IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2009 000139

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of SAROLTA ELESITS

Delivered On:	12 September 2013
Delivered At:	Coroners Court of Victoria Level 11, 222 Exhibition Street Melbourne 3000
Hearing Dates:	26/08/2013
Findings of:	CORONER PHILLIP BYRNE
Representation:	Mr John Snowden for Southern Health
Police Coronial Support Unit	Leading Senior Constable Tania Cristiano

I, PHILLIP BYRNE, Coroner, having investigated the death of SAROLTA ELESITS
AND having held an inquest in relation to this death on 26/08/2013
AT MELBOURNE
find that the identity of the deceased was SAROLTA ELESITS
born on 2 August 1954
and the death occurred on or about 8 January 2009
at 4 Colin Road, Clayton, 3168

from:

1 (a) ACUTE ALCOHOL TOXICITY WITH IMMERSION

in the following circumstances:

1. Mrs Sarlota (Sarah) Elesits, 54 years of age at the time of her death, resided with her son, Frank, at 4 Colin Road Clayton.

2. Unfortunately, Mrs Elesits suffered for some years with a major depressive disorder, exacerbated by a severe addiction to alcohol. She had numerous admissions to hospital for treatment for alcohol toxicity/detoxification, generally with extremely high blood/alcohol concentrations.

3. Due to her major depressive disorder, Mrs Elesits had made numerous threats to suicide and on at least three occasions had attempted to take her own life, significantly on one occasion by attempting to drown herself at Mentone beach.

4. On a number of occasions Mrs Elesits had involuntary admissions to hospital usually after suicide ideation/attempts in the context of high intoxication.

5. In his statement to the Court, Dr Larry Osborne, Mrs Elesits' General Practitioner, and a specialist in Addiction Medicine, provides valuable insight into Mrs Elesits' struggle with alcoholism, attendances at detoxification programs and extended stays in residential rehabilitation facilities, together with major stressors, that resulted in lapses after periods of abstinence.

6. Ms Susan Thornton, Team Manager and Occupational Therapist with Clayton Community

Mental Health Service, part of Southern Health, who had been mainly responsible for Mrs Elesits' mental health treatment, in her statement provides details of the circumstances of Mrs Elesits last admission to hospital, subsequent discharge, assessment and arrangements for follow up involvement. I include an excerpt from her statement to the court:

> *"In November and December 2008 she experienced an intensification of her depressive symptoms associated with increasing suicidal ideation and alcohol intake. On 23/12/08 Sarah contacted the clinic to cancel her appointment. In a return phone call, she told the psychologist that she was feeling despairing and wanted to kill herself. Her speech was slurred but she denied drinking today but admitted to drinking the day before. I went to see Sarah at home with the psychologist and found Sarah dressed in a nightie, pounding her legs and her chest with her fist, teary and swearing. Sarah begged me not to take her to see the doctor and needed to be assisted in getting dressed and physically escorted to the clinic. She was seen by covering consultant, Dr Prasad Patange. She was diagnosed with major depression with active suicidal ideation, alcohol dependence and acute alcohol intoxication, was recommended under section 9 of the* Victorian Mental Health Act (1986) *and escorted to Monash medical Centre by myself and another staff member. She made several attempts to leave the Emergency Department whilst waiting to be medically cleared prior to admission to P Block. Sarah was stabilised and found to have a blood alcohol level of 0.323, then admitted to P Block where she remained as an involuntary patient from 23/12/08 – 01/01/09."*

7. On 30 December 2008, anticipating that Mrs Elesits would be discharged the following day, the Middle South Crisis Assessment Team (hereafter referred to as CATT) assessed her. The plan was that Mrs Elesits was to be accepted for Early Discharge Management by CATT if, after review by the Consultant Psychiatrist, she was to be discharged.

8. On 1 January 2009, Consultant Psychiatrist Dr Vivienne Mak assessed Mrs Elesits and concluded she no longer met the criteria under the Mental Health Act to be detained as an involuntary patient. Mrs Elesits was discharged of involuntary status and discharged with follow up home visits by CATT. Mrs Elesits denied suicide ideation or plan and said if she developed suicidal thoughts, she would contact CATT. The case manager, Ms Thornton, was on leave at the time and not due back until 12 January 2009.

9. Mrs Elesits was driven home by a member of CATT and was visited at home for assessment by members of that Team on 2 January 2009, 3 January 2009, assessment by phone on 4 January 2009 and by way of home visit again on 5 January 2009. On each

occasion Mrs Elesits was pleasant and co-operative and the clinical risk assessments reported as overall low risk with denial of suicidal ideation.

10. On 6 January 2009, Mrs Elesits was seen by Consultant Psychiatrist Dr Prasad Patange, who was covering for his colleague, Dr Kirsty McIntyre, as Psychiatric Registrar. In his statement Dr Patange advises he concluded Mrs Elesits had "chronic long-term risk of suicidal ideation but denied any imminent plans to self harm". He says Mrs Elesits was to contact CATT and see Ms Thornton and Dr McIntyre (both of whom were on leave) for follow up upon their return. There was an expectation that CATT would continue to monitor Mrs Elesits' mental state in the meantime.

11. Involved in the psychiatric care of Mrs Elesits (other than inpatient care) were two separate entities within Southern Health Mental Health Services, CATT and the Clayton Community Mental Health Service (CCT). For the purposes of this finding, there was a breakdown in communication between the two entities, so that on 7 January 2009 and 8 January 2009 (when Mrs Elesits was found deceased) there was no follow up due to non-conveyance of the expectation of Dr Patange that CATT would monitor Mrs Elesits until the return of her case manager. In his statement, Dr Patange – who, I might add, only saw Mrs Elesits twice – said:

> *"She was to contact CATT and see Dr McIntyre and Susan Thornton for follow up"*

12. In broad terms, apparently CCT thought CATT would monitor Mrs Elesits but CATT were not aware of that expectation, not having been advised of it.

13. Unbeknown to those providing care, Mr Karoly Elesits had been attending at his ex-wife's house daily for 1 January 2009 through to 6 January 2009 to check on her welfare. The last time he saw Mrs Elesits was late in the evening of 6 January when he attended with food which he says Mrs Elesits ate while he was there. He says after the meal his ex-wife asked him to leave because CATT were coming.

14. Mr Elesits returned on 8 January 2009 and found Mrs Elesits dead in the bath. Interestingly, Mr Elesits says Mrs Elesits made numbers threats to end her own life, but he said because she made the threat so often he did not take seriously a comment she made on 1 January 2009, while an inpatient, that this was "the last time she was going to be admitted". Having found Mrs Elesits deceased he rushed to the address of his son, Charles, and police were contacted.

15. Acting on coronial direction an autopsy and other ancillary tests were undertaken at the Victorian Institute of Forensic Medicine. Forensic Pathologist Dr Paul Bedford advised

death was due to:

1 (a) Acute alcohol toxicity with immersion

Toxicological analysis of post mortem specimens revealed an extraordinarily high vitreous alcohol level of 0.54g/100ml , the second highest level I have ever seen.

Dr Bedford further advised:

> *"No clear indication of drowning is identified, however typically in the post mortem situation this is a difficult conclusion to make."*

That, in my view, leave the position open that the cause of death is due to toxicity to alcohol and the immersion in the bath is incidental, an important issue when considering whether Mrs Elesits' death was an act of suicide, or an accidental death. That is a matter I will return to later in this finding.

I listed this matter initially for a Mention/Directions Hearing specifically to see if Southern Health, through in house counsel, Mr John Snowden, would concede the issue of the breakdown in communication between the entities responsible for the ongoing care of Mrs Elesits. Prior to the hearing Southern Health provided two further statements addressing the issue of concern together with newly developed protocols/procedures (call them what you may) designed to ensure the breakdown that occurred here does not occur in the future. Those procedures/protocols titled:

- Transfer and Discharge in Mental Health;
- Principles for Referral Processes from CATT to Continuing Care, and Continuing Care to CATT

In my view adequately address the deficiency observed in this case.

16. I turn to consider whether what I refer to as the deficiency in psychiatric management represents a causal factor in the death of Mrs Elesits, or is a regrettable "background circumstance" , to adopt the Callaway dichotomy in *Keown v Khan.* [1]

17. Applying what I understand to be the appropriate standard of proof,[2] and considering the surrounding circumstances I could not be comfortably satisfied that even if an attendance on 7 January by CATT to monitor Mrs Elesits had occurred, she would not have died in the manner she did in any event.

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[1] *Keown v Khan* [1999] 1 VR 69.

[2] *Briginshaw v Briginshaw* (1938) 60 CLR 336; *Chief Commissioner of Police v Hallenstein* [1996] 2 VR 1; *Department of Health and Community Services & Ors v Gurvich* [1995] 2 VR 69.

18. I return to the issue of whether Mrs Elesits intentionally took her own life. I have considered a number of matters including:

- Previous documented attempts to take her own life;
- Often expressed suicide ideation;
- The note referred to as a "suicide note", penned we know not when and somewhat ambiguous;
- The knives on the floor beside the bath;
- The suggested method of suicide;
- The extraordinary high alcohol concentration which raises the issue of whether Mrs Elesits would be in any position to form the precise intention to end her life;
- The number threats made to suicide which did not result in her death

In the final analysis, again applying the comfortable satisfaction standard of proof, I cannot form a firm view on the issue. Mrs Elesits may have intended the result that eventuated, but then again she may not have; I just do not know.

19. In light of the concessions made on behalf of Southern Heath, I determined that the matter could be satisfactorily concluded. Ms Tania Christiano, Police Coronial Support Unit (PCSU), assisting the Coroner, tendered the Brief of Evidence, including the additional material lodged by Southern Health (including the new/refined protocols) so that the formal inquest hearing could proceed forthwith.

20. I formally find Mrs Sarlota Elesits died on or about 8 January 2009 at 4 Colin Road, Clayton due to:

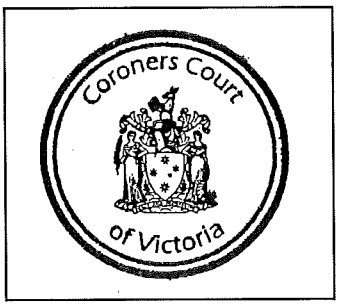
1 (a) Acute alcohol toxicity with immersion

On the available evidence, I am unable to say whether Mrs Elesits intended to take her own life or her death was accidental.

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

The family of Mrs Sarlota Elesits
Mr John Snowden, In House Counsel, Southern Health

Ms Susan Van Dyk, Southern Health Medico-Legal, Monash Medical Centre
Professor George Kuravilla, The Chief Psychiatrist,
Senior Constable Gary Steel, Investigating Member, Clayton Police Station



Signature:

CORONER PHILLIP BYRNE

Date: 12 September 2013