IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: 3839/10

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of TRAVIS ANDREW MCNEES

Delivered On:	30th April 2012
Delivered At:	Coroner's Court of Victoria Level 11, 222 Exhibition Street Melbourne
Hearing Dates:	1st December, 2011 2nd December, 2011
Findings of:	JOHN OLLE, CORONER
Representation:	Mr J Constable appeared on behalf of the deceased's family Dr P Halley appeared on behalf of Eastern Health
Police Coronial Support Unit (PCSU):	Sergeant David Dimsey

I, JOHN OLLE, Coroner having investigated the death of TRAVIS MCNEES

AND having held an inquest in relation to this death on 1st and 2nd December, 2011
at Melbourne

find that the identity of the deceased was TRAVIS ANDREW MCNEES

born on 10th July, 1992

and the death occurred on 4th October, 2010

at train line Mont Albert, Victoria, 3127

from:

1a. MULTIPLE INJURIES DUE TO IMPACT BY TRAIN

in the following circumstances:

PURPOSES OF A CORONIAL INVESTIGATION

1. The primary purpose of the coronial investigation of a *reportable death*[1] is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which the death occurred.[2] The practice is to refer to the *medical* cause of death incorporating where appropriate the *mode or mechanism* of death, and to limit investigation to circumstances sufficiently proximate and causally relevant to the death.

2. Coroners are also empowered to report to the Attorney-General on a death they have investigated; the power to comment on any matter connected with the death, including matters relating to public health and safety or the administration of justice; and the power to make recommendations to any Minister, public statutory or entity on any matter connected with the death, including recommendations relating to public health and safety or the administration of justice.[3]

3. The focus of a coronial investigation is to determine what happened, not to ascribe guilt, attribute blame or apportion liability and, by ascertaining the circumstances of a death, a coroner can <u>identify opportunities to help reduce the likelihood of similar occurrences in future.</u>

BACKGROUND

4. Travis McNees was aged 18 years at the time of his death. He lived at home with his parents. At the time of his death, Travis was an in-patient at Upton House,[4] Eastern Health.

5. On the 29th September, 2010, Travis presented to the Maroondah Hospital Emergency Department (ED) following a reported overdose of paracetamol and panadeine forte tablets. The overdose occurred in a context of emotional distress following a recent relationship breakdown. On the

[1] Section 4 of the Act requires certain deaths to be reported to the coroner for investigation. Apart from a jurisdiction nexus with the State of Victoria, the definition of a reportable death includes all deaths that appear "to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from accident or injury."

[2] Section 67 of the Act.

[3] Sections 72(1), 72(2) and 67(3) of the Act regarding reports, recommendations and comments respectively.

[4] A 25 Bed Unit comprising high dependency and low dependency units.

30th September, 2010 following medical assessment and treatment in the ED, Travis was transferred to Upton House and admitted as a voluntary patient.

6. At approximately 9.40pm on the 4th October, 2010, Travis deliberately ran into the path of an eastbound train at Mont Albert.

UNCONTENTIOUS MATTERS

7. At the completion of the police investigation and prior to the commencement of the inquest, it was apparent that a number of the facts about Travis are known and were uncontentious. These include his identity, the medical cause of his death and aspects of the circumstances, including the place and date of his death.

8. Given this, I formally find that the deceased was Travis Andrew McNees, born on the 10th July, 1992, late of 452 Chum Creek Road, Healesville; that he died on the 4th October, 2010 on a rail line at Mont Albert; and the medical cause of his death is multiple injuries due to impact by train.

THE FOCUS OF THE INVESTIGATION

The management of Travis following his ED discharge on 28th September, 2010

1. CATT involvement
2. Psychiatric Assessment
3. Nursing Observations
4. Escorted Leave
5. Missing Patient Procedures

Overview

9. Aspects of Travis' management which ideally, could have been performed better, both individually and systemically, have been identified and are referred to in this finding. However, the professionals involved in Travis' care could not have reasonably foreseen his imminent risk of death. Having considered all the evidence, I am unable to conclude that any individual failing contributed to Travis' death. I note that Eastern Health have implemented a system of change following Travis' death. I am not satisfied that the absence of the identified systemic failings would have averted the tragic outcome. A conclusion such as this would be based on speculation only.

CATT involvement

10. Allan Page is a vastly experienced clinician[5]. He was an impressive witness. Allan's involvement with Travis commenced following Travis' discharge from Maroondah Hospital ED on the 28th September, 2010.

11. Allan and a co-worker attended the McNees home and spoke initially with Travis and subsequently his parents. The pertinent points noted by Allan were as follows:

- Travis was co-operative and appeared to speak freely, though his mood was flattened;

[5] CATT Outer East.

- Eye contact was not greatly reduced and posture upright;
- He was casually dressed with no deficits to hygiene;
- He described experiencing tearfulness, loss of interest and lowered mood;
- His behaviours had changed with isolation to his room, not eating and reduced communication with his parents.

12. Allan assessed the initial ED presentation occurred in a context of a recent relationship breakup. Travis reported feeling calmer and more accepting of the situation.

13. Travis provided a history of self-harming behaviour about two years earlier. He carved words into both wrists following an argument with a mate. He was not intoxicated. Travis further disclosed impulses to harm himself after conflictual situations during his teenage years. According to Travis, he was in control of his suicidal tendencies and did not intend to self-harm.

The Treatment Plan

14. Travis agreed to attend an appointment with his GP for review and accept referral to a psychologist. Further, he was agreeable to CATT follow up. Importantly, Travis acknowledged minimising contact with his former girlfriend, though difficult, would allow more control over his emotional state.[6]

15. The following day work pressure prevented Allan visiting Travis. After unsuccessful attempts to telephone in the morning, he made phone contact with Travis about 1.30pm. Allan had liaised with the GP and provided verbal and documentary handover to psychiatric triage at the ED.

16. Following the telephone conversation Allan considered Travis had made improvement. He reported sleeping the previous night, eating breakfast, but still felt the same as the previous day. He was able to control impulses to self-harm. Travis confirmed he would attend his GP for review in the afternoon. Attempts by Allan to contact Travis' parents were unsuccessful.

17. At 10.00pm ED advised Allan of Travis' overdose.

18. Allan revised his risk assessment and clinical opinion.

19. Allan advised the psychiatric triage nurse at the ED:

> *"...for potential reasons of circumstance, impulsivity and changeability in client's presentation or inability to honestly convey to clinicians or seek help when risks increased, psychiatric hospitalisation should occur post medical clearance from overdose."* [7]

20. Allan expressed his opinion that:

[6] Dr Katz - *"I'd certainly try my utmost to discourage the contact."* T - 137.
[7] Statement Allan Page.

"...community treatment was no longer an option."[8]

21. In addition, Allan phoned nursing staff at Upton House to ensure the relevant notes had been faxed and provided a verbal handover.

22. At 7.00pm Ian returned Allan's call. Allan provided Ian various treatment options, including his preferred option of Upton House.

23. A telephone review is not ideal. Work pressure prevented Allan from having a face to face meeting. Within the limitations of a telephone call, his assessment was thorough. Allan had no reasonable basis to foresee the subsequent overdose.

24. Ideally:

a. On review, Allan should have held a face to face meeting with Travis;

b. Allan's verbal communication with Upton House should have been entered in the clinical file.

Psychiatric Assessment

25. On the 1st October, 2010, Dr Duraiswamy[9] conducted a psychiatric review of Travis. Regrettably, the content of the verbal communication between Allan Page and nursing staff at Upton House was not entered in the clinical file. In evidence, Dr Duraiswamy agreed he should have been informed of Allan's revised assessment of Travis[10]. He maintained the information would not have altered his assessment that Travis could be safely housed in the LDU[11].

26. Dr Duraiswamy acknowledged he did not read the material faxed by Allan to Upton House[12] In evidence he explained Allan's notes would not have assisted his assessment:

> *"...because Travis clearly explained ...about the chain of events which led to the overdose and I was assessing the lethality and the intentionality of that event, he was saying that even though these thoughts were coming and going, he did not - so, as I mentioned, it was just on the spur of the moment, he thought that it's not going to work and he was so worried about that break-up and went and took the overdose. So that made me decide that it was an impulsive attempt."*[13]

> Dr Duraiswamy's diagnosis
>
> *"Travis reported that even tough he was feeling sad and suicidal before his admission, he did not plan the recent attempt and that he did not accumulate any medication for the purpose of overdosing. He reported that it was a spur of the moment decision and that he had consumed the pills because they were available at home. He had contacted family and friends to say good-bye.*

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[8] T - 21.
[9] Consultant Psychiatrist, Upton House.
[10] T - 36
[11] T - 36
[12] T - 36
[13] T - 38

After his admission to Upton House, Travis reported feeling remorseful about having tried to kill himself. He was particularly concerned that he had caused stress to the family. Despite this, he was expressing positive plans for the future. He had not reported or demonstrated any suicidal behaviour over the previous two days in hospital and was willing to stay in the hospital and receive treatment. For these reasons, I considered that the immediate risk to himself from suicide was low to moderate.

Based on the history of 4 weeks of depressive symptoms with sad mood, lethargy, loss of interest with disturbed sleep and appetite, a diagnosis of Major Depressive Disorder was considered possible. However, in view of the above symptoms being precipitated by a relationship break-up and the sudden improvement in mood and mental state over the ensuing 24 hours, a diagnosis of Adjustment Disorder with Mixed Depression and Anxiety was considered more likely. Given his history of feelings of perceived rejection and previous self-harm behaviours, a diagnosis of Borderline Personality Disorder was also considered. I felt that I required further information from collateral sources, including family and friends, before I could be more definite about his diagnosis." [14]

27. Dr Duraiswamy spoke to Travis about situational crisis and the diagnosis and differential diagnosis were explained.

28. Travis would remain a voluntary patient in the low dependency unit (LDU):

"To help him in his recovery and to reduce of the stress of an acute inpatient unit, he was permitted to leave the hospital premises, but only if escorted by a reliable adult, such as family or friend, and only for short durations."[15]

29. Dr Duraiswamy did not commence antidepressant medication at the initial stage:

"There was a clear precipitant for his crisis; the suicide attempt was impulsive; there was a past history of a similarly impulsive self harm attempt; there was a rapid improvement in his mental state; and there is a reported risk of antidepressants increasing suicidal behaviour in the adolescent population. However, my plan was to reassess this decision on 4th October."[16]

30. In light of the recent suicide attempt, Travis was placed on 15 minute nursing observations. Travis consented to a family meeting being convened:

"...the reason for the family meeting is to get additional information to understand about the diagnosis and make a definitive plan about what's going to be the short-term and long-term treatment, and that is the reason why I wanted to have a family meeting."[17]

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[14] Statement Dr Duraiswamy
[15] Statement Dr Duraiswamy
[16] Statement Dr Duraiswamy
[17] T-41

31. According to Dr Duraiswamy, the family meeting would assist to explain the discord between a reported history of major depressive symptoms:

> *"Cross-sectionally he did not have those features and they were also mismatched, and that is the reason - even though he was giving all the symptoms, fulfilling the criteria for a major depressive episode, I also entertain a diagnosis of a possible adjustment disorder. The reason for getting additional collateral information is to clarify the task but can also, to understand his level of mental history and also the ways he has been coping. So that to see whether he has some maladaptive personality style and that also needs to be addressed in long-term follow up treatment."* [18]

32. Dr Duraiswamy was unable to conduct a psychiatric review on the morning of 4th October, 2010. Travis had left the ward. Due to a prior commitment, Dr Duraiswamy was unable to conduct a review in the afternoon and requested Dr Moolchandani to assess Travis. Following the 4.00pm review by Dr Moolchandani, Dr Duraiswamy was informed that Travis was quite oriented and showed good eye contact. He spoke spontaneously and his affect was reactive. Dr Moolchandani:

> *"...told me that Mr McNees rated his mood as 7/10, that he did not have any suicidal ideas, that he was expressing regret over his suicide attempt and its impact on the family, that he did not want it to happen again and that he was discussing future plans of returning to TAFE.*
>
> *He apparently expressed an interest in receiving Cognitive Behaviour Therapy from a psychologist on discharge. Dr Moolchandani also reported to me that Mr McNees' mother was in the room with him and had felt that he was looking better and was looking forward for the family meeting the next day."*[19]

33. At inquest, I heard evidence from Dr Moolchandani. Her assessment of 4th October, 2010 was appropriate within the parameters of her experience. The clinical observations were accurately conveyed to Dr Duraiswamy.

34. I endorse the evidence of Dr Katz:

> *"..the onus would be on the consultant then to either be comforted by information that he or she's received or to intervene and instruct otherwise."*[20]

35. Ideally:

a. Dr Duraiswamy should have precisely set out the proposed duration of escorted leave periods;

b. Travis should not have been permitted escorted leave on Monday morning, 4th October;

c. Dr Duraiswamy should have performed the psychiatric review of 4th October;[21]

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[18] T - 42
[19] Dr Duraiswamy
[20] T-185
[21] Dr Katz T-149,150

d. Dr Duraiswamy should have been informed of Allan's revised opinion of Travis;[22]

e. Dr Duraiswamy should have read the notes faxed by Allan.

Nursing Observations

36. On Saturday 2nd October, 2010 Travis was placed on hourly observations.

37. On Sunday 3rd October, 2010 nursing notes recorded Travis had settled, was superficially pleasant and selectively socialising. He was not exhibiting suicidal or self-harm ideation.

38. On Monday 4th October, 2010 Travis was placed on general observations.

39. In hindsight, Dr Katz considers close observation would be appropriate for the 1st 2-3 days of admission. The nursing file entries set out the basis for reducing observations over the week-end. On the risk assessment documents however, the justification is less clear. Dr Katz in evidence was not critical of the reduction from 15 minute observations to hourly.

40. I am satisfied Rosie Bourke[23] spoke to Travis at 7.00pm on the 4th October, 2010. Further, I am satisfied Rosie first became aware Travis was not on the ward at 9.00pm.

41. Ideally

a. Nursing observations documentation must be accurate;

b. For the 1st days of admission, close observations should be maintained;[24]

c. There should be medical input in all decisions to reduce visual observations;[25]

d. Travis should not have been permitted periods of unescorted leave on Monday 4 October;

e. Travis should have remained on hourly observations on 4 October.[26]

Escorted Leave

42. Over the week-end, Travis had periods of escorted leave with family and friends. I do not consider escorted leave inappropriate. Travis enjoyed his leave and returned to the ward as agreed.

43. Ideally

a. The intended duration of periods of leave should be proscribed by the Consultant Psychiatrist;

b. Visitors should meet nursing staff on arrival at the ward;

c. Patients and visitors accompanying patients for escorted leave should meet contact nurse prior to leaving the ward and upon return;[27]

d. Patients should be assessed before and after periods of escorted leave;[28]

e. Visitors should enter their names in a visitor book;

[22] Dr Katz described Allan's information "extremely helpful" T - 134
[23] Contact nurse for Travis on 4 October 2010
[24] Dr Katz T-189
[25] T-225
[26] T-178
[27] Dr Katz T-144
[28] Dr Katz T- 155

f. A sign should be placed in reception requesting visitors to contact nursing staff.[29]

Missing Person Procedure

44. I accept the evidence of Dr Katz. I do not consider the time frame inappropriate for instigating phone contact with Travis, his family or police.

45. Travis had at all times returned from leave. His family had visited him on the ward that evening. He had expressed a willingness to participate in a family meeting the following day. Staff would not have reasonably considered Travis "at risk" when his absence from the ward was noted around 9.00pm.[30] I do not consider staff response unreasonable in the circumstances. I endorse the opinion of Dr Katz that in all the circumstances, the staff response was appropriate.[31] The family telephoned ward staff before Dr Katz would have expected staff to telephone the family.[32]

46. It is unknown whether Travis absconded prior to the ward being locked at 8.00pm It is clear Travis contacted family members, who in turn contacted police prior to 9.30pm.

47. The 9.00pm handover is important for the reasons set out by Dr Katz;[33] the attendant patient contact equally important.[34] However, I consider a head count at 8.00pm locking of the ward a sensible undertaking.

CONCLUSION

48. Travis was a terrific young man, much loved by family and friends. He reciprocated their love. The circumstances of his death are tragic. Travis had a lengthy history of depression and chronic suicidal ideation.[35] He had previously self-harmed.

49. His death was not reasonably foreseeable. Dr Katz referred to the not insignificant associated mortality with each one of the mental illnesses. Further, in the most experienced of hands, the prediction of an intention to end ones own life is notoriously difficult.[36]

50. Travis family has suffered a devastating loss.

51. No one could have reasonably foreseen or prevented the tragic outcome.

[29] Dr Katz T-180
[30] Exhibit G.
[31] Dr Katz - T-178/179
[32] Exhibit G: T-165
[33] Dr Katz T-168
[34] Dr Katz T-169
[35] Dr Katz - "Travis had a four year history of intimate and suicidal ideation." T-135
[36] Dr Katz T-192

COMMENTS:

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

1. Dr Katz gave compelling evidence in respect to the paradigm of treatment:
   - the least restrictive care;
   - limit the length of admission to the shortest possible time;
   - where appropriate, day leave be granted;
   - try our utmost to maintain voluntary status;
   - if arrive involuntary, strive to make voluntary at the earliest opportunity;
   - coupled with that to keep the door to the unit open during the day.[37]

2. Further, Dr Katz spoke of the distress caused by the first presentation into an acute psych setting.[38] He spoke of explaining to the first time patient:

   "...the purpose of the admission was to provide containment and a safe environment, albeit the doors are open." [39]

3. I embrace his rationale and endorse the open door philosophy. I consider the policy meets the spirit and intent of the Mental Health Act.

4. Travis died in circumstances in which he absconded. Dr Katz explained that Travis:
   - had not lost contact with reality;
   - was certainly not psychotic;
   - was capable of making decisions.

5. Further Dr Katz could not abide the prospect of placing a severely depressed patient in a five bed HDU of acutely unwell patients. It is trite to say the experience would be distressing. Further, I have no doubt the upgrade would destroy any prospect of a therapeutic relationship between consultant and patient.[40]

6. If Travis had been identified as an imminent absconding risk, what options were open to clinical staff?

7. Rosie Bourke explained that LDU is locked since Travis death:

   "At the moment it's not open at all." [41]

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[37] T-181
[38] T-187
[39] T-188
[40] T-191
[41] T-101

8. Dr Katz acknowledged there are exceptions to the open door policy, but disputed it is locked on a regular basis. He repeated:

> *"The ideal practice is to have the doors open if the level of acuity in the ward is such that the doors need to be closed, then the doors would be closed. But I'm certainly insistent that the doors are kept open where possible."*[42]

9. Dr Katz agreed that currently, the acuity in the ward may result in the LDU being locked. It follows, the ward may remain locked as long as the need presents.

10. The open door policy is vital in meeting the spirit and intent of the Mental Health Act.

11. I urge Eastern Health to consider the creation of an intermediate option. From time to time, patients will require containment, but not in the HDU. Patients assessed as appropriately housed in LDU should not be locked in during daylight hours.

12. If an LDU patient, irrespective of status, requires containment but not in an HDU, an intermediate option should be available. Further, it is not difficult to envisage circumstances where the intermediate unit could be beneficial as a step down unit from HDU.

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

- Senior next of kin;
- Investigating Member, Victoria Police;
- Eastern Health.

Signature:

JOHN OLLE
CORONER

30 April 2012

[42] T-194