IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2018 000250

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

*Section 67 of the **Coroners Act 2008***

Findings of:	Coroner Paresa Antoniadis Spanos
Deceased:	CJ[1]
Date of birth:	2 February 1995
Date of death:	15 January 2018
Cause of death:	1(a) Hanging
Place of death:	Cannons Creek, Victoria, 3977

[1] The finding has been de-identified in accordance with the family's wishes.

INTRODUCTION

1. On 15 January 2018, CJ was 22 years old when he was found deceased at home in circumstances indicative of suicide. At the time, CJ lived in Cannons Creek, with his uncle and cousins.

2. Since 2012, CJ had experienced numerous traumatic events, including the deaths of his parents, sister, and friend. CJ also suffered from an alcohol addiction which contributed to his ongoing depression and suicidal ideation.

THE CORONIAL INVESTIGATION

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

4. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

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

6. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of CJ's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

7. This finding draws on the totality of the coronial investigation into the death of CJ including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[2]

[2] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Identity of the deceased

8. On 15 January 2018, CJ, born 2 February 1995, was visually identified by his uncle, who signed a formal Statement of Identification to this effect before a member of Victoria Police.

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

Medical cause of death

10. Forensic Pathologist Dr Heinrich Bouwer from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on 16 January 2018 and provided a written report of his/her/their findings dated 31 January 2018.

11. The post-mortem examination revealed a ligature abrasion about the upper neck consistent with the stated circumstances.

12. Routine toxicological analysis of post-mortem samples detected ethanol/alcohol at a concentration of ~ 0.08 g/100mL (colloquially 0.08%) and diazepam (an anxiolytic/sedative drug of the benzodiazepine class) at ~ 0.03 mg/L.

13. Dr Bouwer provided an opinion that it would be reasonable to attribute the cause of CJ's death to *hanging,* without the need for autopsy.

14. I accept Dr Bouwer's opinion.

Circumstances in which the death occurred

15. At the time of his death, CJ had been separated from his long-term partner for seven months and shared equal custody of their son. He was employed and had good social support from his friends and family and stayed socially active. CJ loved sport, although he stopped playing cricket due to the pressures of shared parenting and working, which in turn resulted in a loss of friendships and reduced socialisation.

16. In December 2017, CJ attempted suicide but was interrupted by a neighbour. Following this, he began seeing psychologist Tina Giordano, who advised him to attend an appointment with his

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evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

General Practitioner (**GP**) for the purposes of completing a mental health care plan. CJ was encouraged to commence antidepressants but was reluctant to do so.

17. CJ's employer stated that he continued working during this time and did not appear to have any mental health issues. However, Ms Giordano noted that since his separation in 2017, CJ appeared to be suffering from extremely severe depression, anxiety, and stress. He was encouraged to engage in cognitive behavioural therapy, mindfulness, and grief and loss counselling, but he did not find these modalities helpful.

18. On 11 January 2018, CJ took a day off work to attend his friend's funeral. He did not return to work afterwards. The following evening, CJ enjoyed a night out with his friends.

19. On 14 January 2018 at 8.39pm, CJ was taken to Frankston Hospital Emergency Department (**ED**) by family after becoming distressed after his cousin's birthday party.

20. On arrival in the ED, CJ reported suicidal ideation with a plan, on the background history of depression, marked weight loss, increased alcohol consumption, and confusion about his relationship with his ex-partner. He told the triage nurse that he intended to hang himself but would wait until after work when he was not caring for his son.

21. Following a medical assessment, CJ was referred to the Mental Health Consultation Liaison (**MHCL**) who spoke to him just after midnight on 15 January 2018, determining that CJ required a comprehensive assessment. Initially, CJ was happy to wait and was given diazepam for his anxiety symptoms, as well as a nicotine replacement patch while he waited.

22. On 15 January 2018 at 7.45am, a mental health assessment was conducted. CJ reported no ongoing suicidal ideation, stating that he thought those thoughts "were stupid." He continued to report symptoms of depression including amotivation, decreased sleep, weight loss, and fleeting suicidal ideation which had increased since his relationship breakdown. CJ said his symptoms were worse at night and were associated with increased alcohol use. He appeared to be help-seeking. There is no documentation indicating whether his earlier disclosed plan to hang himself was explored during this assessment.

23. A plan was made for CJ to engage with his GP to commence antidepressants and for follow-up by the Monash Crisis Assessment and Treatment Team (**CATT**) via the Psychiatric Triage Service (**PTS**) that day. CJ also agreed to a referral to the drug and alcohol service. Unfortunately, CJ self-discharged at 11.30am as he did not want to wait any longer.

24. At discharge, CJ was rated as at medium risk of suicide and was referred to the Frankston and Morning Drug and Alcohol Service (**FMDAS**). Prior to leaving, CJ and his cousins were provided with the Mental Health Telephone Triage details should his suicidal ideation increase prior to the CATT contact or his GP appointment.

25. The MHCL sent CJ's mental health assessment to his GP accompanied by a request to commence an antidepressant. She later spoke to Monash Health PTS and advised them of CJ's presentation, including his shared custody of his son as a protective factor. She also reported CJ's history of loss, alcohol use, and discharge plan, including a request for follow-up. Relevantly, no secondary contact or Next of Kin (**NOK**) information was communicated during the call.

26. After returning home, CJ told his family that the only people he wanted to see were his mother and sister (both deceased), that he was okay, and that he wanted to see his ex-partner. CJ later met with his ex-partner and asked her if they could reconcile. She told him that the time wasn't right, but they agreed to spend time together with their son. CJ's ex-partner left his residence at 3.30pm. Half an hour later, he contacted her in a distressed state telling her to tell their son that he loved him.

27. Following the call, CJ's ex-partner quickly collected their son and tried to call him but was unsuccessful. She then contacted his cousin who, after a search of the premises, discovered CJ hanging from a crossbeam on the back veranda. CJ's cousin cut him down and alerted neighbours who commenced cardiopulmonary resuscitation.

28. Emergency services attended the property a short time later and took over resuscitation efforts. CJ was unable to be revived and was declared deceased at 4.37pm. When police later attended, they found no suicide note at the scene.

FAMILY CONCERNS

29. CJ's Cousin provided a statement to police in which she expressed concern that she was not asked to participate or consulted during CJ's comprehensive mental health assessment on 15 January 2019. CJ's Cousin stated that she felt pressured to agree to CJ leaving the ED due to his reluctance to stay, and that she received little information regarding his discharge other than to expect the CATT team to make contact that day.

CPU REVIEW

30. To assist my investigation into the death of CJ, I asked the Coroners Prevention Unit[3] to undertake a review of the clinical management and care provided to him by Frankston ED, Monash Health Psychiatric Service, and his private psychologist Tina Giordano. Statement questions were sent to Peninsula Health, Monash Health, and the Office of the Chief Psychiatrist of Victoria. As to the various entities involved in CJ's clinical management and care, CPU advised as follows:

Peninsula Health

31. While CJ was not noted to be substance-affected when he presented to Frankston Hospital ED, he reported an increase in suicidality when using alcohol and said he had been consuming alcohol daily. Whilst CJ was referred to the Drug and Alcohol service, due to a heavy workload that day, the referral was not actioned as planned.

32. CJ was appropriately referred to FMDAS after he elected to self-discharge. In addition, it would have been reasonable to expect that, given its strong association with increased suicidality,[4] CJ would have been advised not to use alcohol after his discharge and to seek help if he experienced withdrawal symptoms.

33. CJ's discharge plan, which included urgent referrals to his GP and to the Monash Health CATT for same-day contact and follow-up, was reasonable given that CJ denied ongoing suicidal ideation, agreed to the treatment plan, and was supported by his family. Furthermore, there was no evidence to suggest that he met the strict mandatory criteria for compulsory treatment under the *Mental Health Act 2014* (Vic).

34. Neither CJ's family members nor Ms Giordano were involved in the assessment to provide collateral information. This may have impacted on the discharge plan. Nor was there evidence that, following CJ's mental health assessment, consideration was given to an inpatient admission or to a review by a psychiatrist or psychiatric registrar (a service available 24/7). Given that this service was available at the time, that CJ was not known to the health service and in the context of CJ's risk factors, it is unclear why an escalation to a medical review or discussion did not occur.

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[3] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

[4] National Centre for Education and Training on Addiction (NCETA) Consortium. 2004, Alcohol and Other Drugs: A Handbook for Health Professionals. Australian Government Department of Health and Ageing.

35. An internal review of CJ's care conducted by Peninsula Health found that whilst communication between Frankston ED and Monash Health was clear, had collateral information been obtained, it may have affected the clinician's assessment of CJ's overall risk. Consequently, changes have been made that explicitly require liaison with external service providers, and that family and/or support persons are welcomed as part of the mental health assessment processes and treatment planning.

36. A statement provided by the Manager of Peninsula Health's Mental Health Consultation Liaison explained that the delay owing to sick leave taken by one clinician, only one clinician of the usual two worked the night shift on 14-15 January 2018, and there were eight patients requiring mental health input during the night shift. While the statement does not explain the level of input required by these patients, the Manager did concede that CJ's wait and for a mental health assessment was extensive.

37. A statement was also provided by the Manager of Peninsula Health's Alcohol and Other Drugs service who confirmed that a referral for CJ was received on 15 January 2018. While the agreement was that a peer worker would ring CJ after his discharge, this did not occur as the worker was busy with patients in the ED for the remainder of the day.

Transfer of care

38. Whilst the MHCL contacted Monash PTS by phone regarding CJ's case at 1.33pm, this was some four hours after completion of CJ's mental health assessment, and about three hours after his discharge, with the assessment information being faxed at 4.41pm. It was not until 5.30pm that Monash PTS attempted to contact him, following the upgrading of his risk assessment to "high", resulting in the Monash PTS clinician attempting contact sooner than was initially planned but nevertheless too late in the circumstances.

39. According to submissions by Monash Health, standard operation procedures dictate that a verbal handover is conducted by phone which allows for an allocation of urgency category via their triage database and clinician assessment, with supporting documentation sent to Monash Health within one to two hours of the phone contact.

40. The MHCL noted that a larger-than-normal workload in the context of an unfilled shift resulted in a delay in CJ's case being appropriately communicated as per standard operating procedures. Whilst I acknowledge this difficulty, timely and proximate transmission of critical information allows the receiving health service to make an informed decision and appropriate response.

41. It is not reasonable to expect another mental health service to provide timely same day review and contact based solely on a telephone contact without supporting documentation. Furthermore, there was no evidence that family or NOK details were provided to Monash Health. If an individual is assessed as requiring same-day contact from an acute-crisis team, then communication of all required and relevant information to the receiving service, including family or responsible party contact details, should be a priority.

State-wide Mental Health Databases

42. The Chief Psychiatrist Dr Neil Coventry, Professor Clarke from Monash Health and Professor Newton from Peninsula Health were asked to provide information on the state-wide public mental health services client information management systems and their role, if any, in the communication of critical clinical information and referrals.

43. Dr Coventry advised that the Victorian public mental health client information management system is comprised of the Client Management Interface (**CMI**) and the Operational Data Store (**ODS**). CMI is the local client information system used by individual public mental health services which holds information on clients' demographic details, mental health admissions, changes in legal status, clinical contact and the like. Some but not all of this information is uploaded from CMI to ODS which is maintained by the Department of Health and Human Services (as it then was), however the department does not own the services' data but holds custody of the ODS. Data held in the ODS is visible to all mental health services.

44. There is agreement that the CMI/ODS is not a medical records management system or a clinical referring system and that the CMI/ODS complements the local Area Health Service's own medical records management systems. There are local systems and processes in place to support inter-service referrals outside of the CMI/ODS. There are clear guidelines requiring certain critical information to be uploaded to the ODS at which time all other mental health services can access the data. This can only be achieved if the client has been formally registered. It is unclear if CJ was to be formally registered and because of the time lag in uploading to the ODS, it is unlikely that formal registration would have affected the outcome.[5]

[5] The information is only required to be uploaded to the ODS (twice a day seven days per week) and therefore accessible to other Area Mental Health Services is information about admissions, transfers and separations and legal status). Professor Newton noted that Peninsula Health uploads all registration paperwork from the ED the following business day and the medical records provided to the Court do not suggest that Hayden's assessment in the ED

45. There is agreement that the purpose of the CMI/ODS is not as a single point of referral and that in its current form it would not have the capacity to be so. Both Professor Newton and Professor Clarke and agree that a combination of verbal handover and clinical documentation are utilised to make inter-services referrals.[6]

FINDINGS AND CONCLUSION

46. 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.[7] Adverse findings or comments against individuals in their professional capacity, or against institutions, are not to be made with the benefit of hindsight but only on the basis of what was known or should reasonably have been known or done at the time, and only where the evidence supports a finding that they departed materially from the standards of their profession and, in so doing, caused or contributed to the death under investigation.

47. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

a) the identity of the deceased was CJ;

b) the death occurred on 15 January 2018 at Cannons Creek, Victoria, 3977;

c) the cause of CJ's death was *hanging*; and

d) the death occurred in the circumstances described above.

48. The available evidence supports a finding that given the disclosures of his recent suicidality, his final conversation with his ex-partner, and the lethality of means chosen, CJ intentionally took his own life, although the possibility remains open that this was an impulsive act assisted by the disinhibiting effect of alcohol.

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resulted in formal CMI registration. All other uploading of local CMI data on registered clients to the ODS usually occurs on the 10th day of each month.

[6] The Chief Psychiatrist provided information about the DHHS Digitising Health Strategy which is across all of health and includes the Area Mental Health Services. While there are no plans to use the CMI/ODS as a single point of referral or as a clinical information sharing system, projects include the Clinical Information Sharing (CIS) project across public health services including mental health and will achieve information sharing. Relevantly, Dr Coventry providing a Clinical Information Sharing Fact Sheet which included the following - *"The implementation of clinical information sharing solutions will enable more effective and efficient clinical handover and continuity of care between heath services. Handover and transitions in care are high-risk steps in the patient care journey. The need for a clinical information sharing solutions is highlighted in emergency situations, where a patient's medical history is unknown but immediately clinical decisions are necessary."*

[7] *Briginshaw v Briginshaw* (1938) 60 CLR 336 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…'.

49. CJ was in crisis and during his presentation to Frankston ED on the night of 14 January 2018 and the following morning, waited 13 hours for a comprehensive mental health assessment and a further three hours for contact with Drug and Alcohol services which did not eventuate before he self-discharged being 'tired of waiting'. Regrettably, the possibility of a different outcome with counselling about the need to refrain from alcohol and/or assistance with alcohol withdrawal was lost.

50. The assessment completed by the MHCL and the discharge plan was reasonable and appropriate as far as it went but, lacked collateral information from CJ's family and other service providers that may have provided vital insights into his mental state and background and was therefore less comprehensive than it could have been.

51. Whilst the phone referral to Monash Health was timely, it would be reasonable to expect that the faxing of critical information should have occurred at the same time, or close to, since same-day contact was envisaged. Given that CJ's risk rating was upgraded from "medium" to "high" following the incorporation of the data when it was ultimately faxed, it is reasonable to infer that the PTS would likely have attempted earlier contact with CJ.

52. Whilst I acknowledge the difficulties inherent with balancing a heavy workload overnight, it should not dimmish the responsibility of the assessing clinician to ensure that the communication of critical clinical information, including NOK details, to the receiving mental health service is prioritised.

RECOMMENDATIONS

Pursuant to section 72(2) of the Act, I make the following recommendations on a matter connected with a death, including recommendations relating to public health and safety or the administration of justice:

1. That Peninsula Health improves the quality of the referral information between acute mental health services for same-day contact requested as a safeguard in the discharge planning of a person assessed by a mental health services in the Emergency Department by ensuring that:

    a. Initial verbal referral for same-day contact includes a patient's contact details and a secondary or next of kin contact, subject to consent of the patient and the secondary contact.

    b. Critical clinical and/or comprehensive assessment information in written form is communicated proximate to and as soon as practicable to the verbal referral to

enable the receiving service to arrive at their own informed assessment of the acuity of the patient and to plan the appropriate clinical response.

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

Senior Next of Kin

The Chief Psychiatrist, Dr Neil Coventry

Peter Ryan, Monash Health

Amber Salter, Peninsula Health

Senior Constable Aaron Trinder, Victoria Police, Coroner's Investigator

Signature:

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Paresa Antoniadis Spanos

Coroner

Date: 11 April 2022

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.