IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2016 2572

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	**ROSEMARY CARLIN, CORONER**
Deceased:	**SIMON SMITH***
Date of birth:	1993
Date of death:	9 June 2016
Cause of death:	1(a) ACUTE BLOOD LOSS 1(b) INCISED INJURIES LEFT FOREARM
Place of death:	Frankston Hospital, 2 Hastings Road, Frankston, Victoria

* This is a redacted version of the original signed finding. Names have been replaced with pseudonyms to preserve the privacy of Simon's family.

HER HONOUR:

Background

1. Simon Smith was born in 1993. He was 22 years old when he took his own life on 9 June 2016.

2. Simon lived in Frankston North with his partner and other housemates. It is clear that he was a very much-loved son, brother, and friend.

3. When Simon was about 16 years old he began self-harming and expressing suicidal ideation following a traumatic incident. He engaged with a school counsellor, a psychologist, and other supportive organisations. He also had admissions to Frankston Youth Prevention and Recovery Care (**YPARC**)[1] and the mental health ward at Monash Medical Centre.

4. Peninsula Health medical records indicated that Simon was given a diagnosis of bipolar affective disorder[2] during his admission to Monash Medical Centre, however it is unclear whether this diagnosis was made by a psychiatrist (or other qualified professional) or whether Simon himself provided this information to Peninsula Health staff.

5. After his admission to YPARC, Simon was diagnosed with depression, anxiety, and an emerging borderline personality disorder.[3] According to the state-wide Client Management Interface database,[4] Simon had been given previous diagnoses of mixed anxiety and depressive disorders and adjustment disorder.[5]

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[1] The Youth Prevention and Recovery Care (**YPARC**) unit is a short term "step up / step down" residential facility for people aged 16 to 25 with a serious mental illness. YPARC allows mental health services to care for young people living in the community who require short-term intensive residential support to prevent deterioration or relapse of mental illness, without which may lead to a hospital admission. YPARC also offers services to young people being discharged from a mental health ward, who no longer require acute hospital admission but who would benefit from a short period of intensive treatment and support before returning home.

[2] Bipolar affective disorder is a mental illness characterised by episodes of mania and sometimes also depression that last for weeks or months at a time.

[3] Borderline personality disorder is characterised by a pervasive pattern of instability in interpersonal relationships, efforts to avoid real or imagined abandonment, unstable self-image, impulsive behaviours, recurrent suicidal behaviours or threats, affect instability, chronic feelings of emptiness, inappropriate or intense anger, transient stress related paranoid ideation and severe dissociative symptoms.

[4] Client Management Interface is the Victorian public mental health client information management system used by each public mental health service.

[5] An adjustment disorder is characterised by the presence of emotional or behavioural symptoms in response to an identifiable stressor, with the symptoms occurring within three months of the onset of the stressor. The type of adjustment disorder relates to its specific symptoms, giving the diagnosis of adjustment disorder with: depressed mood, anxiety, mixed depressed mood and anxiety, disturbance of conduct, mixed disturbance of emotions and conduct, or unspecified.

6. In September 2014 Simon suffered a morphine overdose, allegedly as a result of a man with whom who he was in a casual relationship forcibly injecting him. The subsequent hospitalisation led to him being diagnosed with focal segmental glomerulosclerosis (**FSGS**)[6], although it is likely that he had had that condition since about May 2013. An underlying metabolic disorder was thought to have caused the FSGS which became more pronounced with the morphine.

7. Simon 's condition progressed to end stage renal failure (**ESRF**) and in mid-2015 he commenced dialysis via permacath[7] three times per week. In February 2016, he had surgery to create a fistula for ongoing dialysis.

8. Simon suffered multiple complications of his ESRF from refractory hypertension, posterior reversible encephalopathy syndrome, hypertensive retinopathy, heparin induced thrombocytopaenia, eosinophilia, viral myocarditis, and resultant cardiomyopathy in August 2015 that resolved by March 2016. He had also suffered idiopathic seizures in 2013. Multiple teams were involved in his treatment including the renal, neurology, ophthalmology, cardiology, haematology, infectious diseases, pain management, and psychiatry teams.

9. Simon was advised that to be considered suitable for a kidney transplant, he would need to stop smoking, gain weight, have his co-morbid medical conditions addressed, and maintain stable mental health. He was reluctant to increase his weight from 45 kilograms to 60 kilograms. His frequent blood transfusions also impacted his suitability for a kidney transplant. He was advised that there would likely be a seven-year wait for a kidney transplant and that even with a kidney transplant, it was likely that FSGS would affect the new kidney.

10. In August 2015, the cardiology team documented that Simon was likely not a suitable candidate for a kidney transplant.

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[6] Focal Segmental glomerulosclerosis (**FSGS**) is a type of glomerular disease and describes scarring (sclerosis) in the kidney. Glomeruli are sets of looping blood vessels in the nephrons. Each kidney contains up to one million nephrons. The glomeruli filter the blood allowing excess fluid and waste to pass into the tubule and become urine. The scarring of FSGS only takes place in small sections of each glomerulus (filter), and only a limited number of glomeruli are damaged at first.

[7] A permacath is a piece of plastic tubing which can provide access to the vascular system for patients who need dialysis, to avoid multiple catheter insertions.

11. After starting dialysis, Simon reported a deterioration in mental health and regularly requested to cease dialysis and receive palliative care. He reported that chronic pain, visual impairment, dietary restrictions, and regular dialysis prevented him from engaging in activities that he enjoyed and therefore significantly impacted his quality of life.

12. In the days prior to his death, a Consultation Liaison Inpatient Psychiatry Service (**CLIPS**) psychiatrist documented an impression of personality traits and mild adjustment disorder.

The coronial investigation

13. Simon 's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

14. Coroners independently investigate reportable deaths to find, if possible, identity, medical cause of death and with some exceptions, surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. Coroners make findings on the balance of probabilities, not proof beyond reasonable doubt.[8]

15. The law is clear that coroners establish facts; they do not cast blame, or determine criminal or civil liability.

16. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

17. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation into Simon 's death. The Coroner's Investigator investigated the matter on my behalf and submitted a coronial brief of evidence.

[8] In the coronial jurisdiction facts must be established on the balance of probabilities 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.

18. I reviewed Simon's medical records with the assistance of the Coroners Prevention Unit (CPU)[9] and obtained statements from his treating medical practitioners at Frankston Hospital.

19. After considering all the material obtained during the coronial investigation I determined that I had sufficient information to complete my task as coroner and that further investigation was not required.

20. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity.

Identity of the deceased

21. Simon was visually identified by his mother, Jennifer Smith, on 9 June 2016. Identity was not in issue and required no further investigation.

Circumstances in which the death occurred

Admission to Frankston Hospital

22. On 4 June 2016, Simon attended dialysis at Frankston Hospital. Whilst it was not uncommon for him to be drowsy after dialysis, he was noted to be sedated and complaining of nausea and a headache. He was taken to the emergency department and when more alert, he was reviewed by a CLIPS nurse. Simon told the nurse that he took an unknown quantity of sleeping tablets the previous evening.

23. Simon denied that this was a suicide attempt but could not explain why he took the tablets. He admitted to intermittent suicidal ideation secondary to his physical health and psychosocial issues (which were not specified) but denied current suicidal ideation. His partner, Ben Collins, advised the nurse that Simon researched taking a lethal medication overdose online and had possibly taken magnesium tablets, as approximately 15 of these appeared to be missing. Ben also told the nurse that Simon's physical and mental health were deteriorating as he lived in a share house with seven other people and slept on a mattress in the kitchen.

[9] The role of the CPU is to assist coroners investigating deaths, particularly deaths that occur in a healthcare setting. It is staffed by healthcare professionals, including practising physicians and nurses, who are independent of the health professionals and institutions under consideration.

24. Simon was subsequently admitted to the Short Stay Unit (**SSU**) overnight and a further CLIPS review was scheduled for the following day.

25. At 12.00pm on 5 June 2016, Simon was reviewed by another CLIPS nurse. At this time, he admitted to researching lethal medication overdoses online over a two-week period as he was tired of dialysis. However, he described the overdose as impulsive. He said he took an overdose of temazepam but did not know how many. He did not regret taking the overdose and denied current suicidal ideation. He wanted to be discharged and agreed to community mental health follow up.

26. Later, Dr Marcus Aitkin, psychiatric registrar, also reviewed Simon. Simon told him that he had taken an overdose of temazepam, domperidone,[10] and an antihypertensive medication after weeks to months of planning. He reported a belief that his life was not worth living due to his chronic kidney disease, the associated serious medical complications, and his poor prognosis. He attempted to minimise the overdose by saying that it was because he was upset that Ben planned to move out of their share accommodation. However, Ben reported that in the week leading up to the overdose, Simon had been sending messages indicating his plan to overdose due to his medical issues.

27. Dr Aitkin's impression was that Simon was not clinically depressed but had a calculated belief that his life was not worth living due to his renal disease and the impact this had on his quality of life. He thought that Simon had a potential ongoing suicide risk over the following 48 to 72 hours and planned a further CLIPS review the following day.

28. Simon reluctantly agreed to stay in hospital overnight, and Dr Aitkin advised staff that if he tried to leave, a code grey should be called, and an Assessment Order be completed. Such an Order would allow Simon to be assessed and receive compulsory mental health treatment under the *Mental Health Act 2014* (Vic).

[10] Domperidone is a dopamine antagonist with antiemetic properties. It is used in the short-term treatment of symptoms associated with idiopathic or diabetic gastroparesis, intractable nausea and vomiting from any cause in adults.

29. At 2.33am on 6 June 2016, Simon reported chest pain and it was thought that he may have experienced a non-ST segment elevation myocardial infarction (**NSTEMI**).[11] He required cardiac monitoring and was awaiting a bed on the cardiac ward.

30. Later that day, Dr James Whitelaw, psychiatric registrar, reviewed Simon. Simon acknowledged his previous suicidal ideation but denied anything current. He attributed this change to having gained an understanding that palliative care was an option. He acknowledged that without dialysis he would likely die within two weeks and became angry and uncooperative when advised that Dr Whitelaw would not discharge him to palliative care.

31. Simon 's lack of cooperation meant that Dr Whitelaw was only able to complete a limited assessment and was unable to properly assess Simon 's judgement. Dr Whitelaw contacted an inpatient consultant psychiatrist to discuss his concerns about Simon 's risk of suicide given his poor medical prognosis, risk of absconding, poor engagement with the assessment, and psychological loss.

32. Dr Whitelaw subsequently made Simon subject to an Inpatient Assessment Order under the *Mental Health Act 2014* (Vic). A recommendation was made that the medical team arrange for Simon to undergo a capacity assessment to determine his ability to decide to cease active treatment.

Transfer to the cardiac ward

33. At approximately 5.30pm, Simon was transferred to the cardiac ward with a nursing special.[12]

34. Throughout the evening of 6 June 2016 and morning of 7 June 2016, Simon was escorted by nursing staff or a personal care assistant (**PCA**)[13] to the emergency department smoke room and outside the hospital for cigarettes on several occasions.

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[11] A non-ST segment elevation myocardial infarction (**NSTEMI**) is a type of heart attack. In a NSTEMI, the blood clot only partly occludes the artery and as a result, only a portion of the heart muscle being supplied by the affected artery dies.

[12] A nursing special is a nurse allocated to provide constant visual observations to a single patient. This sometimes occurs when a patient is subject to the *Mental Health Act 2014* (Vic) but requires treatment on a medical ward.

[13] Patient care assistants provide basic patient care under the supervision of nursing staff.

35. Simon was also reviewed by the renal team who noted that he clearly wanted to stop dialysis and clearly understood that he would die without dialysis. The possibility of a renal transplant was discussed including the waitlist, and the requirements to stop smoking, improve diet, and improve medication compliance. It was documented that Simon refused to undertake these changes.

36. Simon went to dialysis (on site) from 10.00am to 1.00pm on 7 June 2016.

37. At approximately 1.30pm, Dr Xu, consultant psychiatrist, reviewed Simon. Simon again spoke about the impact of his medical condition on his quality of life. He denied current suicidal ideation but reiterated his wish to cease treatment and receive palliative care. He denied pervasive depressive or psychotic symptoms. He was noted to have reality-based hopeless themes and his judgement was not impaired.

38. Dr Xu formed the view that Simon 's presentation was consistent with possible personality traits and a mild adjustment disorder; he was not severely depressed. He did not consider Simon to be at imminent risk of suicide, but risk of suicide in the long-term existed due to his history of impulsive behaviour, ongoing medical problems, chronic pain, possible personality disorder, history of substance abuse, and poor psychological supports. At this time, Simon did not satisfy the criteria for a compulsory Treatment Order as he did not have a mental illness that contributed to a risk of serious deterioration in mental or physical health.

39. The Inpatient Assessment Order was subsequently revoked, and a plan was developed to detain Simon under duty of care until his capacity to refuse treatment was assessed. This required reviews by the neuropsychology and renal teams, liaison with his mother, and the obtaining of medico-legal advice via the Victorian Civil and Administrative Tribunal (**VCAT**). Dr Xu believed that constant visual observations were still needed and discussed this with the Associate Nurse Unit Manager, however it is not clear whether it occurred.

40. At 4.50pm, a neuropsychology review was conducted, during which it was determined that Simon did not have any cognitive deficits and a formal assessment of decision-making capacity was therefore not required.

41. Shortly afterwards, Simon requested a period of leave. The renal doctors consulted with CLIPS and it was agreed that he could take three hours of leave escorted by Ben.

42. Simon left the hospital at approximately 5.30pm. At approximately 8.30pm, Ben telephoned the ward to advise that he and Simon 's mother had argued and that she would return Simon to hospital. Nursing staff contacted Simon's mother who advised that she would return her son to hospital when she had sorted a few things out.

43. At approximately 9.30pm, hospital staff again contacted Simon 's mother as he had not yet returned. She said they were only 10 minutes away and returned him to hospital at approximately 10.00pm.

44. Sometime on 8 June 2016, Simon told his mother that he wanted to stop dialysis and discussed with her matters such as assigning a Power of Attorney, Next of Kin, and access to his bank account and superannuation.

45. That day, a further referral was made to neuropsychology for another review of Simon 's decision-making capacity. The neuropsychologist re-attended and reiterated the discussion from the previous day.

46. A referral was subsequently made to social workers to facilitate an application to VCAT regarding Simon 's capacity to refuse medical treatment.

47. A social worker reviewed Simon and contacted the Office of the Public Advocate (**OPA**). The OPA advised that as Simon had been deemed not to have a cognitive deficit by a neuropsychologist, he should be reviewed by the mental health team to explore whether his mental health was affecting his ability to make informed decisions regarding treatment. If the mental health team found that his mental health was impacting his decision-making capacity he could be treated under the *Mental Health Act 2014* and if there were ongoing issues of contention, an application could be made to VCAT for an emergency guardian for medical decisions. The VCAT application was to be postponed until Simon was re-reviewed by CLIPS.

48. Simon was also reviewed by Dr Sze Fung Chiu, renal consultant, during the neuropsychology review. Dr Chiu recommended that Simon be referred to the chronic pain team, who reviewed him the same day.

49. Dr Chiu noted that he discussed transplantation with Simon during this review and said he would contact The Alfred Hospital to seek support for Simon being on the transplant list. Simon agreed he would go to The Alfred Hospital for a transplant work up.

50. A referral was made to the consultant psychiatrist later in the day and a plan was made for a re-review by a consultant psychiatrist the following day.

51. A renal hospital medical officer reviewed Simon again at 5.30pm after he requested leave. After discussion with a registrar, it was decided that Simon could have leave until 8.30pm. He returned on time with no issues.

Transfer to renal ward

52. On his return Simon was transferred from the cardiac ward to the renal ward as he no longer required cardiac monitoring and the bed was needed for another patient. Dr Chiu was not made aware of the transfer.

53. While on the renal ward, nursing observations were completed at approximately 9.00pm and 11.00pm.

54. A progress note at 1.40am on 9 June 2016 documented that Simon complained of pain and was given fentanyl. There was no documentation in the medical record between 1.40am and 5.50am, however Jane Roberts, Peninsula Health Operations Director Department of Medicine, reported that Simon went to sleep after 1.40am and was last seen sleeping in bed at approximately 5.00am.

55. At approximately 5.50am, a nurse checked another patient in Simon 's room and noted that Simon was not in bed. She then found him in the bathroom in a pool of blood with a wound to his left arm.

56. A code blue[14] was called sometime between 5.55am and 6.00am and the code blue team arrived at approximately 6.05am.

57. Simon could not be resuscitated and was pronounced deceased at 6.44am.

[14] A code blue is a hospital-wide coordinated clinical response to a medical emergency requiring immediate assistance. The code blue team consists of specialist medical staff from within the hospital who attend immediately to assist the staff on the ward in which the medical emergency occurred.

58. It is not known what Simon used to inflict the wounds. A retrospective entry in the medical record dated 9 June 2016 at 8.50am (after Simon 's death) indicated that he was last seen at 5.00am, but there was no contemporaneous record of this sighting.

Medical cause of death

59. On 14 June 2016, Dr Melissa Baker, Forensic Pathologist at the Victorian Institute of Forensic Medicine, conducted an autopsy upon the body of Simon and reviewed a post mortem computed tomography (CT) scan.

60. The autopsy revealed an incised injury on the left forearm. One of the injuries involved the wall of a vein at the site of an arteriovenous fistula on Simon 's left forearm. Dr Baker explained that an arteriovenous fistula is an abnormal (surgically created in the case of dialysis) between an artery and a vein. A venous injury is therefore akin to an arterial injury due to this connection and would result in significant and rapid blood loss.

61. There was a further superficial incised wound on the left anterior chest, overlying the heart. The injury involved skin and subcutaneous fat only.

62. The post mortem examination also confirmed end stage kidney disease. The examination also revealed cardiomegaly (enlarged heart) and hypertrophy of the left ventricle. Dr Baker explained the most likely underlying cause of cardiomegaly and left ventricular hypertrophy in Simon is hypertension. He had a well-documented history of refractory hypertension with other sequelae, including hypertensive retinopathy and posterior reversible encephalopathy syndrome.

63. Dr Baker noted a further finding within the heart was areas of haemorrhage within the mitral valve papillary muscles. Histologically, these areas showed myocyte necrosis and haemorrhage with early granulation tissue formation consistent with acute myocardial infarction of several days age. Simon 's recent medical records referred to chest pain, heart attack, and an NSTEMI. This was an incidental finding which did not contribute to death. Myocardial infarction within papillary muscles can lead to valvular dysfunction and in some cases, papillary muscle rupture.

64. Toxicological analysis of ante mortem specimens taken from Simon on 4 June 2016 identified oxycodone,[15] paroxetine,[16] quetiapine,[17] temazepam,[18] and cannabis. Toxicological analysis of post mortem samples identified paroxetine and paracetamol. Dr Baker noted there is no evidence to suggest a toxicological cause or contribution to death.

65. After reviewing toxicology results, Dr Baker completed a report, dated 17 October 2016, in which she formulated the cause of death as *"1(a) Acute blood loss"* and *"1(b) Incised injuries left forearm"*. I accept Dr Baker's opinion as to the medical cause of death.

Findings

Pursuant to section 67(1) of the *Coroners Act 2008* I find as follows:

(a) the identity of the deceased was Simon Smith, born 31 August 1993;

(b) Simon died on 9 June 2016 at Frankston Hospital, 2 Hastings Road, Frankston, Victoria, from acute blood loss and incised injuries to his left forearm;

(c) Simon intentionally took his own life; and

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

Comments

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

1. Simon's mother, Ms Smith, wrote to the Court on several occasions outlining concerns about the care her son received at Frankston Hospital. Some concerns fell outside my jurisdiction as they were not directly related to the circumstances of her son's death. However, I referred the concerns which were within the scope of my investigation to the CPU for advice on those concerns and Simon 's treatment generally. The CPU provided an advice which is set out below and with which I agree.

[15] Oxycodone is a semi-synthetic opiate narcotic analgesic related to morphine used clinically to treat moderate to severe pain.
[16] Paroxetine is used clinically as an antidepressant.
[17] Quetiapine is an antipsychotic drug used in the treatment of schizophrenia.
[18] Temazepam is a sedative/hypnotic drug of the benzodiazepine class.

Access to means

2. The item that Simon used to cut his forearm has not been identified. Ms Roberts (refer paragraph 54) stated that to the best of her knowledge, there were no items found at the scene that could have been used to inflict the wounds. When police attended after Simon 's death, they found medical waste, a mobile telephone, a packet of tic tacs, and an unknown black plastic object with sharp edges in the bathroom where Simon was found. The plastic object was a possible source of Simon 's injuries; but might also have been part of the medical equipment used during the code blue. It is also possible that when Simon returned from leave on 8 June 2016 he brought a sharp object into the hospital, which he disposed of in the bathroom after cutting himself.

3. Dr Dhiren Singh, Acting Clinical Director of Mental Health Services, said that no restrictions are placed on sharps on medical wards. Patients are served meals with cutlery and have access to a pantry (containing additional cutlery).

4. While Simon was subject to an Inpatient Assessment Order, he was under constant visual observations and therefore his access to means was closely monitored. However, after he was taken off that order he had leave during which he would have had access to various means of harm.

5. Given Simon was considered safe enough to leave the hospital, it was reasonable that his access to means on the ward was not restricted or supervised on the day of his death.

Observations leading up to Simon 's death

6. Ms Smith questioned how many times her son called for assistance shortly prior to his suicide and why these requests were not responded to by nursing staff. Additionally, she questioned how long Simon had been in the bathroom prior to being found and why he was not being supervised at the time of his death.

7. There was in fact no evidence in the medical records that Simon called for nursing staff shortly prior to his suicide. Nursing staff responded to his request for pain relief at 1.40am and he was observed to be asleep shortly after this until 5.00am.

8. Sometime between 5.00am and 5.50am, Simon went to the bathroom where he took his own life. His willingness and ability to ambulate to the bathroom unassisted suggest he would

have been able to ambulate to the nurses' station if he had called for assistance and received no response.

9. It is not known for how long Simon was in the bathroom before he was found, except that it was less than 50 minutes. The level of nursing observations was appropriate to the care required and risks associated with his presentation. That is, he was being nursed on four-hourly nursing observations and had not been left unobserved for longer than that period. He had been on leave earlier in the evening for three hours and returned without incident. He also had not demonstrated any medical, behavioural or psychiatric symptoms after his return to warrant an increase in the level of observations.

10. Dr Xu suggested continuing Simon's constant visual observations as a voluntary patient, however it appears this did not occur. A few hours later the renal team and CLIPS agreed that Simon could go on leave, indicating that they did not consider him to be at such a risk that he required constant visual observation. There were no issues over the following one to two days either on the ward or while on leave to suggest that Simon required constant visual observations. As he was a patient of the renal team (and not the psychiatry team) the decision about his level of observations was for the renal team.

11. Even if Simon had been under constant visual observations it is unlikely they would have extended to observing him in the bathroom. His assessed level of risk simply did not require this. Further, it is unlikely that constant visual observations would have prevented his death because he cut from his fistula. This would have resulted in rapid blood loss.

Leave from hospital

12. Ms Smith questioned why her son was allowed leave in the days prior to his death.

13. Simon was a voluntary patient throughout his admission from 4 to 9 June 2016, except between 2.30pm on 6 June 2016 to 1.30pm on 7 June 2016, during which he was subject to an Inpatient Assessment Order. While Simon was subject to that order he was on the SSU until approximately 5.30pm and was then transferred to the cardiac ward. He frequently left the wards throughout the entire admission for cigarettes (however remained on hospital grounds) and left the hospital grounds for three hours of escorted leave on 7 and 8 June 2016. On 7 and 8 June 2016, the psychiatry registrar was consulted and agreed Simon could have leave. While subject to a compulsory order, Simon was taken for on-ground escorted

leave by nursing and PCA staff (to the emergency department smoke room and outside the building for a cigarette).

14. When Simon was a voluntary patient he could not be prevented from leaving the hospital. There was evidence that he was advised of the risks of leaving hospital with regards to his cardiac monitoring. He did not satisfy the criteria to be treated as a compulsory patient under the *Mental Health Act 2014*, although it was documented that he could be detained under duty of care if he attempted to self-discharge. He was not at imminent risk from his medical condition and as he planned to return to the hospital for treatment he could not be held under duty of care.

15. In any event, no adverse events occurred while Simon was on leave. Whilst it is possible that he brought a sharp item back with him, it would have been unreasonable to deny him leave because of that possibility.

Transfer to renal ward

16. Ms Smith stated that her son disliked the way he was treated on the renal ward and asked to remain on the cardiac ward. He subsequently returned from leave on 8 June 2016 to the cardiac ward.

17. Simon was transferred from the cardiac ward to the renal ward later that evening, because he no longer required cardiac monitoring and the specialist renal medical and nursing staff were in the renal ward. This is entirely appropriate.

18. There was no evidence in the medical record that Simon told hospital staff that he was upset about being transferred. Similarly, he did not present in a distressed or irritable state after being transferred to the renal ward.

Involvement of Simon 's partner in treatment

19. Ms Smith claimed her son was upset by the behaviour of Ben, whom she described as abusive and controlling. She said her son had asked for security to remove Ben on several occasions but nothing had happened.

20. Although there was some evidence from Simon 's family and friends regarding the nature of their relationship, there was no evidence in the medical records of the behaviours described

by Ms Smith. Similarly, there is no record that that Simon had asked for Ben's visits to be limited or that he had ever asked security to remove him.

21. Ben was frequently present at hospital with Simon and took him for leave. Ben engaged in discussions with Simon 's treating team on multiple occasions and discussed his concern for his physical and mental health. There is no evidence that Ben's behaviour was inappropriate when engaging with Simon or the treating team.

22. There is no evidence that Ben's involvement was negatively impacting Simon 's treatment.

23. Ben was also listed as an emergency contact when Simon was admitted on 4 June 2016. Without being alerted to any concerns about his behaviour, it was reasonable that Frankston Hospital staff did not object to Ben visiting Simon and remaining involved in his treatment.

Medication

24. In the days leading up to his death, Simon was prescribed aspirin, buprenorphine, calcitriol, calcium, carvedilol, fondaparinux,[19] frusemide, gabapentin, lanthanum, lercanidipine, magnesium, nicotine patches, ondansetron, pantoprazole, paracetamol, paroxetine, prazosin, telmisartan, fentanyl, glyceryl trinitrate, hydromorphone, morphine, oxycodone, quetiapine and salbutamol.

25. While some of these medications require caution and monitoring when used together, none are contraindicated to use together. As Simon was being closely monitored in hospital by medical staff of multiple specialties including renal, cardiac, pain management and psychiatry, his medication regime was appropriate.

26. Simon had been on several antidepressants in the past but was taken off them due to his kidney disease. This was a reasonable decision.

27. On 5 July 2015, Simon was reviewed by Dr S. Curcic, psychiatric registrar. He presented with a worsening of depressive and anxiety symptoms. Dr Curcic commenced him on 10mg paroxetine, which was later increased to 20mg under the supervision of CLIPS. Dr Curcic documented that the half-life of paroxetine is prolonged in those with renal failure. In

[19] Fondaparinux is an anticoagulant used to treat blood clots and prevent blood clots from forming in patients who are recovering from orthopaedic or abdominal surgery.

August 2015, Simon 's paroxetine was reduced due to a low global filtration rate.[20] Many antidepressants require caution when prescribing to patients with renal impairment. Dr Curcic appropriately identified this risk, communicated it to the treating team, and ensured that Simon was monitored for adverse effects while commencing paroxetine. Simon was attending regular medical reviews where any potential adverse effects of paroxetine could be monitored.

28. As to other past medication regimes, they were not contributory to death and are not within the scope of my investigation.

Pain management

29. Ms Smith believed her son's pain was not appropriately managed.

30. During an admission in August 2015, Simon pain was assessed on many occasions by the renal team and the pain management team. Other medical teams were also asked to consult about his persistent headaches, mainly during and following dialysis. Neurology and ophthalmology assessments resulted in MRI scans to investigate headache. MRI diagnosed probable posterior reversible encephalopathy syndrome[21] as a potential cause of headache. High blood pressure was also thought to contribute. Medications were reviewed and adjusted.

31. Simon also had pain in his large muscle groups of unclear origin. He described total body pain and haemorrhoids. He was examined for these conditions, appropriate tests to investigate for underlying causes were conducted, but nothing treatable was identified.

32. On 27 August 2015, the chronic pain team reviewed Simon and noted that he was receiving regular buprenorphine, paracetamol, Endone, and intravenous tramadol when required along with medications to manage the underlying conditions. They noted that, due to the chronic nature of the pain, opioids were best avoided. The pain team organised a review by Headspace psychiatric team.

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[20] Global filtration rate is a test used to check how well the kidneys are working. It estimates how much blood passes through the glomeruli each minute.

21 Posterior reversible encephalopathy syndrome (PRES), also known as reversible posterior leukoencephalopathy syndrome (RPLS), is a syndrome characterized by headache, confusion, seizures and visual loss. It may occur due to a number of causes, predominantly malignant hypertension, eclampsia and some medical treatments.

33. During the June 2016 admission, there was a thorough assessment by the chronic pain team on 5 June 2016. At this time, Simon was receiving regular buprenorphine, gabapentin, and paracetamol, and fentanyl and hydromorphone as required, along with an antidepressant and major tranquiliser. He complained of generalised pain all over and said that none of the medications helped. He was angry during the consultation and walked out. The registrar concluded that Simon displayed high risk behaviour, but was uncertain whether there was continuing suicidality, drug dependence/drug abuse or a psychiatric condition. He could not identify a particular pattern or cause of the pain.

34. During Simon 's admissions there were multiple assessments of his pain. Reasonable investigations were undertaken. Several underlying causes were identified, and efforts were made to address potential causes. The pain management team and multiple other specialists were involved over time. He was provided with multiple pain-relieving medications. Simon expressed that his pain remained a problem, but the medical care and degree of medication provision was reasonable.

Code blue response

35. Ms Smith questioned whether resuscitation attempts were appropriate after her son was found unresponsive on 8 June 2016.

36. The response of the code blue team was reasonable. After observing that Simon was not in his bed at 5.50am, the nurse noted a bathroom light, knocked on the door, received no response, and then opened the door to find Simon. She immediately called for assistance, checked for responsiveness, and called a code blue at approximately 6.00am. The first nursing observation recorded during the code blue was at 6.05am. The time from noticing Simon 's absence to calling a code blue and commencing resuscitation was reasonable.

37. The code blue was attended by the nursing staff, medical registrar, intensive care unit (**ICU**) registrar, ICU consultant, and an anaesthetic registrar. The resuscitation followed standard advanced life support protocols. Additionally, two units of blood were urgently administered. Throughout the resuscitation, Simon remained in asystole. Cardiopulmonary resuscitation (**CPR**) was continued for 45 minutes and in view of no response to resuscitative efforts CPR was ceased. The management of the code blue was reasonable.

38. Simon 's arrest could have occurred any time within a 50 minute interval. Survival from unwitnessed asystolic cardiac arrest is extremely low.

Consideration of transplant and request for transfer of services

39. Dr Kim Meng Wong, head of Nephrology, Peninsula Health, stated that Simon was referred to the Alfred Transplant Physician for assessment for kidney transplantation on 23 October 2015, five months after commencing dialysis.

40. Simon attended the nephrology clinic at Peninsula Health on 4 February 2016 and the transplant assessment was to be expedited, however Simon did not attend. It was necessary to address his multiple medical comorbidities to maximise his chances of a transplant.

Management of requests to cease dialysis

41. The renal team noted Simon 's continued wish to cease dialysis. He was placed under a compulsory Assessment Order on 6 June 2016. The review by the psychiatrist on 7 June 2016 determined that Simon did not meet the treatment criteria of the *Mental Health Act 2014*. A neuropsychology assessment on the same day determined he had capacity to make decisions. The neuropsychologist suggested VCAT involvement.

42. Dr Wong noted that while the renal team was working through the complex ethical aspects of this issue, Simon was encouraged to continue dialysis. He was informed that transplantation remained a possibility and that he would be re-referred to the transplant team. He was advised to stop smoking, decrease cannabis use, and that his medical issues would likely resolve over time, increasing his chance of transplantation. Simon agreed to continue dialysis at this time.

43. Dr Wong did not discuss the *Medical Treatment Act 1988* (Vic) with Simon as the team was of the view that his request to stop dialysis was not an informed choice unaffected by his mental state. The team was working through all the issues to ensure he was fully informed before making a decision.

44. Dr Wong noted that had Simon not ended his life prematurely, and it was deemed he was competent in a second (planned review) and if an independent VCAT appointed enduring power of attorney had been involved in the decision-making process, the renal team would have respected his wish and referred him to the palliative care team.

Conflicting information from health professionals

45. A number of health professionals from various specialties made up Simon 's treating team. The information provided by these health professionals was conflicting at times.

46. The medical records variously indicated that Simon was not a suitable candidate for a renal transplant or his suitability was unclear. Simon reported that he was advised of a likely seven-year wait for a renal transplant and even if this occurred, FSGS would likely affect the new kidney. Dr Wong indicated that Simon was a suitable candidate for a renal transplant, except that he did not attend his transplant assessment.

47. The neuropsychologist documented that Simon did not have a cognitive impairment that impacted his decision-making capacity. The renal team requested that she return the following day to again assess his decision-making capacity. The neuropsychologist reiterated her assessment from the previous day.

48. On 7 June 2016, Dr Xu determined that Simon did not have a major mental illness and his decision-making ability was not affected by mental illness.

49. Dr Chiu reviewed Simon on 8 June 2016. Despite the psychiatric review she requested a referral to psychiatry because she believed he was depressed and required psychiatric medication and cognitive behaviour therapy. Dr Chiu also requested that VCAT not be contacted about Simon 's request to cease dialysis until another assessment was completed by the psychiatry team.

50. Dr Chiu said that after her review of Simon on 8 June 2016, she had a round table discussion with the nurse in charge (presumably of the cardiac ward), the neuropsychologist, social worker, the senior renal registrar, and two renal house officers. There was no evidence that mental health staff were involved, or that a case conference (or similar) occurred involving Simon and the health professionals involved in his decision to cease treatment.

51. Such a case conference may well have been beneficial to ensure there was agreement amongst health professionals about how the situation was to be handled and to ensure that consistent information was being provided to Simon.

Peninsula Health internal review and updated processes

52. As well as the CPU advice I also had access to the results of a Peninsula Health root cause analysis (**RCA**) which was conducted after Simon 's death. The RCA identified two issues:

    (a) there were no clear guidelines around the process of 'specialling' (constant visual observations) for patients who were managed in non-mental health units; and

    (b) Simon 's autonomy with respect to medical treatment choices was compromised.

53. The RCA recommended clear guidelines be developed around constant visual observations for patients with mental health symptoms who are being managed in non-mental health settings. As a result, in November 2017, the *Peninsula Health Specialling of the General Hospital Patient* clinical practice guideline was introduced.

54. I note that as Simon was not being nursed on constant visual observations at the time of his death, such a guideline would probably have been inapplicable. However, I support Peninsula Health's implementation of this guideline.

55. The RCA also recommended that Simon 's case be referred to the End of Life Choices and Care Steering Committee for review and policy/practice development. This occurred in August 2016. That committee provides clinical governance and oversight of strategic improvements to clinical practice in the context of end of life care across Peninsula Health. It does not review individual cases, as this is a function of the clinical incident investigations (i.e. the RCA).

56. After the introduction of the *Medical Treatment Planning and Decisions Act 2016* (Vic),[22] Peninsula Health introduced the *Medical Treatment Decisions & Consent* policy. Relevantly, this policy outlines:

    (a) whether medical treatment decisions are to be made by the patient, medical treatment decision maker (**MTDM**) or OPA;

    (b) the process for obtaining and documenting consent or refusal of medical treatment from a patient or MTDM;

    (c) when a patient is considered to have decision making capacity;[23] and

[22] The *Medical Treatment Planning and Decisions Act 2016* (Vic) replaced the *Medical Treatment Act 1988* (Vic).

(d) the escalation pathway for health practitioners who are concerned about a patient's decision-making capacity or MTDM's decision.

57. Under the *Medical Treatment Planning and Decisions Act 2016* (and the *Peninsula Health Medical Treatment Decisions & Consent* policy), a person who has decision-making capacity may appoint a Support Person to support the patient to make, communicate, and give effect to medical treatment decisions and represent the interests of the patient in respect to their medical treatment (including when the patient no longer has decision making capacity).

58. The *Peninsula Health Medical Treatment Decisions & Consent policy* appears likely to assist patients and health professionals in complex situations such as Simon's in the future.

Opportunities for prevention intervention

59. Simon developed a complex medical condition at a young age that required him to make important medical treatment decisions, including the decision to continue treatment or seek palliative care. He did not have a mental illness or cognitive deficit that impacted his decision-making ability and therefore was acknowledged to have had capacity to make treatment decisions. Despite his capacity to make treatment decisions, Peninsula Health identified that Simon's autonomy with respect to medical treatment choices was compromised.

60. There were several factors that likely affected Simon 's judgement when making such decisions, but not to such a degree that he lacked capacity. His young age, limited previous engagement in the health system, complex medical condition, symptoms and side effects of his medical condition, uncertainty regarding his prognosis, unstable social supports, and conflicting information regarding his medical and psychiatric conditions may have affected his treatment decisions.

61. These factors were not sufficient for Simon to require a medical treatment decision maker. However, having an independent person to assist him in gathering information would have allowed him to make a comprehensively informed judgement about his choices.

[23] An adult (over the age of 18 years) is presumed to have decision making capacity unless there is evidence to the contrary. To have decision making capacity, a patient must be able to a) understand the information relevant to the decision and the effect of the decision; b) retain that information to the extent necessary to make the decision; c) use or weigh up that information as part of the process of making the decision; and d) communicate the decision in some way, including by speech, gestures or other means.

Nonetheless, it is unknown whether this would have changed his ultimate decision to seek palliative care or to take his own life.

62. Such Support People are available via the OPA for people with a disability. However, there appears to be a lack of available support for those who do not have a disability but are vulnerable due to age, inexperience, psychosocial issues, and/or symptoms of a mental illness not sufficient to constitute a disability.

Recommendations

Pursuant to section 72(2) of the *Coroners Act 2008*, I make the following recommendations connected with the death:

1. The OPA review opportunities to expand their support system for people who do not have a disability but:

   (b) have complex and/or time critical medical needs; and

   (c) have capacity to make treatment decisions, but may be vulnerable because of the risk of incomplete information and/or lack of understanding of their treatment options, risks and benefits; and

   (d) where an appropriate Support Person under the *Medical Treatment Planning and Decisions Act 2016* cannot be identified.

   This support service should be independent of health services, and assist patients in supported decision-making, where the patient has capacity to make treatment decisions but would benefit from assistance to ensure that their judgement is based on comprehensive information.

Publication

Given that I have made a recommendation, I direct that this finding be published on the internet pursuant to section 73(1A) of the *Coroners Act 2008*.

I convey my sincere condolences to Simon's family.

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

Simon's family

Office of the Chief Psychiatrist

Office of the Public Advocate

Peninsula Health

Senior Constable Mark Aitken, Coroner's Investigator, Victoria Police

Signature:

ROSEMARY CARLIN
CORONER
Date: 10 May 2019