IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE Court Reference: 2013 1584

FINDING INTO DEATH WITH INQUEST

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

Deceased:	Damon Brenden AMIET
Delivered on:	31 January 2020
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing dates:	Directions Hearing: 27 July 2017 Inquest: 30 April - 3 May 2018 Written Submissions: June 2018
Findings of:	Coroner Paresa Antoniadis SPANOS
Assisting the Coroner:	Leading Senior Constable Tracey RAMSEY from the Police Coronial Support Unit
Representation:	Ms Debra FOY, instructed by Susannah Whitty of Eastern Health, appeared on behalf of Eastern Health
Catchwords:	Involuntary psychiatric patient, complex presentation including chronic suicidality, impulsivity, absconding, polysubstance use, risk assessment, clinical observation guideline, suicide

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I, PARESA ANTONIADIS SPANOS, Coroner, having investigated the death of

DAMON BRENDEN AMIET and having held an inquest in relation to this death

at Melbourne on 30 April – 3 May 2018:

find that the identity of the deceased was DAMON BRENDEN AMIET

born on 19 July 1987, aged 25 years

and that the death occurred on 13 April 2013

near East Ringwood Railway Station, Ringwood East, Victoria 3135

from:

I (a) INJURIES SUSTAINED WHEN STRUCK BY A TRAIN

in the following circumstances:

INTRODUCTION[1]

1. Damon Brenden Amiet, was the 25-year old son of Elise Amiet and Robert Dux. Mr Amiet remained in his mother's care when his parents separated during his infancy. After his mother re-partnered, Mr Amiet was raised by her and Keith Coombe in the eastern suburbs of Melbourne.[2]

2. During primary school, Mr Amiet exhibited challenging behaviours, described by his mother as 'anger issues' and was referred by Mooroolbark East Primary School to a program to address them. Around this time, Mr Amiet was diagnosed with Attention Deficit Hyperactivity Disorder (**ADHD**) and prescribed medication for its management.[3] Ms Amiet was concerned her son was misdiagnosed as the medication 'actually made him more hyper', in addition to producing side effects including weight loss and sleeplessness.[4]

3. At the age of about ten, Mr Amiet sustained head injuries in a car accident.[5] It is believed that he had an acquired brain injury (**ABI**) as a result.[6] According to Ms

[1] This section is a summary of background and personal circumstances and uncontentious circumstances that provide a context for those circumstances in which the death occurred.
[2] Exhibit A.
[3] Ibid.
[4] Transcript pages 2-3.
[5] Exhibit A and Transcript pages 31-32.
[6] Exhibit K and Transcript pages 32 (Amiet) and 370 (Katz).

Amiet, she noticed a 'significant change in him' after the accident including memory loss, fear of travelling in a car, and paranoia about hygiene and foods.[7]

4. Mr Amiet reportedly found school challenging. His education was interrupted by expulsions from secondary schools in Year 8 and Year 9, and from a community school when he was about 16 years old, on each occasion due to disruptive behaviour. After leaving school, his mother encouraged him to obtain employment, but Mr Amiet was unable to sustain work for more than a couple of weeks at a time, largely due to conflicts with co-workers.[8]

5. According to Ms Amiet, during adolescence her son started using cannabis, and was introduced to heroin by Mr Dux when Mr Amiet lived with him for six months at the age of 15 years.[9] At 16 years, Mr Amiet's drug use became more pronounced and adversely affected his mental health and behaviour, resulting in psychosis and aggression.[10]

6. Mr Amiet's violent outbursts were difficult to manage at home, particularly with a sibling there nine years his junior.[11] To mitigate this risk, Mr Coombe lived with Mr Amiet for a period at a caravan park.[12]

PSYCHIATRIC HISTORY

7. Mr Amiet's first contact with psychiatric services occurred when he was about 14 years old.[13] While under the care of the Child and Adolescent Mental Health Service, his diagnosis of ADHD was confirmed and he was also diagnosed with Oppositional Disorder and Dysthymia.[14] He was sometimes difficult to engage in psychological counselling, especially when in 'a defiant mode'.[15] Mr Amiet was treated as a psychiatric inpatient once as an adolescent.[16]

8. As an adult, Mr Amiet was diagnosed with Schizoaffective Disorder and Antisocial Personality and Borderline Personality Disorders.[17] His mental health conditions were complicated by ongoing polysubstance use involving cannabis, amphetamines, heroin

[7] Exhibit A.
[8] Exhibit A.
[9] Exhibit A and Transcript page 4.
[10] Exhibit A.
[11] Transcript page 5.
[12] Transcript page 6.
[13] Exhibit D.
[14] Exhibit L.
[15] Transcript page 16.
[16] Exhibit D.
[17] Exhibit L.

and benzodiazepines, and by a mild cognitive disability.[18] A number of antipsychotic, antidepressant and mood stabilising medications were trialled, and Mr Amiet underwent Electroconvulsive Therapy.[19]

9. Between November 2004 and March 2011, Mr Amiet was managed in the community at various times by Maroondah, Chandler, Koonung and Murnong mental health teams.[20]

10. The frequency of inpatient psychiatric treatment increased over this period, with four admissions between November 2004 and February 2010 and six admission in the 12 months to February 2011.[21] During inpatient admissions, Mr Amiet often required chemical and mechanical restraint, spent periods in the High Dependency Unit (**HDU**), damaged hospital property, made threats of violence to individuals and had repeated episodes of self-injurious behaviour, such as head banging.[22]

Management by Maroondah Mobile Support and Treatment Service

11. On 17 March 2011, due to his complex needs, Mr Amiet's psychiatric care was transferred to the Maroondah Mobile Support and Treatment Service (**MMSTS**), a division of Eastern Health's Mental Health Service.[23]

12. MMSTS is an intensive home and community-based recovery service for people living with mental illness. The service provides active outreach and intensive support, treatment and recovery-focused goal setting to assist patients to develop meaningful connections in the community and minimise the risk of relapse, in collaboration with other community service providers. MMSTS patients have a primary and secondary Case Manager to ensure that a clinician familiar with the patient is available to assist when needed, with back-up provided by the daily duty worker.[24] Clinical care is directed by a MMSTS Consultant Psychiatrist, with multidisciplinary clinical reviews occurring at regular intervals to optimise treatment and management plans.[25]

13. If MMST patients require inpatient psychiatric treatment, they are ordinarily admitted to the Inpatient Unit 1 at Eastern Health's Maroondah Hospital (**IPU1**) under the care

[18] Ibid.
[19] Exhibit L and Transcript page 12.
[20] Exhibit D.
[21] Exhibit D.
[22] Exhibit L.
[23] Exhibit C.
[24] Transcript pages 52-53.
[25] Transcript pages 52 and 81.

of their MMSTS Consultant Psychiatrist to facilitate continuity of care.[26] If admitted outside usual business hours, patients are reviewed by the IPU1 Consultant Psychiatrist within 24 hours of admission,[27] with review by their MMSTS psychiatrist on the next business day. Progress notes, discharge summaries, and treatment and management plans are accessible to all Eastern Health staff in the patient's electronic Clinical Patient File (**CPF**).[28]

14. Mr Amiet was an involuntary patient of MMSTS, subject to a Community Treatment Order (**CTO**)[29] pursuant to the *Mental Health Act* 1986 (**MHA**). Until about three weeks prior to his death, Dr Xenia Prodromou was Mr Amiet's MMSTS Consultant Psychiatrist.[30] His primary and secondary case managers changed three times in the two years he was a patient of MMSTS, with Trevor Tratter commencing as his primary Case Manager on 19 June 2012.[31] Additional support for psychosocial rehabilitation was provided by EACH, initially seven hours per week through the Intensive Home Based Outreach Service (**IHBOS**) was reduced to three hours per week via the Reach Out program due to Mr Amiet's poor engagement with the IHBOS.[32]

15. Frequency of review by Dr Prodromou was dependent on clinical need.[33] Mr Amiet was seen on a twice-weekly basis by MMSTS and twice-weekly by EACH, generally with his primary and secondary case managers alternating visits.[34] During MMSTS attendances, Mr Amiet's mental state and alcohol and drug use were monitored, risks were assessed, depot (fortnightly) and oral medications (every few days) provided, along with encouragement to develop recovery goals and harm minimisation strategies.[35] Both MMSTS and EACH endeavoured to engage him in psychosocial programs, reduce social isolation and assist him with activities of daily life.[36]

16. Mental Health Rehabilitation Services Clinical Review[37] and Mental Health Management[38] plans were developed to assist MMSTS' management of Mr Amiet.

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[26] Exhibit O and Transcript page 378.
[27] Exhibit O.
[28] Exhibit O and Transcript page 323.
[29] Community Treatment Order authorises psychiatric treatment without the patient's consent while in the community.
[30] Exhibit L and Transcript page 301.
[31] Exhibit C.
[32] Exhibit C.
[33] Transcript pages 301-302.
[34] Exhibit C.
[35] Exhibit C.
[36] Transcript page 78.
[37] Exhibit D: last reviewed on 21 January 2013.
[38] Exhibit E: date of document, 18 July 2012.

These documents contain an overview of Mr Amiet's primary diagnosis and co-morbid conditions, contact with psychiatric services and status under the MHA, social history, medication regime, mental state assessment, early warning signs and relapse prevention strategies, and management plans for ongoing day-to-day care, crisis presentations and inpatient admissions. Formulated by MMSTS clinicians, in collaboration with other services providers,[39] the management plans aimed to support the agencies that had contact with Mr Amiet and in so doing, improve outcomes for him by reducing the risk of harm to him or others, and decrease the frequency and duration of inpatient admissions.[40]

17. Mr Amiet was regarded by Dr Prodromou and Mr Tratter as a 'very complex'[41] if not the 'most complex'[42] patient of MMSTS. His complexity arose from the combination of his diagnosed mental health conditions, for which medication produced 'limited benefit',[43] and his cognitive limitations, personality vulnerabilities and substance use, which together compounded poor emotional regulation[44] and coping skills,[45] limited patience[46] and insight,[47] and significant impulsivity.[48]

18. Mr Amiet was considered a significant risk to himself. His risk of deliberate self-harm, overt suicidal threats and behaviours, and of harm through misadventure was chronically high.[49] In the 12 months prior to his death, he lacerated his own neck in a suicide attempt, sustained a significant injury to his right knee while absconding from IPU1 and was known to bang his head against walls repeatedly in times of perceived frustration or distress.[50] Mr Amiet's suicidality was sometimes impulsive, and at other times, planned;[51] while, acute suicidality could be triggered by drug use, depressed mood, psychosis and not having his needs met.[52]

[39] Input provided by Spectrum (a specialist service for individuals with personality disorders), EACH, local hospital Emergency Departments, Triage and Police.
[40] Exhibit E and Transcript page 92.
[41] Transcript pages 307 (Prodromou) and 363 (Katz).
[42] Transcript page 75 (Tratter).
[43] Transcript page 314.
[44] Transcript page 57.
[45] Transcript page 79.
[46] Transcript pages 79 and 319.
[47] Exhibit L.
[48] Transcript page 319.
[49] Transcript pages 308-309 and Exhibit L. He also posed a high risk to others: Transcript page 56 and Exhibit L.
[50] Exhibit L.
[51] Transcript page 319.
[52] Transcript page 317.

19. Mr Amiet also frequently used threats to harm himself or others instrumentally.[53] Mr Tratter reported that during 'nearly every visit',[54] Mr Amiet would 'pull a knife, or make some sort of threat'[55] in order to 'get his own way'[56] such as demanding a lift to the bottle shop to buy alcohol or to see his drug dealer.[57] In such circumstances, pursuant to the service-wide management plans, firm limits[58] and their consistent application[59] – particularly if conveyed by a staff member with whom Mr Amiet was familiar or had rapport[60] – were sometimes sufficient to diffuse situations.

20. One of the most challenging aspects of Mr Amiet's management was determining when he genuinely required additional support (including inpatient treatment) and when he was 'acting out to get something'[61] given his chronically high risk of self-harm, fluctuating suicidality[62] and impulsivity. Mr Tratter[63] and Dr Prodromou[64] emphasised the importance of mental state examination and risk assessment to clinical decision-making in these situations.

21. In the 12 months prior to his death, Mr Amiet's hospital admission rate increased. Between March 2012 and April 2013, he had 12 psychiatric inpatient admissions, half of which occurred in the two months prior to his death, in addition to three admissions to Maroondah Prevention and Recovery Centre (**PARC**)[65] and two admissions to the Orthopaedic Unit of Maroondah Hospital.[66] Psychiatric admissions were precipitated by threats of suicide or deliberate self-harm, increasing loneliness, inability to cope at home, dysphoric mood and brief psychotic symptoms in the context of illicit drug use.[67]

22. Of concern to MMSTS, was a pattern of psychiatric admission in the context of threats of self-harm made directly to police outside MMSTS' business hours. MMSTS clinicians believed that Mr Amiet was, sometimes at least, using this strategy to

[53] Transcript page 53.
[54] Transcript page 55.
[55] Transcript page 55.
[56] Transcript page 53.
[57] Transcript page 309.
[58] Transcript page 53.
[59] Transcript page 54.
[60] Transcript page 54.
[61] Transcript pages 55 (Tratter) and 317 (Prodromou).
[62] Transcript page 310.
[63] Transcript pages 55-56.
[64] Transcript pages 309-310.
[65] PARC offers community-based, short-term supported residential services for people experiencing a mental health conditions, but who do not need (or no longer require) a hospital admission. Mr Amiet was reportedly 'banned' from PARC in January 2013 following inappropriate behaviour: Exhibit D and Transcript page 77.
[66] Exhibit L.
[67] Ibid.

achieve psychiatric admission – because he was lonely, had run out of food or money, or was 'scared of drug dealers'[68] – when he was unlikely to be assessed by MMSTS as actually meeting the criteria for admission.[69] Such admissions were often accompanied by Mr Amiet absconding from hospital once his 'immediate needs were met'[70] or remaining there until his finances, administered by State Trustees,[71] had accrued so that he could procure illicit drugs upon discharge into the community.[72]

23. Dr Prodromou and Mr Tratter considered that Mr Amiet was becoming increasingly difficult to manage safely in the community. The Consultant Psychiatrist perceived that his condition had been deteriorating for about 12 months.[73] Mr Tratter thought Mr Amiet was 'spiralling out of control'[74] in the six weeks prior to his death as he was 'having multiple [inpatient] admissions, multiple presentations to the [hospital emergency department] ED, the substance use was getting worse … and he wasn't engaging with us … [or the] psychosocial supports … he was such high risk as well'.[75]

24. The Case Manager attributed Mr Amiet's worsening presentation to increased use of methylamphetamine (ice) and the risky behaviours and 'questionable people' with whom drug use brought him in contact.[76] Mr Tratter observed Mr Amiet to be increasingly impulsive 'jumping within seconds' from good decisions, like staying in hospital, to poor ones, such as leaving without permission.[77] He considered 'more containment' was required to mitigate the risks to his wellbeing and it was a 'constant source of frustration'[78] at MMSTS that there was no timeline yet for admission to a Secure Extended Care Unit (SECU)[79] despite Mr Amiet having been referred in November 2011.[80]

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[68] Transcript page 55.
[69] Transcript page 54 and Exhibit L.
[70] Transcript page 95.
[71] Exhibit D.
[72] Exhibit L.
[73] Transcript page 304.
[74] Transcript page 112.
[75] Transcript page 61.
[76] Transcript page 112.
[77] Transcript page 113.
[78] Transcript page 61.
[79] SECU beds provide medium to long-term involuntary inpatient treatment and rehabilitation (in a less clinical environment than a psychiatric unit) for people who have unremitting and severe symptoms of mental illness, who may have difficulty living in the community due to their behaviour, are at high risk of self-harm and have co-morbid acquired brain injury or disability. SECU beds are a regionally allocated scarce resource of the mental health system in Victoria.
[80] Exhibit D.

Admission to IPU2: 31 March 2013 – 1 April 2013

25. On 31 March 2013, Mr Amiet contacted police, threatening to lacerate his own throat in the context of auditory hallucinations. He was transferred to Maroondah ED where his CTO was revoked, and he was admitted to the Low Dependency Unit (**LDU**) of IPU2. On review, Mr Amiet admitted cannabis use the previous day, command hallucinations, vivid dreams and erratic sleep, and that he was lonely at home.[81]

26. At about 1.00am on 1 April 2013, Mr Amiet was noted to be missing from the ward; the On-Call Psychiatrist was notified and an Authority to Apprehend was completed and faxed to Ringwood Police. Mr Amiet returned to IPU2 of his own volition around 3.30am, reporting that he had smoked cannabis while absent without leave (**AWOL**).[82]

27. At 5.00am on 1 April 2013, Mr Amiet was again noted to be missing from the LDU. The police were notified and located him on his way home and returned him to IPU2. At 7.40am, Mr Amiet was reviewed by the On-Call Psychiatrist who found him neither behaviourally disturbed or psychotic, nor showing any evidence of a relapse of Schizoaffective Disorder. He was 'deemed to be drug-seeking and manipulative', discharged home on a CTO and given a taxi voucher.[83]

28. MMSTS visited Mr Amiet at home on 2 April 2013. Mr Amiet was polite and had a friend visiting. His regular oral medications were delivered.[84]

Admission to Upton House: 5 April 2013 – 10 April 2013

29. On the morning of Friday, 5 April 2013, MMSTS conducted a home visit. Mr Amiet reported feeling 'good' that day and that he intended to visit a friend.[85] His mental state appeared stable and no risks were identified at that time.[86] His regular oral medications were delivered.

30. On the night of 5 April 2013, Mr Amiet was admitted under a revoked CTO to Eastern Health's Box Hill Hospital psychiatric inpatient unit, Upton House. Prior to admission, he had made superficial lacerations on his forearm with a butter knife before calling an ambulance.[87] On review, he reported low mood and paranoia, and

[81] Inquest Brief (IB) pages 139-141.
[82] Exhibit L.
[83] Exhibit L.
[84] Exhibit F (Clinical note dated 2 April 2013).
[85] Exhibit F (Clinical note dated 5 April 2013).
[86] Ibid.
[87] IB page 227.

suicidal ideation in the context of cannabis use that day and increasing cannabis use over the previous three weeks.[88]

31. During the admission, Mr Amiet was behaviourally challenging, aggressive and intimidatory to staff and repeatedly banged his head against the wall if his demands were not immediately met.[89] He was placed in the HDU, and on 7 April 2013 absconded after breaking a window.[90] He returned to Upton House 30 minutes later, reporting that he had used heroin while AWOL.[91] At one point during the admission he threaten suicide if he was discharged.[92] Mr Amiet's presentation settled over time and he was discharged home at 10am on 10 April 2013.[93]

32. Mr Tratter conducted a med a home visit on the afternoon of 10 April 2013. Regular medications were delivered. Mr Amiet said he was 'waiting for a mate' and when reminded of a planned home visit by EACH in two days' time, he told Mr Tratter to 'tell them not to bother'.[94]

Presentation to Maroondah ED: midnight on 12 April 2013

33. At about 11.45pm on 11 April 2013, Mr Amiet attended Ringwood police station saying that he wanted to die and threatening to cut his throat. Police used their powers under the MHA to transport him to Maroondah ED for psychiatric assessment. On review, Mr Amiet reported using ice and cannabis earlier that night and was verbally abusive and agitated, with ongoing suicidal ideation but no psychotic symptoms. He refused further examination around 2.45am on 12 April 2013 at which time the clinical impression was that his agitation was likely due to illicit drug use; 'suicidal ideation' and 'high risk' were noted in the medical record.[95]

34. At 3.00am on 12 April 2013, Mr Amiet became threatening and aggressive towards nursing and security staff, and repeatedly banged his head against a wall. A Code Grey[96] was called and when Mr Amiet was non-compliant with verbal instructions to desist, 3mg midazolam[97] was administered intravenously and he was mechanically retrained. By 3.15am, Mr Amiet appeared sedated. He was given supplementary

[88] IB page 226-227
[89] Exhibit L.
[90] IB page 228.
[91] IB pages 228 and 30, and Exhibit L.
[92] Exhibit L.
[93] IB page 30 and Exhibit L.
[94] Exhibit F (Clinical note dated 10 April 2013).
[95] IB page 200.
[96] An Emergency response to aggression in the hospital setting.
[97] Midazolam is a benzodiazepine used for procedural sedation, insomnia, and severe agitation.

oxygen and his vital signs were monitored. Mr Amiet was calm at times but intermittently verbally disruptive and at 4.00am was observed attempting to chew through a wrist restraint.[98]

35. At about 4.30am, when reviewed by the psychiatric triage nurse, Mr Amiet presented as polite and co-operative.[99] The nurse's impression was that Mr Amiet was 'not of high risk' given his denial of further suicidal ideation.[100] He reportedly told the nurse, 'you know I just say that I am going to kill myself, but I actually won't'.[101] When discharged from the ED at 4.40am on 12 April 2013, he was calm, reasonable and agreeable to discharge.[102] Police members gave him a lift home.

Re-presentation to Maroondah ED: 6.25am on 12 April 2013

36. Around 6.15am on 12 April 2013, Mr Amiet reported to police that he had attempted suicide and police and ambulance units were dispatched in response. Sometime after returning home from the ED, Mr Amiet had taken a blind cord and a chair to a nearby park and attempted suicide by hanging.[103] He told attending paramedics that after being suspended by the cord around his neck for a time, he had burnt the cord to release it.[104] Mr Amiet was transported by ambulance to Maroondah ED, with police accompanying the ambulance to hospital.

37. Mr Amiet was somewhat compliant in the ED in the presence of police, though tearful and distressed.[105] The prominent ligature marks on his neck were examined and he was medically cleared of any serious injury.[106] He was persuaded to take a nicotine replacement when he wanted to leave the ED for a cigarette but was non-compliant with requests that he sit on the bed or a chair. He complained of being hungry and that he was 'useless and wanted to die'.[107]

38. On being advised of Mr Amiet's re-presentation to the ED and serious suicide attempt, the psychiatric triage nurse considered that his 'risk profile is now unacceptable'.[108] She contacted the On-Call Consultant Psychiatrist, Dr Cyril Been, who revoked Mr

[98] IB page 200.
[99] IB Page 200.
[100] IB page 200.
[101] IB page 200.
[102] IB page 195.
[103] IB page 187.
[104] IB page 184.
[105] IB page 185 and 187.
[106] IB page 185.
[107] IB page187.
[108] IB page 187.

Amiet's CTO and arranged admission to Upton House. Mr Amiet was transported to Upton House by police, arriving at about 8.30am.[109]

39. MMSTS were notified of Mr Amiet's admission to Upton House at 9.15am, at which time he was being nursed in the HDU due to being 'substance-affected, quite demanding and irritable' but had not yet been seen by the Consultant Psychiatrist.[110] The Upton House Team Leader sought information about possible supports for Mr Amiet should he be discharged over the weekend and was told a 'short admission is more ideal' and that Mr Tratter would be able to provide a thorough handover when he commenced work at midday.[111] Mr Tratter and Mr Amiet's MMSTS Consultant Psychiatrist, Dr Catherine Kariuki, were informed of his admission.

40. At some point while at Upton House, Mr Amiet was transferred from the HDU to the LDU as he was banging his head due to frustration at being 'locked up'.[112] His behaviour settled in the LDU.[113]

41. Around 11.30am, Mr Amiet called MMSTS and asked that Mr Tratter visit him at Upton House because he 'has no cigarettes or food and has not eaten in the last 5 days'.[114] Although initially asking to speak with his Case Manager, Mr Amiet changed his mind, saying that he would 'work something out himself'.[115]

42. A bed became available for Mr Amiet at Maroondah Hospital's IPU1 before Dr Jia Lin Lee had completed admission documents for Upton House and he was transferred.[116]

CIRCUMSTANCES PROXIMATE TO DEATH

43. The clinical management and care Mr Amiet received proximate to his death will be discussed in greater detail below. Suffice for present purposes to say that at around lunchtime on 12 April 2013, Mr Amiet arrived at IPU1 and was admitted to the LDU where he was initially nursed on 30-minutely visual observations.[117]

44. Around 2.50pm on 13 April 2013, Mr Amiet absconded from IPU1.[118]

[109] Exhibit F (Clinical note made on 12 April 2013 at 9.14am).
[110] Ibid.
[111] Exhibit F (Clinical note made on 12 April 2013 at 9.14am).
[112] Exhibit K
[113] Exhibit K.
[114] Ibid.
[115] Ibid.
[116] IB pages 146-154 and Exhibit O.
[117] Exhibit L.
[118] Exhibit L.

45. At about 2.55pm, a Flinders Street to Lilydale train, consisting of six carriages, was travelling north along a straight section of track at about 80 kilometres per hour between the Ringwood East and Croydon railway stations.[119] As the train approached the Eastfield Road overpass, the driver saw a male, later identified as Mr Amiet, emerge from bushes on the western side of the rail corridor some distance ahead and run in an easterly direction across the tracks.[120]

46. The train driver thought the male was taking a short-cut across the tracks, however, the male then turned around, ran back across both tracks and then lay face down on the left-hand rail of the out-bound tracks. The train driver sounded the horn and applied the train's emergency brakes but could not avoid impact. The train driver contacted the Metrol Train Control Centre to report the incident and the emergency services were notified.[121]

47. Attending Ambulance Victoria paramedics confirmed that Mr Amiet was deceased.[122]

48. Constable David Grey of Croydon police station arrived at the scene and commenced the coronial investigation on which this finding is largely based.

49. Rob Sayer, Safety Investigator at Metro Trains Melbourne, attended the collision scene to investigate the incident. Mr Sayer's investigation found that there were no pedestrian crossings in the vicinity of the collision,[123] the train was driven in accordance with prevailing rules and operating procedures[124] and that the train operated, braked and stopped within expected performance limits.[125] The train driver's preliminary breath test was negative for the presence of alcohol.[126]

INVESTIGATION AND SOURCES OF EVIDENCE

50. This finding is based on the totality of the material obtained in the coronial investigation of Mr Amiet's death. That is, the original coronial brief prepared by Const Grey, the inquest brief compiled by Leading Sen/Const Tracey Ramsay from

[119] IB page 12.
[120] IB Page 13.
[121] IB page 13.
[122] IB page 42.
[123] IB page 48.
[124] IB pages 50 and 52.
[125] IB pages 50-51: The train's data logger indicated that the horn was sounded and the emergency brakes were applied almost simultaneously at 2.57pm. When the brakes were applied, the train was travelling at an approximate speed of 73km/p/h. Allowing for a reaction and response time of one-to-two seconds, Mr Sayer estimated that Mr Dennis initially observed Mr Amiet when he was between 292 and 315 metres from the collision point. The total emergency braking distance was recorded as 276 metres, which is 78 metres less than the maximum allowable breaking distance.
[126] IB pages 52 and 42.

the Police Coronial Support Unit **(PCSU)**, the statements, reports and testimony of those witnesses who testified at inquest and any documents tendered through them, and the final submissions of counsel. All of this material, together with the inquest transcript, will remain on the coronial file.[127] In writing this finding, I do not purport to summarise all the material and evidence; rather, I will refer to the evidence only in such detail as is warranted by its forensic significance and the interests of narrative clarity.

PURPOSE OF A CORONIAL INVESTIGATION

51. The purpose of a coronial investigation of a *reportable death*[128] is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which the death occurred.[129] Mr Amiet's death was reportable because of his status as a person placed in custody or care as he was a patient detained in an approved mental health service within the meaning of the MHA 1986 immediately before death.[130]

52. The phrase 'cause of death' refers to the *medical* cause of death, incorporating where possible the mode or mechanism of death.

53. For coronial purposes, the term 'circumstances in which the death occurred' refers to the context or background and surrounding circumstances but is confined to those circumstances sufficiently proximate and causally relevant to the death, and not merely all circumstances which might form part of a narrative culminating in death.[131]

54. The broader purpose of any coronial investigations is to contribute to a reduction in the number of preventable deaths, through the findings of the investigation and the making of recommendations by coroners, generally referred to as the 'prevention role.'[132] Coroners are empowered to report to the Attorney-General in relation to a death; to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and to

[127] From the commencement of the *Coroners Act* 2008 (the Act), that is 1 November 2009, access to documents held by the Coroners Court of Victoria is governed by section 115 of the Act.
[128] The term is exhaustively defined in section 4 of the Act. Apart from a jurisdictional nexus with the State of Victoria (s 4(1)), reportable death includes "a death that appears to have been unexpected, unnatural of violent or to have resulted, directly or indirectly, from an accident or injury" (section 4(2)(a)).
[129] Section 67(1) of the Act.
[130] See section 3 of the Act for the definition of a "person placed in custody of care" and section 4 for the definition of "reportable death", especially section 4(2)(d) and note amendments consequent to the passing of the MHA 2014. The death also falls within section 4(2)(a) being both unnatural and a result of accident or injury.
[131] This is the effect of the authorities – see for example Harmsworth v The State Coroner [1989] VR 989; Clancy v West (Unreported 17/08/1994, Supreme Court of Victoria, Harper J).
[132] The 'prevention' role is now explicitly articulated in the Preamble and purposes of the Act, compared with the *Coroners Act* 1985 where this role was generally accepted as 'implicit'.

make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health and safety or the administration of justice.[133] These are effectively the vehicles by which the Coroner's prevention role can be advanced.[134]

55. It is important to stress that coroners are not empowered to determine the civil or criminal liability arising from the investigation of a reportable death and are specifically prohibited from including in a finding or comment any statement that a person is, or may be, guilty of an offence.[135]

MEDICAL CAUSE OF DEATH

56. Senior Forensic Pathologist Dr Matthew Lynch of the Victorian Institute of Forensic Medicine (**VIFM**), reviewed the circumstances of Mr Amiet's death as reported by police to the coroner,[136] post-mortem computerised tomography (**PMCT**) scanning of the whole body and performed an external examination. Having done so, Dr Lynch provided a four-page written report, dated 7 May 2013.[137]

57. Among Dr Lynch's anatomical findings were abrasions over the neck, and abrasions and a penetrating injury to the abdomen. PMCT scans revealed fractures of the left twelfth rib, fracture dislocation with significant displacement at the second lumbar vertebra, and intra-abdominal haemorrhage.[138]

58. Routine toxicological analysis of post-mortem specimens detected olanzapine (~0.06mg/L),[139] zuclopenthixol (~50ng/ml),[140] diazepam (~0.1mg/L) and its metabolite,[141] mirtazapine (~0.02mg/L),[142] carbamazepine (~5mg/L),[143] codeine (~0.04mg/L)[144] and paracetamol (~8mg/L).[145] No alcohol or other commonly

[133] See sections 72(1), 67(3) and 72(2) of the Act regarding reports, comments and recommendations respectively.
[134] See also sections 73(1) and 72(5) of the Act which require publication of coronial findings, comments and recommendations and responses respectively; section 72(3) and (4) which oblige the recipient of a coronial recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation.
[135] Section 69(1) of the Act. However, a coroner may include a statement relating to a notification to the Director of Public Prosecutions if the coroner believes an indictable offence may have been committed in connection with the death. See section 69(2) and 49(1) of the Act.
[136] Police Report of Death to the Coroner (Police Form 83) prepared by Constable David Grey on 13 April 2013.
[137] Dr Lynch's autopsy report is at IB pages 1-4 and includes his formal qualifications and experience.
[138] Ibid.
[139] Olanzapine, marketed in Australia as Zyprexa, is used in the treatment of schizophrenia and related psychoses, and can also be used as a mood stabiliser.
[140] Zuclopenthixol is a antipsychotic medication used in the initial treatment of acute psychosis or exacerbation of psychosis associated with schizophrenia.
[141] Diazepam is a sedative of the benzodiazepine class.
[142] Mirtazapine is an antidepressant.
[143] Carbamazepine is an anti-convulsant used in the treatment of epilepsy, some forms of neuralgia and schizophrenia.
[144] Codeine is a narcotic analgesic.

encountered drugs or poisons were detected.[146] Toxicology results were consistent with Mr Amiet's medication regime.[147]

59. Dr Lynch concluded that it was reasonable to attribute the cause of Mr Amiet's death to injuries sustained when struck by a train, without the need for an autopsy.

60. I accept the cause of death proposed by Dr Lynch and find that the cause of Mr Amiet's death is injuries sustained when struck by a train.

IDENTITY & NON-CONTENTIOUS FINDINGS AS TO CIRCUMSTANCES

61. Mr Amiet's identity was not in issue. On 14 April 2013, Elise Amiet visually identified the deceased's body as being that of her son Damon Brenden Amiet, born 19 July 1987, and completed a Statement of Identification.[148]

62. Nor was there any contention around the date and place where Mr Amiet died. Accordingly, I find, as a matter of formality, that Mr Amiet died near East Ringwood Railway Station, Ringwood East, Victoria 3135, on 13 April 2013.

FOCUS OF THE CORONIAL INVESTIGATION

63. As is often the case in this jurisdiction, the focus of the coronial investigation and inquest into Mr Amiet's death was on aspects of the circumstances in which the death occurred.

64. The focus of the inquest was the adequacy clinical management and care provided to Mr Amiet whilst an inpatient of the IPU1 on 12-13 April2013, and in particular:

(a) The quality of risk assessments conducted by clinical staff;

(b) The level of therapeutic support and engagement;

(c) Compliance with relevant Eastern Health guidelines.

I have endeavoured as far as possible to identify the evidence relevant to each issue under the appropriate heading in the paragraphs that follow.

CLINICAL MANAGEMENT & CARE IN IPU1: 12-13 April 2013

65. Two Eastern Health policies were central to understanding Mr Amiet's clinical management and care provided to Mr Amiet during his last admission to IPU1 and assessing its adequacy. Those policies were the Mental Health Program Clinical Risk

[145] Paracetamol is an analgesic drug.
[146] IB pages 5-11 (Toxicologist's report).
[147] Save for the absence of Benztropine, an anticholinergic used to decrease muscle stiffness, sweating, and the production of saliva: see Exhibit L.
[148] Statement of Identification (reference 1584/13) dated 14 April 2013.

Assessment and Management Practice Guideline[149] (**Risk Guideline**) and the Therapeutic Support and Engagement for IPU Clients[150] policy (**Observation Guideline**).

Risk Guideline

66. The Risk Guideline was developed assist Eastern Health clinicians when conducting risk assessments and managing a patient's identified risk factors, in order to promote the most appropriate level of safety for him/her and others.[151] It defines key terms, enumerates guiding principles for risk assessment and mitigation planning, establishes a 'collaborative' risk assessment and mitigation process and sets standards for the documentation of risk assessments and rationale for risk management interventions.[152]

67. In short, to ensure that current and reasonably foreseeable risks and the contexts that trigger or exacerbate them are identified, risk management is undertaken collaboratively and risk management interventions are congruent with the risks identified.

Observation Guideline

68. The Observation Guideline explicitly links the level of psychological support, therapeutic engagement and visual observation of patients to risk assessment.[153] The purpose of the Observation Guideline is to set a minimum standard for staff when monitoring and supporting psychiatric inpatients to ensure their safety and wellbeing; it also sets standards for documentation of these clinical decisions.[154] Three levels of support and monitoring are delineated, from the least intrusive, Level 1 'General', through Level 2 'Intermittent', to the most intrusive, Level 3 'Intensive' support and monitoring.[155]

69. Relevantly, Level 2 observation is designed for individuals 'who are potentially, but not immediately, at risk of harming themselves or others, or alternatively, are vulnerable and at risk of harm from others'.[156] The frequency of intermittent

[149] IB pages 291-306. The Risk Guideline was developed in April 2008, reviewed in July 2013 and due to be reviewed again in July 2015.
[150] IB pages 307-311. The Observation Guideline was developed in July 2012, reviewed in August 2012 and due to be reviewed again in July 2014.
[151] IB page 291.
[152] See particularly, IB pages 291-295.
[153] IB page 307.
[154] Ibid.
[155] IB page 308.
[156] IB page 309.

observation can be fixed as clinically indicated, for instance, 15-minutely or 30-minutely.

70. The purpose of intensive support and monitoring is to ensure active monitoring of a patient's behaviour and mental state, enabling rapid response to any change while fostering positive therapeutic relationships.[157] Level 3 observation is appropriate for individuals who 'may or may not have recovery goals and are unable to work towards them due to the level of psychological disturbance; and are considered to pose high risk of harm to themselves or others; and/or are likely to leave the ward without prior permission'.[158]

71. There are two types of intensive support and monitoring: specialling, which requires continuous observation of the patient with a clinical staff member within arm's length at all times; and continuous observation, where the patient must be visible at all times.[159] Level 3 observation 'will be considered for patients who are extremely impulsive at the highest risk of suicide, self-harm or harm to others'.[160] Continuous observation is routinely used before a patient is allocated a "special" and the clinical rationale for Level 3 observation must take into account the potential risks to staff safety attendant upon intrusive observation.[161]

72. The Observation Guideline requires a level of observation to be set for each patient upon admission and, thereafter, reviewed daily at a minimum. The supervising RN may increase a patient's level of observation in consultation with the ANUM, 'with corresponding documentation and risk assessment,' but reduction of the level of observation must be discussed with the Consultant Psychiatrist.[162]

Assessment on Admission to IPU1: 12 April 2013

73. The IPU1's Medical Officer (**MO**), Dr Mithira Nithianandan, completed Mr Amiet's admission documents and a mental state examination shortly after his arrival on the ward on 12 April 2013.[163] Before meeting him – for the first time[164] – the MO reviewed the CRP, including previous discharge summaries and the ED notes.[165]

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[157] IB page 309.
[158] IB page 309.
[159] Ibid.
[160] Ibid.
[161] Ibid.
[162] IB page 310.
[163] Exhibit J. I note that Mr Amiet's time of arrival at IPU1 on 12 April 2013 is unclear from the available materials: Exhibit F suggests he was still at Upton House in the HDU around 11.30am though a LDU Clinical and Risk Assessment appeared to have been completed by RN Leggett at 10am (IB page 157). I note that independent expert Associate Professor Harvey was critical of this document on the grounds it (a) failed to account Mr Amiet's historical

74. Dr Nithianandan noted that Mr Amiet was 'very dishevelled', appeared 'sedated' and mildly anxious, with poor eye-contact, minimal engagement, 'slightly slurred' speech and underlying irritability.[166] He was 'vague' and unable to give a clear account of what precipitated his admission, becoming increasingly agitated on questioning,[167] saying, 'I can't remember' and 'I told people what happened already'.[168] Though his answers were 'making sense', the MO's impression was that he was 'mildly thought disordered' because he 'wasn't answering questions directly'.[169]

75. Mr Amiet was not specifically responding to internal stimuli but answered, 'I don't know … maybe' to questions about experiencing psychotic symptoms such as hallucinations.[170] As he was reluctant to answer these questions, Dr Nithianandan could not rule out psychotic relapse and so formulated her clinical impression as 'possible psychotic relapse in the context of methylamphetamine use and personality traits'.[171]

76. Although Mr Amiet reported ongoing suicidal ideation, he denied any suicidal intent or plan.[172] He was unable to identify any suicide stressors and seemed preoccupied with the need to enter drug rehabilitation.[173] He told the MO he felt 'safe on the ward' and would remain in hospital[174] but terminated the assessment early, saying that he felt 'claustrophobic' in the interview room.[175]

77. Dr Nithianandan completed a LDU Clinical and Risk Assessment at 2.20pm.[176] She noted that Mr Amiet was 'mildly sedated' and 'behaviourally settled'.[177] The MO

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and recent risks of absconding, (b) assigned 30-minutely observations, contrary to the relevant policy, (c) failure to comment on the MMSTS recommendation that 'HDU be considered' and (d) contrary to the relevant policy, did not appear to have been discussed with or counter-signed by another clinician (Exhibit S). I note, too, that Associate Professor Katz, Executive Clinical Director of Eastern Health's Mental Health Program conceded those criticisms (Exhibit O).

[164] Transcript page 236.
[165] Transcript page 238.
[166] IB pages 215 and 219.
[167] Transcript page 239.
[168] IB page 215.
[169] Transcript age 238 and Exhibit J.
[170] Transcript page 240.
[171] Transcript page 240 and IB page 217.
[172] Transcript page 239 and IB page 215.
[173] IB page 215.
[174] IB page 215 and Transcript page 239.
[175] Ibid.
[176] IB page 157. The form requires clinicians to assess the presence or absence of 'past history' and current degree of risk (low, medium or high) across 17 domains (suicide/self-harm; aggression/harm to others; absconding/wandering; sexual risk; withdrawal/isolation; poor self-care; fire risk; level of sedation; agitation/hostility; substance use/abuse; disorganisation; poor engagement/guarded; impulsivity; non-adherence to treatment; property destruction; family/visitors; other) and the presence or absence of past and current medical comorbidities.
[177] IB page 157.

noted only two historical risks, suicide/self-harm and substance use/abuse[178] and did not rate any current risk as being high.[179] Of particular relevance is Dr Nithianandan's assessment of Mr Amiet as being at low risk of suicide/self-harm (though noting his impulsivity), aggression/harm to others, absconding and poor engagement or being guarded; among the medium risks noted were his level of sedation, agitation/hostility, disorganisation and impulsivity.[180]

78. At inquest, Dr Nithanandan explained the rationale for her assessment of Mr Amiet's risks. She acknowledged that risk is a fluid concept and that risk assessment is cross-sectional in the sense that it represents an assessment of the patient's static[181] and dynamic[182] risk factors at a particular point in time.[183] Notwithstanding Mr Amiet's Cluster B traits, such as chronic suicidality, impulsivity and irritability, she had to take his denial of suicidal intention or plan 'at face value'[184] and was reassured sufficiently to assess his risk of suicide/self-harm as low by this and his help-seeking conduct after attempting suicide, his willingness to remain on the ward and the fact of his containment in IPU1.[185] Dr Nithanandan recognised that fluctuation of that and other risks was 'unpredictable' and dynamic risk factors could change over time due to external factors.[186]

79. Dr Nithanandan's risk management plan involved monitoring Mr Amiet's suicidal ideation, self-care and agitation, including with administration of as needed medications, and performing Level 2, 30-minutely visual observation of him in the LDU.[187] She anticipated that Mr Amiet's admission would be short, noting review by MMSTS on 15 April 2013.[188]

80. Sometime that afternoon, Mr Amiet telephoned his mother and spoke to her for about 45 minutes.[189] Although he disclosed that he was speaking to her from hospital, he did not mention that he had attempted suicide.[190] Ms Amiet recalled that her son 'just talked about this girl' he had met on the ward, and that he was 'going to live with this

[178] Ibid.
[179] IB page 157.
[180] IB page 157.
[181] For instance, factors like diagnosed mental health conditions, the presence of cognitive disability and history of suicide attempts: Transcript page 245.
[182] Such as presence or absence of suicidal ideation, suicidal intent or plan, and observed irritability.
[183] Transcript pages 241 and 245.
[184] Transcript page 241.
[185] Transcript page 244.
[186] Transcript page 241.
[187] IB page 157.
[188] IB page 217.
[189] Transcript page 17.
[190] Transcript page 18.

girl, and everything's going to be great'.[191] She was 'stunned',[192] because he sounded 'so happy, and had been … so depressed recently'.[193]

81. Nursing notes for the remainder of 12 April 2013 indicate a reduction of Mr Amiet's irritability and the absence of behavioural issues.[194] During the afternoon shift he was 'settled,' 'socialising well' and denying perceptual disturbance.[195] He told staff that he 'has a girlfriend on the ward'.[196] Mr Amiet was asleep at the start of the nightshift, waking at midnight and wanting to be allowed out for a cigarette. The nurse said he could go out if he took his nightly medication, but he refused, becoming irritated.[197] Security staff were called.[198] Mr Amiet agreed to take his medication, and when he had done so was escorted by security staff to have a cigarette. He returned to bed afterwards and was asleep at the change of shift.[199]

Morning Shift 13 April 2013

82. Associate Nurse Unit Manager (**ANUM**) Balwant Singh was the morning shift leader, with responsibility for delegation of nursing responsibilities and overseeing staff and patient safety and welfare in IPU1 between 7am and about 2.45pm on 13 April 2013.[200] During the verbal handover from the previous shift, ANUM Singh was told that Mr Amiet, whom he knew well from previous admissions, had had an 'uneventful night'.[201] The IPU1 was locked.[202]

83. The ANUM supervised six staff that shift; the LDU was at capacity with about 20 patients, and there were no patients in the HDU.[203]

84. Primary responsibility for Mr Amiet's care during the morning shift, and that of three other patients, was allocated to Registered Nurse (**RN**) Tammy Lees.[204] RN Lees received a verbal handover about Mr Amiet from the ANUM (though at inquest five years later she could not remember its content),[205] and in keeping with her usual

[191] Transcript page 17.
[192] Transcript page 18.
[193] Transcript page 18.
[194] IB Pages 106-107.
[195] IB page 106.
[196] Ibid.
[197] IB page 106.
[198] Ibid.
[199] Ibid.
[200] The morning shift hours are 7am until 3.30pm, however start and ends with verbal handover of information about each patient to the incoming shift.
[201] Exhibit K.
[202] Transcript page 261 and Exhibit I.
[203] Transcript page 172.
[204] Exhibit G.
[205] Transcript page 117.

practice would 'flick through' progress notes from the previous shifts 'quite quickly' and then 'physically eyeball' her patients.[206] RN Lees had not previously nursed Mr Amiet as a psychiatric inpatient.[207]

85. When she came on the ward, Mr Amiet was asleep. He woke at about 7.50am and approached RN Lees, 'visibly distressed', and complaining of pain in his arm and requesting analgesia.[208] Due to 'obvious signs of agitation',[209] RN Lees dispensed 10mg olanzapine, one of Mr Amiet's as needed medications to manage agitation, along with Panadeine Forte as analgesia.[210] When Mr Amiet refused the medications she sought the assistance of ANUM Singh, and with some encouragement from him, Mr Amiet took the analgesia but refused Olanzapine, throwing the medication cup on the ground.[211]

86. A short time later, Mr Amiet approached RN Lees asking to be discharged from IPU1. She notified the ANUM who, in turn, contacted the On-Call Consultant Psychiatrist.[212] RN Lees continued to have frequent contact with Mr Amiet throughout the morning and recorded visual half-hourly observations on an LDU Functional and Visual Observations form.[213]

Visit by MMSTS' Mr Tratter

87. At about 9.20am, Mr Tratter visited Mr Amiet in the IPU1. At the time, Mr Amiet was smoking in the LDU's walled courtyard; he appeared dishevelled and had significant red abrasions around his neck.[214] Although it was not his role to perform a formal mental state assessment given Mr Amiet was an inpatient,[215] Mr Tratter was struck by Mr Amiet's 'upbeat' mood and that 'there was a calmness about him as well'.[216] The Case Manager considered Mr Amiet to have 'delusional ideas'[217] about a female co-patient whom he hoped would move in with him after he was discharged from the unit, despite having only met her recently.[218]

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[206] Transcript page 116.
[207] Transcript page 136 (though RN Lees had applied a dressing to Mr Amiet's back during a previous admission).
[208] Exhibit G.
[209] Exhibit G and Transcript page 117 (Lees) and 282 (Singh, who did not dispute RN Lees' account of Mr Amiet's refusal of some medications, though he had no independent recollection of the medication cup being thrown).
[210] Panadeine Forte is a codeine and paracetamol analgesic.
[211] Transcript page 117.
[212] Exhibit G.
[213] IB Page 158.
[214] Exhibit C and Transcript page 65.
[215] Transcript page 65.
[216] Transcript page 65.
[217] Exhibit C and Transcript page 65.
[218] Exhibit C and Transcript page 67.

88. Mr Tratter recalled being asked by ANUM Singh whether he thought Mr Amiet should be discharged in the context of him seeking discharge. Mr Tratter said that it was his clinical opinion that Mr Amiet should remain in the IPU1 because of his 'high risk of suicide given the recent serious hanging attempt';[219] he also had an 'intuitive feeling that things had gotten worse for him'.[220] The Case Manager referred ANUM Singh to MMSTS Consultant Psychiatrist Dr Kariuki's weekend plan.[221] The plan made a number of suggestions to guide Mr Amiet's management in the IPU1 including that he be assessed by a Psychiatric Registrar, in consultation with the On-Call Consultant Psychiatrist, if he asked to leave the ward over the weekend.[222]

89. For his part, when giving evidence at inquest, ANUM Singh had no recollection of any discussion with Mr Tratter nor of the weekend plan,[223] though in the statement prepared a month after Mr Amiet's death he referred to the discharge procedure 'drawn up by the treating [MMSTS] Consultant'.[224]

Review by Dr Been

90. At 10am, On-Call Consultant Psychiatrist Dr Been – who had never met Mr Amiet before[225] – attended IPU1 to review Mr Amiet as a new admission and because he had requested discharge.[226] The review occurred in the presence of Psychiatric Registrar Dr Zara Zia and RN Lees. Mr Amiet was noted to be 'slightly restless' at the start of the interview but 'settled during it'.[227] He denied current suicidal ideation, referring to his attempted hanging as 'stupid' and 'impulsive'.[228] He reported being 'tortured' by a co-patient (who was not on the ward) and also that he had 'found [his] soulmate' in IPU1 and wanted to pursue a relationship with her because he felt 'lonely at home'.[229]

91. Mr Amiet became 'frustrated' when asked about his medication regime.[230] He asked to end the interview after about ten minutes, saying that he wanted to stay on the ward.[231] No overt psychotic symptoms[232] or disturbed behaviour[233] were observed

[219] Exhibit C.
[220] Transcript page 66.
[221] Transcript page 67.
[222] IB page 93.
[223] Transcript page 255.
[224] Exhibit K.
[225] Transcript pages 216-217.
[226] Exhibit I and Transcript page 214.
[227] IB page 108.
[228] IB page 107.
[229] IB page 107.
[230] IB Page 108.
[231] IB page 108.
[232] Transcript page 232.
[233] Transcript page 232.

during the 'brief' interview.[234] At inquest, Dr Been stated that they performed 'as much [of a mental state assessment] as we were able to'[235] and it would only be in 'exceptional circumstances' that a patient would be prevented from leaving an 'interim' assessment.[236]

92. Dr Been's plan was that if Mr Amiet sought discharge over the weekend, he would have to wait to until review by MMSTS on 15 April 2013.[237] He also made a note that staff should consider moving either Mr Amiet or the female co-client to IPU2, or to ensure she is in the 'gender sensitive area' of the ward.[238] Dr Been told ANUM Singh that Mr Amiet would not be discharged before 15 April 2013 and that he was 'not suicidal and was guaranteeing his safety'.[239]

Mr Amiet Absconds & is Returned to IPU1

93. Sometime after Dr Been's review was terminated, RN Lees observed Mr Amiet in the courtyard, smoking.[240] About ten minutes later, he approached the nurses' station, appearing agitated and asked to be discharged.[241] After discussing the request with the doctor,[242] RN Lees told Mr Amiet that he would not be discharged before 15 April 2013. His agitation escalated immediately, and he hit his head on the window of the nurses' station before running out to the courtyard.[243] RN Lees decided to give Mr Amiet 'some space' in which to process the discharge refusal and perhaps moderate his behaviour.[244]

94. At 10.30am, RN Lees went to look for Mr Amiet but he was missing from IPU1.[245] The RN Lees informed ANUM Singh, who in turn notified Dr Been.[246] The On-Call Consultant Psychiatrist completed Authority to Apprehend paperwork while RN Lees completed Missing Person and Risk Assessment forms,[247] which were forwarded to Victoria Police in accordance with usual practice.

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[234] IB page 108.
[235] Transcript page 220.
[236] Transcript page 215.
[237] IB page 109.
[238] IB page 109.
[239] Exhibit K and Transcript page 256.
[240] IB page 158.
[241] Exhibit G. I note that RN Lees's shift progress note suggests that the female co-patient with whom Mr Amiet was infatuated had told him, around 10am, that she would not move in with him: IB page 110.
[242] It is not clear to whom RN Lees spoke.
[243] Exhibit G and Transcript page 120.
[244] Ibid.
[245] Exhibit G.
[246] Exhibit I.
[247] IB pages 88-92.

95. Mr Amiet was located at his home by Victoria Police members at about 12.50pm and was returned by them to the IPU1, arriving around 1.15pm.[248]

96. ANUM Singh spoke to Mr Amiet briefly upon his return.[249] He appeared to have been cooperative with police – having not been handcuffed[250] – and was 'quite relaxed', 'cool and calm'.[251] Mr Amiet reportedly told the ANUM that he would remain on the ward, 'guaranteed' his safety and said he 'just wanted to go to [his] room and relax'.[252] He was taken at his word because he 'seemed good'[253] and 'settled'.[254] ANUM Singh encouraged Mr Amiet to approach him if he had any concerns.[255]

97. At about 1.30pm, RN Lees returned to the ward after her lunchbreak.[256]

98. ANUM Singh considered whether to place Mr Amiet in the HDU when he returned to the ward after absconding. Ultimately, he did not consider transfer warranted for several reasons: Mr Amiet had guaranteed his safety; there were no other patients in the HDU and so the environment would have been isolating; he was aware that Mr Amiet had intentionally banged his head while in Upton House's HDU the previous day; Mr Amiet had a history of absconding and voluntarily returning; and because the door from IPU1's HDU courtyard was 'easily pushed open' and awaiting rectification.[257]

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[248] IB page 158.
[249] Transcript page 258; ANUM Singh referred to the interaction as 'minimal conversation'.
[250] Transcript page 283.
[251] Transcript page 258.
[252] Exhibit K and Transcript page 258.
[253] Transcript page 258.
[254] Transcript page 266.
[255] Ibid.
[256] Exhibit G.
[257] Exhibit K. ANUM Singh did not consider that HDU was clinically indicated, as M Amiet was 'settled', and so the IPU1 HDU courtyard door was not a significant factor in his decision that Mr Amiet remain in the LDU: Transcript page 264. Bruce Leslie, Director of Infrastructure Services (**IS**) at Eastern Health, provided a statement (Exhibit N) and testified at inquest (Transcript pages 324-348) about the HDU door and its rectification. The door in question was a single door from IPU1's HDU to its courtyard and as such was also a fire exit: Transcript pages 335 and 337. The door had a mechanical lock opened with a key and was electronically controlled by the hospital's security system: Transcript pages 328-329. The security system is wired to allow the door to be unlocked electronically in the event of a fire: Transcript age 337. The door was secured by a single 'strike' (latch) but flexibility of the door frame meant that application of force allowed the latch to slide free, allowing the door to open: Transcript page 329. According to the relevant Eastern Health policy, "Priority 1" maintenance (work that has an immediate effect on patient/staff/visitor safety) requires a response time (period in which 'initial action', such a telephone call about the work) of 30-60 minutes: Exhibit N. It's not clear when IS first learned of the problem with the HDU door, but a Work Order to assess/rectify the door was created on 17 March 2013, marked "Priority 3", for action within 7 days (to attend, not necessarily complete works in that period): IB page 335.7 and Transcript page 341. A quotation was received by 25 March 2013: Transcript page 342. A capital expenditure request was made on 25 March 2013 and finance approved on 28 March 2013: Transcript pages 339-340. Rectification works were required to comply with Department of Human Services risk management policies applicable to public hospitals and so specialist contractors were engaged to complete some of the works: Transcript page 336-338. The door was rectified, by the addition of two strikes and a key switch, on 27 May 2013: Transcript pages 331 and 344. Mr Leslie testified that 'we could have done better,' in terms of timely completion of the works after the point when the quote was obtained: Transcript page 347.

99. While RN Lees' statement suggests that she was involved in the decision not to transfer Mr Amiet to the HDU,[258] at inquest, neither she nor ANUM Singh had any recollection that this occurred.[259] There does not appear to have been any consideration of increasing the frequency of visual observations of Mr Amiet at this time.

100. When RN Lees attended upon Mr Amiet who was in his room, lying on the bed, he was not receptive to her attempts to engage him therapeutically.[260] Mr Amiet did ask to be seen by a doctor because he had hurt his leg when 'jumping … [IPU1's] perimeter wall'[261] and his head hurt due to banging it on the window of the nurses' station that morning. He also reported that while he was at home he had 'injected water into one of his arms' and drank some alcohol.[262] RN Lees left Mr Amiet's room to ask the ANUM to arrange for the doctor to review him. ANUM Singh contacted Dr Been who suggested that Dr Zia be asked to review Mr Amiet[263] and Dr Zia was called.[264]

RN Lees' Clinical and Risk Assessment

101. At 1.45pm, RN Lees completed an LDU Clinical and Risk Assessment form.[265] She noted among Mr Amiet's observed behaviours that he had been 'aggressive, irritable [and] AWOL'd today'. At inquest, she testified that she should have added that there were 'periods of being settled'.[266]

102. RN Lees noted Mr Amiet's prior history of suicide/self-harm, aggression/harm to others, absconding, impulsivity, non-adherence to treatment and property destruction.[267] She assessed nine of 16 risk types as being currently high – suicide/self-harm, aggression/harm to others, absconding, agitation/hostility, substance use/abuse, disorganisation, impulsivity, non-adherence to treatment and property destruction – though made a notation against most of these as being 'secondary to M/S [mental state]'.[268] RN Lees rated Mr Amiet's risks of poor engagement and poor self-care as medium.[269]

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[258] Exhibit G.
[259] Transcript pages 120 (Lees) and 283 (Singh).
[260] Exhibit G.
[261] Exhibit G.
[262] Exhibit G.
[263] Exhibit I.
[264] Exhibit K.
[265] IB page 155 and Transcript page 122.
[266] Transcript page 123.
[267] IB page 155.
[268] IB page 155. There is a degree of incongruity between the function of a risk assessment as a snapshot of a patient's clinical presentation and RN Lees' use of qualifying notations 'secondary to mental state': it is difficult to understand the role of the modifying phrase (the "high risk" box having been ticked), and some concern that another clinician viewing the risk assessment could divine her intention. I note Professor Harvey's evidence that he disagrees that the

103. Although RN Lees testified that she understood risk assessments to reflect a 'moment in time',[270] she documented risks 'that could happen, not that [Mr Amiet] was actually showing [a risk] … at that time'.[271] She considered him to be 'at high risk of escalating,'[272] 'in a matter of moments,'[273] 'secondary to his mental state'.[274] Her risk assessment was the product of multiple interactions with Mr Amiet during the shift.[275]

104. At inquest, RN Lees agreed that Mr Amiet met the first criterion for Level 3 observation;[276] as noted above, she rated as high his risks of self-harm/suicide and absconding. Nonetheless, her management plan to address the risks she had identified consisted of monitoring Mr Amiet's whereabouts given that he had absconded, provide 'clear succinct boundaries' and administer as needed medications as required.[277] RN Lees noted that he was to remain in the LDU on Level 2, 30-minutely observations.[278] In short, there was no appreciable change to the management plan established by Dr Nithianandan on admission (when risks were assessed quite differently) and no documented rationale for this clinical decision either on the risk assessment form or in Mr Amiet's progress notes.

105. RN Lees agreed that she did not recall consulting with another clinician while completing the risk assessment, nor was the form countersigned, pursuant to the Risk Guideline. She conceded that it was 'normal practice' to do these things but testified that she had discussed Mr Amiet 'many times' with the ANUM and doctors and attributed the lack of a second clinician's signature to the 'very busy shift'.[279]

106. I note ANUM Singh's evidence that he did not see RN Lees' risk assessment prior to the inquest.[280] Although his impression of Mr Amiet that day was that he was 'very settled',[281] the ANUM would have wanted RN Lees to share with him her assessment that Mr Amiet posed several high risks.[282] If she had done so, and his evidence was

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modifier should be interpreted to mean that Mr Amiet was high risk of suicide if his mental [state] deteriorates: Transcript page 455.
[269] IB page 155.
[270] Transcript page 159.
[271] Transcript page 178
[272] Transcript page 177.
[273] Transcript page 123.
[274] Transcript page 178.
[275] Transcript page 180.
[276] Transcript page 143.
[277] IB page 155.
[278] Transcript page 143.
[279] Transcript page 130.
[280] Transcript page 267.
[281] Transcript page 269. ANUM Singh would have made more qualifying notations on the LDU Clinical and Risk Assessment form: Transcript page 270.
[282] Transcript page 269.

that she had not, ANUM Singh would have discussed her concerns about Mr Amiet's risks and whether his visual observations should be increased and/or if he should be transferred to the HDU.[283] ANUM Singh's evidence is somewhat at odds with that of RN Lees who believed that she had discussed Mr Amiet's observation level with the ANUM a 'couple of times' during the shift.[284]

107. RN Lees was closely questioned at inquest about the content of her risk assessment and its relationship to Mr Amiet's level of observation.[285] She was aware of the Observation Guideline[286] but appeared to consider its terms through the lens of the "least restrictive intervention" principle established by soon to be enacted *Mental Health Act* 2014.[287]

108. RN Lees testified that 30-minutely observation was the 'most realistic on the LDU'[288] – though she was seeing Mr Amiet more frequently than that[289] – and she had discussed this with ANUM 'at that time' and they had agreed that Level 2, 30-minutely observation were suitable.[290] She did not consider that Mr Amiet required specialling[291] and thought transfer to the HDU could have caused him distress.[292] RN Lees stated that she did not believe she, alone, had authority to increase a patient's level of observation or transfer a patient to the HDU.[293]

109. Unfortunately, neither RN Lees nor any other clinical witness was asked at inquest whether constant visual observation was considered given Mr Amiet's history of absconding and his absconding earlier that day.

110. When specifically asked whether she formed the view at any time that Mr Amiet needed Level 3 monitoring, RN Lees said she was 'unsure' about the level of monitoring he required, and this was why she had discussed the issue with the ANUM

[283] Transcript page 270.
[284] Transcript page 146.
[285] I note that this questioning failed to clarify when (or whether) escalation of Mr Amiet's level of observation was considered and why.
[286] Transcript page 139.
[287] Transcript page 140.
[288] Transcript page 129.
[289] Transcript page 144.
[290] Transcript page 143.
[291] Transcript page 145. RN Lees' view about specialling was perhaps based on Mr Amiet's increased irritation at her presence in the period 2.15-2.40pm rather than coinciding with RN Lees' 1.45pm risk assessment: Transcript page 128.
[292] Transcript page 146.
[293] Transcript page 156.

and arranged for a medical review.[294] She stated that Mr Amiet 'didn't appear to fit' the criteria for Level 3 observation 'more than other clients'.[295]

Change of Shift

111. Around 1.30pm, the IPU1 afternoon shift nurses commenced work.[296] A verbal handover occurred, with the afternoon shift ANUM, Kelevi Bai, arriving on the ward around 2.30pm before formal responsibility for the ward transferred to him at 2.45pm. Accordingly, during the change of shift there were as many as 13 nurses in IPU1.[297]

112. RN Lees observed Mr Amiet walking in a corridor of IPU1 around 2pm, and again at 2.30pm.[298]

113. At about 2.30pm, during the change of shift nursing round, ANUM Bai saw Mr Amiet talking on one of the patients' phones located opposite the nurses station. He was not loud and did not appear to be distressed or agitated.[299] By the end of the round about ten minutes later, Mr Amiet had ended his phone call and approached ANUM Bai to complain that the phone was not working properly.[300] He was swearing and shaking the handset, demanding that it be fixed immediately.[301] ANUM Bai described Mr Amiet as exhibiting a 'low level of agitation',[302] and suggested he use the other phone to make a call. Mr Amiet reiterated his demand and ANUM Bai repeated his suggestion, also informing Mr Amiet that the doctor would review him shortly.[303]

114. Mr Amiet followed ANUM Bai to the medication room and appeared increasingly agitated and irritable.[304] Mr Amiet kicked the medication room door and then walked away. ANUM Bai told Mr Amiet that his behaviour was unacceptable, to which he responded, 'Well, you should've fixed the f….. phone' in a loud, angry tone.[305] Mr Amiet then appeared to settl, walked down a corridor and into an interview room and activated a duress alarm.

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[294] Transcript page 144.
[295] Transcript page 129.
[296] Exhibit H.
[297] Transcript page 205.
[298] IB page 156.
[299] Exhibit H.
[300] Exhibit H.
[301] Exhibit H.
[302] Transcript page 204.
[303] Exhibit H.
[304] Exhibit H.
[305] Ibid.

115. When staff responded to the duress alarm, they saw Mr Amiet walking out of the interview room 'calm and behaviourally settled'.[306] When he was asked what had happened, he responded, 'Nothing happened'.[307] Mr Amiet then walked out to the courtyard, lit a cigarette and socialised with other patients.[308]

116. Some time prior to 2.40pm,[309] RN Lees attended upon Mr Amiet who was in his room, lying down. She had returned with the equipment necessary to take vital observations and breathalyse him so that the results would be available to Dr Zia when she arrived to review him. Despite encouragement to comply, Mr Amiet refused to be examined, became irritated, and told RN Lees to leave his room.[310] She last saw Mr Amiet in his room at 2.40pm.[311]

117. Around this time, ANUM Singh asked RN Lees about Mr Amiet and she told him that he was in his room, lying down.[312]

118. At about 2.45pm,[313] RN Lees was in an interview room writing progress notes for each of the four patients for whom she had primary responsibility.[314] She timed Mr Amiet's progress note at 3pm and in it documented his irritability, verbal aggression, uncooperativeness (demanding staff time and then refusing assistance), refusal of medication, request for discharge and psychiatric review, his infatuation with a co-patient, AWOL and return, refusal to be physically examined in relation to injuries, the pending review by Dr Zia, and her completion of a risk assessment.[315] An addendum to that note records that Mr Amiet 'was not suicidal' prior to his AWOL but that after his return, he 'expressed that he had "nothing to live for", and that he did not respond well to one-on-one time.[316]

119. RN Lees could not recall at what point Mr Amiet had told her that he had "nothing to live for".[317] Although it was not uncommon for patients to make such statements,[318] it was of sufficient clinical importance for the comment to be noted.[319] RN Lees did not

[306] Exhibit H.
[307] Ibid.
[308] Ibid.
[309] Transcript page 151.
[310] Exhibit G.
[311] Transcript page 171.
[312] Exhibit K.
[313] Transcript page 172.
[314] Transcript page 169.
[315] IB page 111.
[316] IB page 111.
[317] Transcript page 149-150.
[318] Transcript page 149.
[319] Transcript page 150.

recall him 'saying that he was suicidal, or that he had a plan'[320] and she testified that there was no opportunity to engage with Mr Amiet therapeutically to determine what he meant by his statement.[321] If such a conversation had occurred, she would have documented his responses.[322]

120. Neither ANUMs Singh[323] nor Bai[324] were informed that Mr Amiet had said he had "nothing to live for" and both considered such a statement to be clinically significant.[325] ANUM Singh thought the comment warranted immediate further investigation.[326] Had either ANUM been informed, each testified that it would have prompted a change to Mr Amiet's clinical management.[327] ANUM Singh stated that he would have intervened 'immediately' to discuss with Mr Amiet why he felt that way;[328] he would consider administering medication and think 'seriously again' about transferring him to HDU or seeking psychiatric review.[329] ANUM Bai testified that he would have increased visual observation of Mr Amiet and monitored him closely.[330]

Mr Amiet Absconds a Second Time

121. At about 2.50pm, ANUM Singh observed Mr Amiet walking in a corridor of IPU1.[331] However, at 3.00pm when Dr Zia arrived in the IPU1 to examine Mr Amiet, he could not be found on the ward.[332] ANUM Bai contacted the On-Call Psychiatrist so that Authority to Apprehend paperwork could be prepared.[333]

122. RN Lees was not aware that Mr Amiet was missing prior to leaving IPU1 at the end of her shift at 3.30pm.[334]

123. At about 4pm, staff in the IPU1 were advised that Mr Amiet was deceased.[335]

[320] Transcript page 129.
[321] Transcript page 160 and 180.
[322] Transcript page 181.
[323] Transcript pages 273 and 275.
[324] Transcript page 200.
[325] Transcript pages 199 and 206 (Bai) and 276 (Singh).
[326] Transcript page 276.
[327] Transcript pages 276 (Singh) and 200 (Bai).
[328] Transcript page 276.
[329] Transcript page 276.
[330] Transcript page 200.
[331] Transcript page 280.
[332] IB page 111.
[333] Exhibit H.
[334] Transcript page 170.
[335] IB page 112.

EXPERT OPINION AND EASTERN HEALTH'S REPSONSE

124. During my investigation and the inquest, I had the benefit of the independent expert evidence provided by Professor Richard Harvey, formerly the Clinical Director of Mental Health, Drugs and Alcohol Services at Barwon Health.[336] Professor Harvey's opinion[337] focussed on the adequacy of the risk assessments performed during Mr Amiet's final admission to IPU1, particularly that which occurred after he was returned to the ward at 1.15pm on 13 April 2013, and his clinical management.

125. Associate Professor Paul Katz, Executive Clinical Director of Eastern Health's Adult Mental Health Service, was afforded an opportunity both before[338] and during the inquest to respond to Prof Harvey's comments.

Adequacy of the Risk Assessments and Adherence to the Observation Guideline

126. Both Prof Harvey and A/Prof Katz testified about the imperfection of risk assessments as clinical tools, agreeing that prediction of risk is 'notoriously unreliable'[339] and that there is more hope than evidence that risk assessments might be predictive.[340] Suicide risk was regarded as a 'very difficult, if not impossible, thing to predict,[341] with "tick box" risk assessments 'much more likely to identify individuals as high risk' while the frequency with which individuals go on to complete suicide is 'extremely low'.[342] A/Prof Katz observed that risk assessments as currently performed are 'not contributing significantly' to overall patient care.[343]

127. They emphasised the need to use risk assessments in the context of other clinical information such as the patient's history, mental state, information from collateral sources[344] and clinical engagement.[345] According to Prof Harvey, the 'best' risk assessments are informed by clinical engagement and take into account both historical risks and an immediate clinical view of risks to identify patients at high risk, and then

[336] A/Prof Harvey had retired from Barwon Health prior to the inquest and was at that time a Clinical Professor at Deakin University, worked part-time with the Australian Health Practitioners Regulation Agency and maintained a private psychiatric practice: Transcript pages 409-410.
[337] Exhibit S. Prof Harvey was asked to comment on several aspects of Mr Amiet's clinical management and care both in the community and while a patient at IPU1 on 12-13 April 2013 and was invited to comment on any other matter he considered relevant. I have not referred to all of his conclusions about Mr Amiet's management in this Finding. Moreover, Prof Harvey moderated some of his criticisms after receiving documents not available to him at the time he prepared his written report during the inquest.
[338] Exhibits O and P.
[339] Transcript page 373 (Katz).
[340] Transcript page 454 (Harvey).
[341]Transcript page 413 (Harvey) and 357 (Katz).
[342] Transcript page 413 (Harvey).
[343] Transcript page 357.
[344] Transcript pages 356 and 374-375 (Katz) and
[345] Transcript page 413 (Harvey).

use them to develop interventions to mitigate those risks:[346] risk assessment as 'planning tool' rather than predictive document.[347]

128. Prof Harvey opined that RN Lees' risk assessment, though 'a more informed assessment of risk' than others he had reviewed from Mr Amiet's final IPU1 admission, was 'inadequate'.[348] He observed that, contrary to the Risk Guideline, RN Lees had not discussed her assessment with another clinician and the form was not counter-signed.[349] Moreover, despite identifying that Mr Amiet had a high risk of absconding and suicide, the assessment failed to respond to the assessed risk and apply Level 3 observation as defined by the Observation Guideline.[350]

129. A/Professor Katz conceded Prof Harvey's criticisms of RN Lees' risk assessment and his conclusion that an inappropriate level of observation had been applied given the terms of the Observation Guideline 'as written at the time'.[351] However, A/Prof Katz added that in the course of preparing a response to Prof Harvey's comments, Eastern Health had discovered that the guideline was 'incorrectly written' due to the inclusion of 'and/or' instead of 'and' between the second and third criteria for Level 3 observation.

130. According to A/Prof Katz, the drafting 'mistake was unfortunately not picked up' in the meantime and 'will be appropriately amended in the near future'.[352] A/Prof Katz opined that the 'level of monitoring of Mr Amiet at the time he absconded from the unit was in line with how the guideline *should have been written*'.[353]

131. In Prof Harvey's view, the criteria for Level 3 observations "as written at the time" was appropriate. He opined that continuous observation or specialling ought to be applied when a patient may or may not have recovery goals and is unable to work towards them due to the level of psychological disturbance, *and* either poses high risk of harm to themselves or others, *or* is likely to leave the ward without prior permission.[354]

[346] Transcript page 414.
[347] Transcript page 459.
[348] Exhibit S.
[349] Exhibit S.
[350] Exhibit S.
[351] Exhibit O.
[352] Exhibit O.
[353] Ibid.
[354] Transcript page 479.

132. While both Prof Harvey and A/Prof Katz agreed that guidelines should 'have an element of clinical judgement built into them,'[355] Prof Harvey considered it important for guidelines to state this explicitly and ensure any clinical reasons for departure from a guideline are documented.[356] The independent expert observed that this approach would encourage clinicians to take ownership over their clinical judgement and address the reality that in 'most acute units … [there are likely to be] a lot of patients fulfilling those criteria, such that it potentially overwhelms the capacity of staff to provide that level of clinical intervention'.[357] Indeed, in his view it is preferable that clinical staff acknowledge when a patient meets, Level 3 observation criteria, for instance, and when it is possible to mitigate identified risks through other interventions, document the decision to apply a lower level of observation.[358]

133. The 'collaborative' approach envisioned in both the Risk and Observation Guidelines does not appear to have materialised in this case. The evidence in relation to this issue is equivocal at best. Acknowledging Mr Amiet's 'extremely difficult presentation',[359] Prof Harvey testified that he would have expected a relatively inexperienced clinician like RN Lees[360] to have consulted with her supervisor, the ANUM.[361]

134. When it was put to him at inquest that experienced clinicians who were familiar with Mr Amiet, such as ANUMs Singh and Bai, did not consider his presentation on 12-13 April 2013 as "psychologically disturbed" as on other occasions – perhaps so as to remove the need for Level 3 observation – Professor Harvey stated that if this were the case, it 'need[ed to have been] documented at the time'.[362] Discussion(s) between RN Lees and the ANUM about Mr Amiet's level of observation, if any, were not documented.

Adequacy of Mr Amiet's Clinical Management

135. Professor Harvey opined that the Observation Guideline – however worded – indicated that Mr Amiet required either specialling or continuous visual observation after he was returned to IPU1 on the afternoon of 13 April 2013, and this should have

[355] Transcript pages 422 (Harvey) and 352-353 (Katz).
[356] Transcript pages 422-423.
[357] Transcript page 422.
[358] Transcript page 422.
[359] Transcript page 448.
[360] RN Lees had completed her graduate year of nursing training three months before Mr Amiet's 12-13 April 2013 IPU1 admission: Transcript page134.
[361] Transcript age 424.
[362] Transcript page 424.

been provided.[363] He acknowledged that both are difficult clinical interventions to put in place and that specialling, which is particularly intrusive, can 'make things worse' for some patients.[364]

136. Both Prof Harvey and A/Prof Katz were asked to comment on the clinical response to Mr Amiet's remark to RN Lees, post-AWOL, that he had "nothing to live for". A/Prof Katz observed that 'any threats of suicide are taken seriously' and should be contextualised but he would expect that such a remark would give risk to a thorough assessment.[365] However, he testified that suicidality does not necessarily lead to admission to hospital or admission to HDU given that the current model of psychiatric care manages a 'significant amount of risk in the community'.[366]

137. Prof Harvey commented that Mr Amiet's remark was indicative of hopelessness and that is 'a strong predictor of a greater likelihood to act on a thought to self-harm.[367] In his view, the appropriate clinical response to hopelessness was 'clinical engagement and the re-instillation of hope … engaging on a human level to re-instil the sense that there is something to live for'.[368] Prof Harvey thought continuous visual observation would be prudent, 'while you wait for hopelessness to pass or to build rapport with the patient; alternatively, transfer to a more restrictive environment may be warranted.[369]

138. Prof Harvey was asked to comment on the situation confronted by RN Lees - a patient who refuses to engage therapeutically or allow physical examination and appears irritated by the clinician's presence. He conceded that such situations were difficult to manage and required a 'very competent clinician' to do so.[370] Although it was necessary to respect a patient's boundaries as regards a physical examination, the clinician should persist in providing opportunities for therapeutic engagement.[371] It is very easy to withdraw and not engage with someone who does not wish to engage but there is 'some evidence that remaining present', even if on the other side of the room, and being available if needed, is a useful technique.[372]

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[363] Transcript page 420-421 and 453.
[364] Transcript page 420.
[365] Transcript page 376.
[366] Transcript page 377. A/Prof Katz noted that Eastern Health manages about 1800 patients in circumstances where there are only about 150 inpatient beds; the average duration of an inpatient stay (in 2018) was only 7.23 days – and no cause for 'pride' – such that most mental health patients remain in the community with varying levels of support: Transcript page 377-378.
[367] Transcript page 415.
[368] Transcript page 415.
[369] Transcript page 419.
[370] Transcript pages 416-417.
[371] Ibid.
[372] Ibid.

Preventability of Mr Amiet's death

139. Prof Harvey considered that the failure to correctly determine the level of observation was the 'primary contributor to the outcome in this case'.[373] He accepted during cross-examination that RN Lees' evidence suggested that the frequency with which she saw Mr Amiet between 1.30pm and 2.40pm was greater than 30-minutely.[374] Nonetheless, he maintained even if it was accepted that Mr Amiet was seen every 15 minutes, he was still able to leave and would not have been able to do so if subject to continuous observation.[375] He concluded that had Mr Amiet been continuously observed as the Observation Guideline required, the 'likelihood of him leaving [IPU1] at that moment would've been reduced'.[376]

140. In contrast, A/Prof Katz testified that intensification of monitoring 'doesn't necessarily correlate with … the tragic outcome being any different'.[377] Moreover, even if staff had been constantly observing or specialling Mr Amiet, though they would have 'done their best to discourage and de-escalate and try and contain him,' they would not have been expected to put themselves in harm's way (given his history of aggression towards staff) to prevent him from leaving.[378] Only if staff were aware at the moment he absconded that Mr Amiet's imminent intent was to take his own life would there have been an expectation for staff to call an emergency code and then use reasonable physical force to detain him.[379]

141. I note Prof Harvey's opinion, that Mr Amiet's suicide was an 'impulsive plan' as opposed to an accident or misadventure[380] and so would 'not necessarily' have been evident to IPU1 staff.[381] This resonates with Dr Prodomou's evidence about Mr Amiet's impulsivity and her view that it was unlikely that he 'would have waited' for a train to complete his suicide.[382]

[373] Exhibit S.
[374] Transcript page 451.
[375] Transcript page 453.
[376] Transcript page 454.
[377] Transcript page 372.
[378] Transcript page 373 and Exhibit O.
[379] Exhibit O.
[380] Transcript page 446.
[381] Transcript page 447.
[382] Transcript page 321.

Commentary on a 'Gap' in Victoria's Mental Health Care System

142. Prof Harvey and A/Prof Katz both agreed that Mr Amiet was a 'very challenging' patient to manage within the current paradigm of psychiatric care.[383] Neither were convinced that Mr Amiet would have been readily accepted into a SECU placement given his co-morbid conditions and poor motivation to engage with services.[384] And while one of the primary benefits of SECU placement would have been to limit his access to illicit drugs,[385] such a placement would have only been of benefit to him 'relative to all the other choices'.[386]

143. SECU placements are a scarce resource within the current mental health care framework, organised regionally, with limited opportunities for clinicians to influence prioritisation of patients.[387] In addition, since about 2013, the duration of SECU stays reduced from years to months.[388]

144. Both Professor Harvey and A/Professor Katz spoke of the 'enormous gap' left in the mental health care system for complex patients like Mr Amiet since de-institutionalisation and the loss of long-term, home-like treatment facilities.[389] They agreed that Victoria's mental health system would benefit from the (re)establishment of adequately resourced, long-term, home-like, rehabilitation-focused treatment units sufficiently available to meet demand.[390]

FINDINGS/CONCLUSIONS

145. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the *Briginshaw* gloss or explications.[391] The effect of the authorities is that Coroners should not make adverse comments or findings against individuals unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death and in the case of individuals acting in their professional capacity, only where there was a material departure from the standards of their profession.

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[383] Transcript pages 448 and 474 (Harvey) 380 (Katz).
[384] Transcript pages 477 (Harvey) and 364-365 (Katz).
[385] Transcript page 477.
[386] Transcript page 371.
[387] IB pages 319-328 and Transcript pages 461 (Harvey) and 362 (Katz).
[388] Transcript page 361.
[389] Transcript pages 474 (Harvey) and 378 (Katz).
[390] Transcript pages 386-387 (Katz) and 474 (Harvey).
[391] *Briginshaw v Briginshaw* (1938) 60 C.L.R. 336, especially at 362-363. "*The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences…*"

146. Having applied the applicable standard of proof to the available evidence, I find that:

a) Mr Amiet diagnoses of Schizoaffective Disorder and Antisocial and Borderline Personality Disordered were complicated by co-morbid conditions that added another layer of complexity to his presentation and clinical management both in the community and as a psychiatric inpatient;

b) Mr Amiet's management in the community by MMSTS was reasonable and appropriate;

c) The decision to revoke Mr Amiet's CTO and admit him for inpatient psychiatric treatment upon his re-presentation to Maroondah ED at 6.25am on 12 April 2013 was appropriate;

d) Notwithstanding some deficiencies in Dr Nithianandan's risk assessment, her decision to apply Level 2, 30-minutely observations was congruent with the current risks identified in that assessment and the Observation Guideline, and was reasonable in the circumstances;

e) ANUM Singh's decision to not transfer Mr Amiet from the LDU to the HDU immediately upon his return to IPU after absconding on the morning of 13 April 2013 was reasonable.

f) That said, transfer to the HDU was not the only clinical intervention available and the absence of any evidence that alternative measures, such as increased monitoring, were considered is suboptimal;

g) RN Lees' risk assessment, conducted upon Mr Amiet's return to IPU1 after absconding, did not comply with the Risk Guideline. The absence of any unequivocal evidence of a collaborative approach to risk assessment suggests a missed opportunity to optimise Mr Amiet's clinical management;

h) Despite identifying Mr Amiet's high risk of suicide and absconding, RN Lees' assessment failed to respond to the assessed risk and apply Level 3 observations as required by the Observation Guideline as drafted at the time.

i) There is no evidence before me that either alone or in consultation with another clinician, RN Lees chose to depart from the Observation Guideline for cogent and documented clinical reasons;

j) RN Lees' request that Mr Amiet be reviewed by the Psychiatric Registrar was appropriate, however, her failure to continuously monitor him in the interim was

a lost opportunity to engage him therapeutically and allowed him to abscond from IPU1 a second time that day;

k) Nevertheless, the weight of the evidence does not support a finding that Mr Amiet's *death* as opposed to absconding was preventable, in the sense that it should have been foreseen and could have been prevented;

l) Given the lethality of the means chosen, Mr Amiet placed himself in the path of an oncoming train intending to end his own life;

m) Mr Amiet's decision to take his own life was impulsive and is unlikely to have been foreseeable by IPU1 staff;

n) No act or omission by the train driver, contributed to Mr Amiet's death.

RECOMMENDATION

Pursuant to section 72(2) of the Act, I make the following recommendation on a matter connected with the death of Mr Amiet which I have investigated:

1. That the Department of Health and Human Services consider the feasibility of establishing long-term residential, rehabilitation-focussed mental health treatment facilities that are appropriately resourced to provide intensive care and meet demand for such services in the Victorian community.

PUBLICATION OF FINDING

Pursuant to section 73(1) of the Act, unless otherwise ordered by a coroner, the findings, comments and recommendations made following an inquest must be published on the Internet in accordance with the rules, and I make no such order.

DISTRIBUTION OF FINDING

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

Ms Elise Amiet

Eastern Health

Professor Richard Harvey

The Office of the Chief Psychiatrist

Constable David Grey, Coroner's Investigator, Victoria Police

Signature:

PARESA ANTONIADIS SPANOS
CORONER
Date: 31 January 2020