. Matters that should be addressed include communication, transparency of arrangements with patients and carers, clinical responsibility in periods of crisis and negotiated care planning.

FINDINGS AND CONCLUSION

124. Having investigated the death, without holding an inquest, I make the following findings pursuant to section 67(1) of the *Coroners Act 2008*:

    (a) the identity of the deceased was Peter Graham Chaucer, born 5 November 1966;

    (b) the death occurred on 5 October 2015 at Frankston, Victoria, from injuries sustained when struck by a train; and

    (c) the death occurred in the circumstances described above.

125. I convey my sincerest sympathy to Mr Chaucer's family.

126. Pursuant to section 73(1A) of the *Coroners Act 2008*, I order that this Finding be published on the internet.

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

    (a) Ms Giovanna Chaucer, senior next of kin.

    (b) Peninsula Health.

    (c) Eastern Health.

[3] State of Victoria, Royal Commission into Family Violence: Summary and recommendations, Parl Paper No 132 (2014-16).

(d) Office of the Chief Psychiatrist.

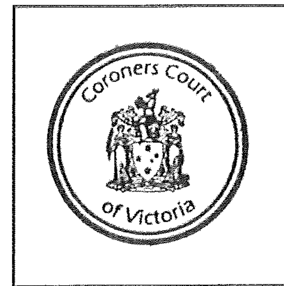
(e) Royal Australian and New Zealand College of Psychiatrists.

(f) Family Violence and Service Delivery Reform Unit, Department of Premier and Cabinet.

(g) Department of Economic Development, Jobs, Transport and Resources.

(h) Constable Amar Malic, Victoria Police, Coroner's Investigator.

Signature:



GREGORY MCNAMARA

CORONER

Date: 20/7/17