IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2016 5874

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	Caitlin English, Acting State Coroner
Deceased:	Michael Travis Kidd
Date of birth:	16 September 1981
Date of death:	Between 10 December 2016 and 11 December 2016
Cause of death:	I(a) Clozapine Toxicity
Place of death:	12/253 Victoria Street, Brunswick, Victoria

INTRODUCTION

1. Michael Travis Kidd was a 35-year-old Aboriginal man who resided at a peer recovery community in Brunswick operated by Mind Australia prior to his passing.[1]

2. Mr Kidd was born to Elizabeth (Betty) Blight and Michael Saunders. He was a descendent of the Wakka Wakka community from South Eastern Queensland.

3. In February 2009, Mr Kidd met Caroline Jandula and commenced an intermittent relationship with her. They had a son together in 2011.

4. On the evening of 11 December 2016, Mr Kidd was found unresponsive in his room at the Mind Australia facility in Brunswick. Emergency services attended and confirmed Mr Kidd had passed away.

THE PURPOSE OF A CORONIAL INVESTIGATION

5. Mr Kidd's passing was reported to the Coroner as it appeared to be unnatural and so fell within the definition of a reportable death in the *Coroners Act 2008.*

6. 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.

7. The Coroner's Investigator, First Constable Matthew O'Neill, prepared a coronial brief in this matter. The brief includes statements from witnesses, including family, the forensic pathologist, treating clinicians, staff members at Mind Australia and investigating officers.

8. As part of the investigation into Mr Kidd's death, I referred the matter to the Coroners Prevention Unit (CPU)[2] to review the care and services provided to Mr Kidd by Mind Australia.

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[1] Mind Australia is a mental health provider within the meaning of the *Mental Health Act 2014* (Vic) and is also a registered National Disability Insurance Scheme provider. Mind Australia is also a registered National Disability Insurance Scheme provider. Mind Australia including the residential facility in Brunswick, is not a clinical mental health service. The facility in Brunswick has 17 single occupancy open plan rooms with ensuite with a double bed, a kitchenette with whitegoods and a fridge. There is an onsite communal lounge, dining area and kitchen. Residents are subject to a tenancy agreement, pay rent and their stay is usually limited to about one year. The goal of the facility is to assist the resident to live independently in the community.

9. I received comprehensive statements from Michael Loh General Manager Clinical Practice & Quality at Mind Australia dated 1 February 2019 and 21 May 2019 with attached records notes and forms.

10. I have based this finding on the review conducted by CPU, the coronial brief, statements from Mind Australia and information provided in the medical records from St Vincent Hospital and North Western Mental Health.

11. I have based this finding on the evidence contained in the coronial brief. In the coronial jurisdiction facts must be established on the balance of probabilities.[3]

IDENTITY

12. On 11 December 2016, Michelle Kealy a community mental health practitioner (CMHP) at Mind Australia, visually identified Michael Travis Kidd, born 16 September 1981.

13. Identity is not in dispute and requires no further investigation.

BACKGROUND

14. Mr Kidd had a lengthy history of mental illness. He had diagnoses of paranoid schizophrenia,[4] alcohol use disorder[5] as well as a history of psychosis, suicidality and illicit substance use including cannabis.

15. In her statement, Mr Kidd's Aunty Vivian Bligh noted that Mr Kidd experienced emotional and physical abuse at times during his early childhood. In 2003, Mr Kidd disclosed allegations of childhood sexual abuse to Ms Bligh.[6] Mr Kidd also disclosed these allegations

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[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. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

[3] 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.

[4] Schizophrenia refers to a group of disorders/spectrum characterized by positive psychotic symptoms at some stage of illness, where mania and major depression are not prominent or persistent features, and where negative and cognitive symptoms are likely to be prominent and associated with varying degrees of disability. Comorbidity is extremely common. In the paranoid type, paranoid delusions are prominent.

[5] Alcohol use disorder is a problematic pattern of alcohol use leading to clinically significant impairment or distress.

[6] Coronial brief, Statement of Vivien Bligh dated 26 June 2017.

to Dr Duncan Howard at the Brunswick Community Medical Centre in December 2015.[7] It does not appear that Mr Kidd reported the allegations to Victoria Police.

16. After finishing year 12, Mr Kidd began working in the construction industry in the Brisbane area. Mr Kidd was described by Ms Bligh as a '*very physically talented young man*' and '*a good sportsman*'.[8] Ms Bligh stated that during this time he played rugby league. He was passionate about traditional Aboriginal dancing and taught children about this.[9]

17. At approximately 21 years of age, Mr Kidd moved to Essendon, Victoria. He lived with Ms Bligh for approximately one year and was employed as a labourer. According to Ms Bligh, following distress associated with his memories of childhood trauma, Mr Kidd left his job and became homeless for a period of time.[10]

18. Mr Kidd had significant interactions with different medical and mental health institutions, with at least 12 mental health admissions which included prevention and recovery centre (PARC) programs. He had a documented history of deterioration in mental state with or without admission, suicidal ideation and attempts to take his own life. He was commenced on clozapine[11] during a hospital admission in September 2015.

19. From December 2015, Mr Kidd was managed by North West Area Mental Health (NWAMH). NWAMH maintained monthly clozapine reviews with the psychiatric registrars. On occasion Mr Kidd missed his review which required proactive follow-up by NWAMH. According to North West Mental Health's medical records Mr Kidd also received treatment through the ReGen Drug counselling service.

20. In March 2016, Mr Kidd moved to accommodation operated by Mind Australia in Brunswick. The residential service did not manage the dispensing of medication and relied on residents to manage their own medication. Mr Kidd would receive his medication weekly from a pharmacy in a blister pack form, which contained Mr Kidd's tablets for each day of the week in separate compartments to assist with adherence and correct dosing.[12] Mr Kidd undertook regular testing of Clozapine levels. On occasion the testing resulted in differing levels, which was suggestive of non-compliance.

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[7] Coronial brief, Statement of Dr Duncan Howard dated 6 June 2017.
[8] Coronial brief, Statement of Vivien Bligh dated 26 June 2017.

[9] Coronial brief, Statement of Vivien Bligh dated 26 June 2017.
[10] Coronial brief, Statement of Vivien Bligh dated 26 June 2017.
[11] Clozapine is currently available for the treatment of schizophrenia unresponsive to or intolerant of classical neuroleptics (i.e. treatment – resistant schizophrenia).
[12] Coronial brief, Statement of Dr Steven Jones dated 9 March 2017.

21. From May 2016, Hannah Lavery Key Clinician at NWAMHS was involved in Mr Kidd's care. Mr Kidd attended regular appointments with Ms Lavery in which she assessed his mental state and provided Mr Kidd support for psycho social issues. Mr Kidd was usually supported by a CMHP from Mind Australia when attending appointments. Ms Lavery reported throughout the seven-month period as Mr Kidd's key clinician, his mental state fluctuated greatly. This appeared to be in the context of psycho social stressors, which included relationship conflict, legal issues, ongoing alcohol use and erratic compliance with medications (Clozapine and Mirtazapine) prescribed by Mr Kidd's treating doctors at NWAMHS.[13]

22. On 26 June 2016, Mr Kidd was assessed and admitted as a voluntary patient to St Vincent's Hospital psychiatry unit due to increasing distress and suicidality following the death of his co-resident on 25 June 2016. Mr Kidd expressed guilt and self-blame for the death as he had provided his co-resident with some of his Clozapine medication. The co-resident had overdosed and subsequently died.[14] Following the death, Mr Kidd expressed thoughts of overdosing on his Clozapine medication. His distress reduced over the course of his admission and he was discharged back to the Mind Australia facility on 11 July 2016. Mr Kidd continued to be case management by NWAMH and had a counsellor at ReGen.

23. On 9 August 2016, Mr Kidd was admitted to the Broadmeadows inpatient unit as a voluntary patient, in the context of increasing auditory hallucinations, increased alcohol use and suicidality. Upon admission, Mr Kidd was experiencing a number of stressors, which included continued feelings of guilt over the death of his co-resident and an ongoing legal matter. Mr Kidd was reviewed by Community Consultant Psychiatrist Dr Steven Jones as part of his admission to the Broadmeadows psychiatric inpatient unit on 8 August 2016.

24. Mr Kidd was reviewed by consultant psychiatrist Dr A Itrat prior to his discharge on 18 August 2016. The care provided was contemporary and Mr Kidd reported no psychotic features. He was discharged to the Mind Australia facility in Brunswick with increased second daily support arranged by NWAMH until he settled.[15]

25. On 9 September 2016, Mr Kidd was reviewed by Dr Sreejayan Kongasseri Psychiatric Registrar at NWAMH. Dr Kongasseri noted that Mr Kidd was continuing his treatment and

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[13] Coronial brief, Statement of Hannah Lavery dated 29 June 2017.
[14] Coronial brief, Statement of Dr Steven Jones dated 9 March 2017.
[15] NorthWestern Mental Health digital medical records pages 51, 388, 398-399 and 416.

did not display any psychotic symptoms. However, his case worker at Mind Australia did express concerns regarding Mr Kidd's mental state and his compliance with medication.[16]

26. On 20 October 2016, Mr Kidd presented to Ms Lavery for review and was accompanied by a staff member from Mind Australia. Mr Kidd reported that he had been spending an increasing amount of time with Ms Jandula at her residence in Maidstone. The pros and cons of staying in Maidstone were discussed. Mr Kidd reported that his mental health had been stable, having only heard voices on one occasion recently. Mr Kidd did not report any further concerns. He noted that he was working with his CMHP at Mind Australia to apply for a disability support pension and accommodation through the Aboriginal Housing Service.

27. On 21 October 2016, Dr Kongasseri reviewed Mr Kidd who reported that he was doing well and that he had been compliant with his medications.

28. On 17 November 2016, Dr Kongasseri reviewed Mr Kidd who was reported to be experiencing minimal psychotic symptoms. He stated that he was coping well and that he had decreased his alcohol intake. Throughout the interview Mr Kidd presented as '*cheerful*' and he '*was happy that he was visiting his mother and son*'.[17] Mr Kidd did not report any suicidal thoughts during his consultation with Dr Kongasseri. Dr Kongasseri provided Mr Kidd with his monthly script of Clozapine tablets and the next review was scheduled.

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

29. Ms Jandula stayed with Mr Kidd at Mind Australia on the evenings of 7 and 8 December 2016. She left early on the morning of 9 December 2016. She noted throughout her stay that '*Mick seemed very shutdown at the time, very unapproachable*' and '*very difficult to engage with*'.[18]

30. At around 6.00pm that evening, Ms Bligh spoke to Mr Kidd and noted that '*he sounded good*'. She asked him to catch up for coffee the next week and suggested that they take lunch to his mother. Mr Kidd stated '*Sounds good. Love you Aunt.*'[19]

31. Ms Jandula texted and attempted to call Mr Kidd over the weekend, but he did not respond.

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[16] Coronial brief, Statement of Dr Sreejayan Kongasseri dated 29 June 2017.
[17] Coronial brief, Statement of Dr Sreejayan Kongasseri dated 29 June 2017.
[18] Coronial brief, Statement of Caroline Jandula dated 28 July 2017.
[19]

32. Mr Kidd was sighted on the morning of 10 December 2016 making a coffee before he returned to his room at the Mind Australia facility.[20]

33. At 12.15pm Mr Kidd attended the office of CMHW Monique Girbau. Mr Kidd stated to Ms Girbau that he was hearing voices and that he was concerned that people were '*talking about him*' and '*looking at him funny*'.[21] Ms Girbau asked Mr Kidd what strategies usually assisted him to get through '*times like these*'[22] and made suggestions to help Mr Kidd which he declined.

34. Ms Girbau also offered to look at Mr Kidd's safety plan with him and organise a plan for the day. Ms Girbau that she had assisted him by listening and that he was going to his room to rest. Ms Girbau informed Mr Kidd that she would attend his room after he had rested to organise a '*strategy to keep him safe for the day*' to which Mr Kidd agreed.[23]

35. At approximately 1.25pm Ms Girbau went to Mr Kidd's room to discuss the safety plan and to provide Mr Kidd with phone numbers for him to access support if needed. Mr Kidd said he was resting so Ms Girbau asked for him to come to the office when he was free.

36. At approximately 3.00pm Ms Girbau returned to Mr Kidd's room and heard him snoring (from outside the room). She placed the safety plan and phone numbers under his door. Ms Girbau made an entry into the electronic file of her interactions with Mr Kidd and documented his current situation and plan which included a request for staff on the next shift to check in on Mr Kidd. At 6.30pm Ms Girbau handed over to CMHP Phoebe Menz.

37. Ms Menz case notes indicate on 10 December 2016 she conducted a check at about 9.00pm. She heard Mr Kidd snoring loudly and did not disturb him.[24]

38. CMHP Michelle Kealy commenced work on the morning of 11 December 2016. Ms Menz provided handover of the events of the previous day including that Mr Kidd was snoring when she had tried to check on him and that she had not interrupted him.

39. On 11 December 2016 CMHP Lisa Vuillermin commenced duty at 6.00pm. According to Ms Vuillermin, Ms Kealy told her that it had been a tough day and that a previous resident had presented to the Mind Australia facility, which had prevented her from completing the required checks during her shift. Ms Kealy reportedly told Ms Vuillermin she would

[20] Coronial brief, Statement of John Bamborough dated 22 August 2018.
[21] Coronial brief, Statement of Monique Girbau dated 14 September 2017.
[22] Coronial brief, Statement of Monique Girbau dated 14 September 2017.
[23] Coronial brief, Statement of Monique Girbau dated 14 September 2017.
[24] Coronial brief, Statement of John Bamborough dated 22 August 2018.

complete the checks prior to leaving work. Ms Kealy returned to the office about 15 minutes later and stated she thought Mr Kidd had passed away. Both CMHPs returned to Mr Kidd's room and contacted emergency services. Emergency services personnel attended the scene and found that Mr Kidd had passed away. A note was found in Mr Kidd's room which indicated an intent to take his own life.

40. Police attended the scene and inspected Mr Kidd's room. In addition to the note, police found packets of pharmaceutical medications, including Clozapine, Mirtazon,[25] and Thiamine. Mr Kidd's mobile phone and a bottle of bourbon were also located in his room.

CAUSE OF DEATH

41. On 15 December 2016, Professor Stephen Cordner, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an examination and provided a written report, dated 15 March 2017. In that report, Professor Cordner concluded that a reasonable cause of death was '*I(a) Clozapine toxicity*'.

42. Toxicological analysis identified the presence of elevated levels of clozapine.

43. Professor Cordner commented upon examination '*there were very early signs of pneumonia developing seen under the microscope. These changes suggest that Mr Kidd survived for some time after the ingestion of drugs, although he would have been unconscious. In these circumstances, pneumonia can develop quite quickly, but perhaps there was a sufficient period of survival for the alcohol he may have ingested to be metabolised. The toxicology results showed a very high level of clozapine in his blood, levels which are well into the range previously associated with death from clozapine toxicity*'.

44. I accept Professor Cordner's opinion as to cause of death.

REVIEW OF CARE

45. Following detailed consideration of the material contained within the coronial brief, I directed the CPU to review the circumstances surrounding Mr Kidd's passing, and in particular his living arrangements whilst at Mind Australia.

46. The CPU review noted that the Mind facility in Brunswick is staffed and it is not the role of the CMHP to establish the clinical risks of a resident because it is not a clinical service. However, Mind Australia CMHPs are responsible for the development of safety plans for

[25] Mirtazapine.

residents which should be complete and current. This is reflected in Mind Australia's Supporting Client Wellness and Safety Planning procedure that applied at the time of Mr Kidd's passing.

47. The CPU advice was that Mind Australia's recovery related support for Mr Kidd was appropriate for a non-clinical mental health adult recovery focused rehabilitation facility. However, there was no specific advice to Mind Australia CMHPs from North Western Mental Health about what to do in circumstances where a resident reports distress associated with an exacerbation of their psychiatric symptoms.

48. Further, the reliance by staff on snoring as an indicator a resident is well was found to be problematic. In addition, the extended period of snoring during the daytime to evening time in circumstances where a resident has Mr Kidd's history, who was known to isolate himself when distressed, and who had sought out staff because of the distress directly associated with his psychiatric symptoms, should have resulted in increased concern and a response.

49. Snoring can suggest a problem with breathing. The extended presence should not be a reassurance in circumstances where a resident is not known to or does not usually snore loudly. The CPU noted that snoring was not documented in any of Michael's records.

50. I notified Mind Australia of my intention to make the recommendations, contained below, in response to Mr Kidd's death. Mr Loh General Manager Clinical Practice and Quality at Mind Australia confirmed that Mind Australia accepted the proposed recommendations. He advised the Court that:

    (a) Mind Australia will undertake a review of its Client Risk Assessment and Management Procedure and Supporting Client Wellness and Safety Planning Procedure to sure they specifically address:

        Where clients or others identify that a client has a history or likelihood of distress associated with psychiatric symptoms, particularly were that distress may lead to increased risk for the client or others;

        Steps to take where it is identified that a client is not following a safety plan, or when the safety plan is ineffective.

(b) Mind has implemented a new Assisting Clients with Medication Management Procedure which advocates for much closer communication with treating teams and prescribing practitioners / regular medication reviews as well as the use of the risk assessment tool.

Mind Australia is currently updating its learning courses to ensure that frontline workers are aware of early signs of deteriorating physical and mental health.

RECOMMENDATIONS

51. Pursuant to section 72(2) of the Coroners Act 2008, I make the following recommendations:

Mind Australia

52. Having a complete and current safety plan for someone who is a resident of an adult residential rehabilitation and recovery-focused facility is appropriate, however it should meet its purpose of promoting safety. It should include information to guide staff to what they can do in circumstances when a resident reports distress (in this case because of psychiatric symptoms) and who is not following the safety plan. When the resident is a current client of the mental health service, inclusion of advice about escalated next steps from the mental health service would be appropriate:

(a) To improve the safety of residents at Mind Australia residential facilities, information is included in a resident's safety plan that can be used by staff to guide an escalated response to a resident who (1) reports distress associated with psychiatric symptoms and (2) who is not following the safety plan, or when the safety plan is ineffective. The plan should be informed by the treating clinical mental health team or practitioner in circumstances where a client is currently case managed or treated by them.

53. A basic understanding of the indicators of overdose is appropriate for the Mind Australia residential facility staff and would assist them in appropriately responding to residents who may be portraying symptoms and be at risk:

(b) Mind Australia provide training to Community Mental Health Practitioners working in the residential rehabilitation facilities about the basic indicators of overdose, appropriate responses and how this interacts with the Mind Australia Client Contact within a Residential Setting Procedure, when a resident's onsite location is not in doubt, but their safety cannot be established.

FINDINGS AND CONCLUSION

54. Having investigated the passing, without holding an inquest, I find pursuant to section 67(1) of the *Coroners Act 2008* that Michael Travis Kidd, born 16 September 1981, died between 10 and 11 December 2016 at Brunswick, Victoria, from clozapine toxicity in the circumstances described above.

55. I convey my sincere condolences to Mr Kidd's family for their loss.

56. Pursuant to section 73(1A) of the *Coroners Act 2008*, I direct this finding be published on the internet.

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

Mr Quinton Kidd, senior next of kin.

Ms Vivian Bligh.

Mind Australia.

Melbourne Health (NorthWestern Mental Health).

Office of the Chief Psychiatrist.

First Constable Matthew O'Neill, Victoria Police, Coroner's Investigator.

Signature:

CAITLIN ENGLISH
ACTING STATE CORONER
Date: 9 October 2019