IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2015 3028

FINDING INTO DEATH WITH INQUEST

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

Deceased:	Christopher David French Hunter
Delivered on:	11 August 2022
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing dates:	Inquest: 26-30 October 2020; 15-16 March 2021
Findings of:	Coroner Paresa Antoniadis Spanos
Counsel assisting the Coroner:	Leading Senior Constable Duncan McKenzie from the Police Coronial Support Unit
Representation:	Mr Hunter and Ms French, the deceased's parents appeared in person. Ms Roslyn Kaye appeared on behalf of Delmont Private Hospital. Mr Sean Cash appeared on behalf of Dr Schuyler Tan. Mr Paul Halley appeared on behalf of Associate Professor Saji Damodaran. Ms Naomi Hodgson appeared on behalf of St Vincent's Health Melbourne.
Catchwords:	

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INTRODUCTION[1]

1. Christopher David French Hunter was the 31-year-old son of Graham Hunter and Allison French. In the period immediately preceding his death, Christopher was living with his parents in Canterbury, having experienced a deterioration in his mental health, abandoned his tertiary studies in South Australia and returned to the family home.

2. Christopher had a history of mental health issues that dated back to his teens. He began seeing a psychologist and psychiatrist around the age of 19, but over the years did not want his parents to be involved, and generally would not discuss his treatment with them. However, they noticed that Christopher slept for long periods of time, was irritable and seemed to be suffering some form of anxiety.

3. Christopher attempted two tertiary courses. In both instances, he discontinued his studies after a short time. He did however undertake TAFE studies, obtaining a Diploma of Broadcasting and a Diploma of Creative Writing leading to an interest in screenwriting. Christopher moved to Blairgowrie to write and, while he developed some friendships there, began to isolate himself from his broader social networks and school friends. Despite this, Christopher continued to be very involved with his family, attending family functions and participating in family holidays.

4. In 2012, Christopher moved to Adelaide and in early 2013, commenced studying for a Bachelor of Behavioural Sciences/Psychology at Flinders University. At first, all appeared well for Christopher in Adelaide. He was making new friends, dating, and participating in sporting activities. However, by early 2015, he began experiencing difficulties with his studies and with accommodation. By April 2015, it was apparent to his parents that his mental health had deteriorated and after several phone calls with them, he drove to Mansfield where he stayed in a family property until 18 May 2015 before moving back to the family home in Canterbury to live with his parents.

5. After moving back into the family home, Christopher was more open about his mental health issues and spoke about the difficulties he was facing in his life. It became apparent that Christopher had paranoid thoughts and spoke of them as his reality. Christopher disclosed recreational drug use in his teenage years; worries that people would harm his reputation by posting about him on social media; a belief that people were trying to follow

[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.

and photograph him; he would rarely leave the house and when he did would try to hide his identity.

CIRCUMSTANCES PROXIMATE TO DEATH

6. On 22 May 2015, Christopher went to see Dr Roni Kabillo, the psychologist with whom he had developed a good therapeutic rapport when much younger, in 2005-2007. Dr Kabillo spoke to Christopher for about two hours and the dominant themes of their discussion were anxiety and paranoia. After another session in which Christopher's parents also participated, Dr Kabillo suggested that the family consider a voluntary admission to Delmont Private Hospital.

7. Christopher attended a pre-admission appointment with consultant psychiatrist Dr Shashjit Varma who diagnosed him with paranoid disorder, depression and tardive dyskinesia and arranged and admission at Delmont Private Hospital from 6 June 2015 (**Delmont**). Christopher was admitted as planned and remained at Delmont until he discharged himself against medical advice on 9 June 2015 and returned home with his parents.

8. The clinical management and care provided to Christopher during this short admission, discharge arrangements and follow-up treatment were the main focus of the coronial investigation and inquest into Christopher's death and will be discussed in some detail below. Suffice for present purposes to note that Christopher was assessed as not satisfying the criteria for compulsory treatment under the ***Mental Health Act 2014*** (**the MHA**) on 9 June 2015 or at any time thereafter, that he remained at home with the support of his parents and had some engagement with St Vincent's Health Crisis Assessment and Treatment Service (**CATS**).

9. On Friday 19 June 2015, Christopher had dinner at home with his parents and older sister. During dinner, Christopher appeared to be calm and enjoying himself. After his sister left, Christopher retired to his bedroom upstairs for the evening.

10. At about 1.00pm the following day, Saturday 20 June 2015, Mr Hunter went upstairs to wake Christopher ahead of an appointment with the CATS. He found Christopher's bedroom door open, the bed made, and the bathroom door locked. Mr Hunter knocked on the bathroom door and called out but there was no response. A short time later he was able to unlock the door and found Christopher hanging from the shower frame. Mr Hunter checked for vital signs and was unable to find a pulse.

11. Ambulance Victoria (AV) paramedics responded to a 000 call a short time later and after assessing Christopher for signs of life pronounced him deceased at the scene. Victoria

Police members also responded and commenced the coronial investigation of Christopher's death on my behalf.

INVESTIGATION AND SOURCES OF EVIDENCE

12. This finding is based on the totality of the material the product of the coronial investigation of Christopher's death. That is, the brief of evidence compiled by Senior Constable Rob Hamilton from Camberwell Police, reconfigured for the inquest by Leading Senior Constable Duncan McKenzie of the Police Coronial Support Unit; the statements, reports and testimony of those witnesses who testified at inquest and any documents tendered through them; and the final submissions of counsel.

13. All of this material, together with the inquest transcript, will remain on the coronial file.[2] 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

14. The purpose of a coronial investigation of a *reportable death*[3] is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which the death occurred.[4] Christopher's death was reportable as it appeared to be unnatural and/or the result of accident or injury.[5]

15. The term 'cause of death' refers to the *medical* cause of death, incorporating where possible the mode or mechanism of death. 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.[6]

[2] 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.
[3] 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)).
[4] Section 67(1) of the Act.
[5] See section 4 for the definition of "reportable death", especially section 4(2)(a).
[6] 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).

16. The broader purpose of any coronial investigations is to contribute, where possible, 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.'[7]

17. 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 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.[8] These are effectively the vehicles by which the Coroner's prevention role can be advanced.[9]

18. 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.[10]

IDENTITY

19. Christopher David French Hunter born 11 May 1984 was identified by his father Graham Hunter who signed a formal Statement of Identification to this effect before a member of Victoria Police on 20 June 2015. Christopher's identity was not in issue and required no further investigation.

MEDICAL CAUSE OF DEATH

20. Senior forensic pathologist Dr Matthew Lynch, from the Victorian Institute of Forensic Medicine (**VIFM**), reviewed the circumstances of Christopher's death as reported by police to the coroner, post-mortem CT scanning of the whole body performed at VIFM (**PMCT**) and performed an external examination of Christopher's body in the mortuary.

21. Having done so, Dr Lynch provided a written report of his findings. He noted the presence of suicide notes at the scene, evidence of a ligature mark around Christopher's neck and an intact hyoid bone and no evidence of occult injury or natural disease on PMCT. Dr Lynch

[7] 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'.
[8] See sections 72(1), 67(3) and 72(2) of the Act regarding reports, comments and recommendations respectively.
[9] 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.
[10] 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.

also noted the results of routine toxicological analysis of post-mortem specimens which detected no alcohol or other commonly encountered drugs or poisons apart from bupropion at a level of ~0.1mg/L.[11]

22. Dr Lynch concluded by advising that it would be reasonable in the circumstances and in the absence of an autopsy to attribute Christopher's death to *1(a) hanging*, without the need for autopsy.

23. I accept Dr Lynch's opinion as to the cause of Christopher's death.

FOCUS OF THE CORONIAL INVESTIGATION

24. As is often the case in this jurisdiction, the focus of the coronial investigation and inquest into Christopher's death was on the circumstances in which the death occurred. More specifically the focus of this inquest was threefold:

    (a) The clinical response to Christopher's request for discharge from Delmont Private Hospital on 9 June 2015, including the soundness of Dr Tan's clinical assessment; Dr Tan's familiarity with the MHA; the supervision of Dr Tan by Associate Professor Saji Damodaran; the adequacy of the discharge plan; and the communication of the discharge plan with Mr Hunter's parents and carers.

    (b) The adequacy of the response to Ms French's approaches to St Vincent's Health CATS on the 12 and 17 June 2015.

    (c) The assessment of Christopher by St Vincent's Health CATS clinicians on 18 June including the supervision of Dr Mark Robertson; and Dr Robertson's familiarity with the MHA.

CHRISTOPHER'S REQUEST FOR DISCHARGE ON 9 JUNE 2015

25. On any view, Christopher's request for discharge from Delmont was premature and needs to be contextualised by reference to his pre-admission review by Associate Professor Shashjit Varma (**A/Prof Varma**), a consultant psychiatrist to whom he had been referred by his general practitioner (**GP**) Dr Bruce Ingram, and Christopher's progress, such as it was, and assessments made by clinicians during his brief admission to Delmont.

[11] According to a monograph from VIFM toxicology "Buproprion is a dopamine reuptake inhibitor, with a lesser inhibition of noradrenalin and serotonin uptake. Buproprion also acts as an antagonist at neuronal nicotinic receptors. It is clinically used to aide in cessation of tobacco smoking." It is available in Australia as "Prexaton" and "Zyban".

26. A/Prof Varma's first and only consultation with Christopher was on Thursday 4 June 2015, by way of pre-admission review and he provided a letter to the court and his report to Dr Ingram dated 5 June 2015 in response to a request for a statement.[12] It is apparent from those documents that Christopher had significant paranoia with themes of rumours around his sexual functioning, bullying and targeting, and concerns about his reputation in social media.

27. Christopher gave a history of past engagement with a psychologist ten years earlier which helped him to some extent and psychiatric management by a Dr Schwarz who had prescribed Stelazine in 2005 (trifluoperazine, an older antipsychotic) which Christopher took for six years but ceased when he developed a 'twitch'. This suggested tardive dyskinesia to A/Prof Varma.[13] Aside from the prescription of Stelazine implying a diagnosis of schizophrenia or a psychotic illness,[14] Christopher also gave a history of anxiety.

28. A/Prof Varma's provisional diagnosis was of a paranoid disorder with depression and tardive dyskinesia. He felt Christopher was psychotic at the time of the review, but amenable to treatment. Christopher was also unwell enough to require almost immediate admission, so he could be treated and supervised more safely in a hospital environment. Although A/Prof Varma suspected paranoid schizophrenia, his evidence was that this was not a diagnosis that he would make after a one-hour consultation and would need to see Christopher a few more times before reaching a more informed or definitive diagnosis. His expectation was that Christopher would be admitted for two-three weeks and he would see him each weekday during evening ward rounds.[15]

29. The following day, Friday 5 June 2015, A/Prof Varma was unexpectedly called away to attend to a family emergency overseas.[16] Rather than a detailed handover that would be done in a more orderly, routine situation, he knocked on the door of a colleague, Associate Professor Saji Damodaran (**A/Prof Damodaran**), two doors down, advised

[12] Exhibit C, pages 34-38 of the inquest brief. See transcript page 99 where A/Prof Varma outlines his formal qualifications and experience. In addition to his medical degrees, A/Prof Varma has 34 years' experience as a consultant psychiatrist, has been an Associate Professor for 25 years, has a Ph. D. in psychiatry and is currently the Chairperson of the Delmont Hospital Medical Board.
[13] Tardive dyskinesia is a condition affecting the nervous system, often caused by long-term use of neuroleptic drugs used to treat psychiatric conditions. It causes repetitive, involuntary movement such as grimacing, sticking out the tongue, eye blinking of smacking the lips. Stopping or tapering the drugs that may be contributing can help, however, the condition is lifelong and cannot be cured. Sedative medications can help relieve the condition to some extent.
[14] Transcript page 101.
[15] Transcript pages 105-106. See also transcript page 175 where A/Prof Damodaran describes two weeks as a standard inpatient admission.
[16] The circumstances were particularly exigent, A/Prof learning of the emergency at 3.00pm and catching an overseas flight at 6.00pm in order to see a relative who was in a coma.

him of the family emergency and asked him to look after Christopher. This was an extraordinary situation and Dr Varma testified that he relied on A/Prof Damodaran's seniority and the trust each had for the other. The handover took no more than five minutes and he testified that he 'would have' conveyed that Christopher had a psychotic condition that needs management. A/Prof Varma expected Christopher to be admitted under A/Prof Damodaran's name and that he would do his own independent assessment of Christopher.[17]

30. Consultant psychiatrist A/Prof Damodaran[18] admitted Christopher to Delmont on 6 June 2015 and was responsible for his care until A/Prof Varma returned. His first review of Christopher was lengthy and led him to document a provisional diagnosis of dysthymia with differential diagnoses of chronic major depression, generalised anxiety disorder and a possibility of a psychotic disorder.[19] In the course of this review Christopher mentioned having been treated with trifluoperazine in the past and developing tardive dyskinesia which was evident to A/Prof Damodaran during the review.

31. As Christopher was quite reluctant to take any medication and requested more information, A/Prof Damodaran discussed various antidepressants with him and offered Zyban (bupropion) to be taken at a dose of 150mg each morning for its more favourable side effect profile. After this explanation, Christopher was willing to take Zyban for the treatment of depression.[20]

32. Christopher was reviewed again by A/Prof Damodaran on the morning of 8 June 2015 in a session documented by him as "long" in the medical records.[21] A/Prof Damodaran was aware that Christopher had remained quite reclusive in his room during the admission. There was significant elaboration of Christopher's paranoid beliefs and how intrusive these were in his life. However, Christopher was adamant that he was not

[17] Transcript pages 107-108. See also A/Prof Damodaran's evidence that the handover was less than satisfactory but dictated by exigent circumstances and that he was an experienced psychiatrist who would be making his own assessment of Christopher on admission – transcript 141, 174.
[18] A/Pro Damodaran's formal qualifications and experience are outlined in Exhibit E, his statement dated 19 April 2017 at pages 39-42 of the inquest brief. In brief, he qualified as a psychiatrist in 1993, was director of clinical service at Gippsland Psychiatric Services from 1994-1999, later became medical director of the mental health program at Monash Health and in 2011 was appointed A/Prof by Monash University in 2011 when he also left public psychiatry and became a full-time psychiatrist at Delmont.
[19] Exhibit E at page 40 of the inquest brief, Delmont medical records at page 139 and transcript page 132.
[20] Christopher was particularly concerned about medications causing sexual dysfunction and, according to A/Prof Damodaran, this antidepressant is less likely to cause sexual dysfunction than other antidepressants. Transcript at pages 135 and following. Arising from a criticism of the prescription of Zyban (bupropion) made by the court's independent expert Professor Richard Harvey in his report, this issue was the subject of extensive cross-examination of a number of witnesses at inquest. As Prof Harvey ultimately resiled from the criticism and I have not addressed this issue in this finding.
[21] Transcript page 142 and A/Prof Damodaran's notes of this review at pages 163-165 of the inquest brief.

paranoid and that the events he recounted were real. He denied hallucinations or bizarre experiences. Christopher mentioned having taken another antipsychotic, aripiprazole, in the past lending further credence to the possibility that he had, in the past, and was now, experiencing psychosis.[22]

33. At this review, A/Prof Damodaran's overall impression was that Christopher had significant delusions of reference and persecution, both symptoms of psychosis, associated with thought disorder and a depressed mood. Christopher was given information about various antipsychotic medications with the suggestion that he commence on Zyprexa (olanzapine).[23]

34. However, Christopher said he wanted to read about the medication first before taking it. A/Prof Damodaran thought it was reasonable to allow him to do so to promote therapeutic engagement, rather than adopt a coercive approach, and also understandable in light of Christopher's interest in neuroscience.[24] Consistent with this approach, later that afternoon, A/Prof Damodaran emailed Dr Tan informing him of the review and asking him (effectively) to encourage Christopher to start taking Zyprexa, initially on a small dose.[25]

35. Dr Schuyler Tan is a consultant psychiatrist who qualified as such on 19 December 2017 and, at the time of the inquest, had been working in private practice at The Melbourne Clinic since 18 February 2018.[26] At the material time, that is in June 2015, Dr Tan was a senior psychiatric registrar, employed by St Vincent's Health, half-way through a secondment/rotation to Delmont as a component of his specialist training.[27]

36. The responsibility for training Dr Tan and other registrars lies with their parent hospital, in this case St Vincent's, which is a teaching hospital, and not with Delmont. However,

[22] Exhibit E, at page 41 of the inquest brief and Delmont medical records page163-165.
[23] A/Prof Damodaran agreed that there was some difference between A/Prof Varma's assessment of Christopher (the details of which were unknown to him at the time) and his own first assessment, and a shift to a diagnosis of psychosis at his second review – transcript pages 170-172.
[24] Transcript pages 134-135, 137, 177.
[25] Email from A/Prof Damodaran to Dr Tan sent at 3:34pm on 8 June 2015 – part of Exhibit G. I note that A/Prof Damodaran is re candid about his evolving diagnosis here than in the Delmont medical records *"He is clearly suffering from a psychotic disorder and possibly a paranoid schizophrenia or possibly delusional disorder with exacerbation. Have a chat with him and see whether you can convince him to be on Zyprexa initially on a small dose."* As to the dose he had in mind, see page 165 of the inquest brief where A/Prof Damodaran documents "Consider Zyprexa 2.5mg nocte". See also transcript pages 146-147 where A/Prof Damodaran testifies that this approach of encouraging a patient to accept medication is consistent with the (then new) *Mental Health Act 2014.*
[26] Exhibit J, Dr Tan's statement dated 23 August 2019 at page 56 of the inquest brief and transcript pages 193 and following where he expands on his qualifications and experience. Briefly, Dr Tan commenced employment with St Vincent's Health on 24 February 2014; his rotation to Delmont was from February 2015 to January 2015; and he obtained his Fellowship of the Royal Australian and New Zealand College of Psychiatrists on 19 December 2017. I note that at transcript page 261 Dr Tan agreed that in June 2015 he was an "advanced trainee" in psychiatry.

the content, nature and requirements of supervision by a consultant psychiatrist of a registrar are dictated by the Royal Australian and New Zealand College of Psychiatrists (the College). Consultants taking on the supervisory role are required to be accredited by the College, refresh their accreditation periodically, and report to the College about the registrar's performance. The College also mandates the minimum amount of supervision to be provided by a consultant to a registrar which does not directly involve the host institution, in this case Delmont.[28]

37. Although not the subject of direct evidence at inquest, it seems reasonable and uncontentious that in stepping-in for A/Prof Varma in a locum capacity, A/Prof Damodaran effectively also took over supervision of Dr Tan, at least as far as his clinical management and care of Christopher was concerned.

38. Relevantly, as a registrar, even a senior registrar, Dr Tan did not have the authority to discharge a patient without consultant approval and his usual practice would be to inform the consultant of the clinical scenario and present his assessment and management plan for approval.[29] Moreover, Dr Tan's evidence was that while he might exercise his own judgement in a public hospital setting about some matters as he became more experienced as a registrar, he would never have done so in the more stringent private hospital setting, particularly in relation to a decision to allow a patient to discharge against medical advice.[30]

39. It is apparent from email exchanges on 5 June 2015 that Dr Tan assumed primary responsibility for A/Prof Varma's patients, made himself the first port of call for nursing staff in respect of those patients and recognised A/Prof Damodaran as the covering consultant psychiatrist. While he passed on brief notes about existing patients to A/Prof Damodaran via email, he simply alerted A/Prof Damodaran to the need to admit Christopher the following morning.[31] A/Prof Varma's report to Christopher's GP dated

[28] This was ultimately uncontroversial in the inquest – see transcript pages 112-114 for A/Prof Varma's evidence; pages 167-168 for A/Prof Damodaran's evidence, page 261 for Dr Tan's evidence; transcript pages 486-487 for Prof Harvey's evidence.
[29] This is reflected in Dr Tan's notation made in the clinical notes at 12.07pm on 9 June 2015 culminating with "Will inform Dr Damodaran" at page 169 of the inquest brief. Transcript page 262.
[30] Exhibit J at page 58 – *"…the private hospital environment differs to a public hospital environment. While as a registrar I would still always sought [sic] advice and direction from a consultant in a case like this in a public hospital, in a private hospital this requirement is even more stringent. Public teaching hospitals are highly structed learning environments in which there may be circumstance in which a registrar, as they become more senior, would exercise their own judgement in certain situations as they develop their skills and experience on their way to becoming a consultant. As a registrar, I would never apply my own discretion in a private hospital and would always seek advice and direction on any such decision, particularly a decision to discharge a patient against medical advice…"* See also transcript page 208 where Dr Tan describes the process of informing the supervising consultant variably as standard, very routine, and ingrained.
[31] Email chain commencing with Dr Tan's email of 5 June 2015 at 5:21pm, part of Exhibit G.

5 June 2015 was not in the medical record and not otherwise available to Dr Tan so he was without the benefit of A/Prof Varma's pre-admission consultation and clinical impression.[32]

40. On the morning of 9 June 2015, Dr Tan acknowledged receipt of an email from A/Prof Damodaran with his clinical impression that Christopher was suffering from a psychotic disorder, possibly paranoid schizophrenia or a delusional disorder with exacerbation. The email included a request that Dr Tan encourages Christopher to start taking Zyprexa (olanzapine) initially on a small dose.[33]

41. As is apparent from nursing notes, Christopher had not slept overnight, was fully dressed and was considered to be at risk of absconding. Christopher was preoccupied with thoughts of being monitored and scrutinized; wanted to go home where he could put his head in books and block out the world; and was encouraged to stay to be reviewed by his psychiatrist.[34]

42. According to Dr Tan, it was common practice for the registrar to be called at first instance to review a patient who wanted to be discharged and, on the morning of 9 June 2015, he was requested to review Christopher in this context. He was also aware that Mr Hunter was coming in to see his son that day. Dr Tan informed himself from the medical records and had a telephone conversation with Mr Hunter to obtain as much collateral history as possible before reviewing Christopher. It was his experience that a history obtained from a patient suffering paranoia might be inadequate, particularly in the context of the patient wanting to discharge themselves against medical advice.[35]

43. Consistent with the family's state of knowledge of Christopher's history, Mr Hunter mentioned paranoia in the context of cannabis use ten years' earlier, no ongoing illicit drug use, no family history of psychosis and no previous suicide or self-harm.[36] The latter was consistent with the nursing notes and risk assessments documented during Christopher's admission to Delmont up to that point which indicated potential risk around behaviour on the ward or absconding, but no perceived risk of suicide or self-

[32] Transcript pages 194-195.
[33] Email chain commencing with Dr Tan's email of 5 June 2015 at 5:21pm, part of Exhibit G.
[34] Nursing notes at pages 165-166 of the inquest brief.
[35] Transcript pages 197-198, 263. Dr Tan's notes of his conversation with Mr Hunter are at pages 167-168 and are dated 9 June 2015 at 1121hours and are deciphered in Exhibit J, Dr Tan's statement dated 23 August 2019. At transcript page 201, Dr Tan concedes that his notes are not a verbatim account of the conversation but its essence.
[36] Ibid.

harm.[37] Dr Tan's evidence was that the notes did not contain anything to suggest to him that Christopher was suicidal.[38]

44. Nor did Dr Tan glean any information in the medical records to suggest that Christopher had been non-compliant with medication while he was at Delmont. He had taken the antidepressant Zyban (bupropion) twice, on the 8 and 9 June 2015 and had indicated he wanted to research the antipsychotic Zyprexa (olanzapine) before agreeing to commence taking it.[39]

45. After speaking to Mr Hunter on the telephone and reviewing the medical records, Dr Tan reviewed Christopher accompanied by Psychiatric Nurse Mark and made a note in the medical records dated 9 June 2015 at 1207 hours.[40] His conclusion under the title of "assessment" was that Christopher was suffering from untreated paranoia and did not completely satisfy the criteria for treatment under the Mental Health Act 2014 (**MHA**).[41] At that juncture, Dr Tan's "plan" was to call Mr Hunter who said he would attend Delmont to try to convince Christopher to stay, or to take him to Box Hill Hospital Emergency Department to attend on the crisis assessment team (CAT).[42]

46. Dr Tan concluded this entry in the medical records with a notation that he "Will inform Dr Damodaran" and maintained that while he had no specific recollection of the timing or content of the discussion, he was certain that he did speak to him about Christopher on 9 June 2015. Dr Tan stated that it would well outside his usual practice to make such a decision without reference to the treating consultant psychiatrist and, further, that he could not imagine a situation in which a private patient would be discharged without the approval of their treating consultant.[43]

47. A/Prof Damodaran testified that while he had no recollection of a discussion with Dr Tan about Christopher's discharge, he had no doubt Dr Tan would have called him.[44]

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[37] Nursing notes at pages 160-170 inclusive of the inquest brief.
[38] Transcript pages 198-199.
[39] See paragraphs 33 and 34 above and the relevant footnotes.
[40] Dr Tan's notes of this review are at pages 168-169 of the inquest brief and are deciphered in Exhibit J, his statement dated 23 August 2019 – *'Window blinds drawn. Spoke softly as to avoid being heard. Affect fatuous guarded. Nil overt formal thought disorder but paranoid persecutory ideations about previous drug associated. Ideas of Reference from social medica. Denied acute suicidal ideation but hinted at hanging self in the future if unable to resolve concerns. No perceptual disturbances. Poor insight into psychosis. Judgement impaired.'*
[41] The correct interpretation of Part 4 (Compulsory Patients) Division 1 (Assessment Orders) of the ***Mental Health Act 2014*** occupied a substantial part of the inquest and the views of various witnesses will be discussed below at paragraphs 97 and following.
[42] Ibid.
[43] Exhibit J at page 58 of the inquest brief. This is consistent with Prof Hopwood's evidence at transcript page 356 that Dr Tan's determination that an Assessment Order was not indicated as the determination of a registrar "should of course be then discussed with the consultant psychiatrist…responsible for the patient's care…"
[44] Transcript page 142.

Indeed, he put it higher than that this in answers to questions from Mr Cash, agreeing that it was virtually inconceivable that Dr Tan would not have discussed Christopher's impending discharge with him.[45]

48. Later that afternoon, at around 1400 hours, Dr Tan and Psychiatric Nurse Mark had a family meeting involving Mr Hunter, Ms French and Christopher which was documented by Dr Tan in the medical records time-stamped 1407 hours. This was effectively the "discharge plan" as Christopher insisted on being discharged against medical advice, despite all encouragement and persuasion attempted by Dr Tan and his parents. This notation in the medical records refreshed Dr Tan's memory of the plan arrived at and his rationale.[46]

Adequacy of the discharge plan

49. The discharge plan as documented by Dr Tan involved him providing a prescription for olanzapine at a dosage of 5mg twice daily which Christopher's parents would supervise; providing the telephone number of the Eastern Health CAT team; providing a request for an organic screen;[47] psychoeducation; and the family making an appointment with A/Prof Varma for follow-up on his return.[48]

50. Both Mr Hunter and Ms French provided statements and gave evidence at inquest.[49] While neither purport to give a full verbatim account of the discussion with Dr Tan on the morning of 9 June 2015 immediately before Christopher discharged himself against medical advice, they gave consistent accounts to the effect that they were aware that Christopher wanted to leave Delmont as he no longer felt safe there; supportive of Christopher's decision and would continue to support him at home; aware of his diagnosis of paranoid schizophrenia (whether drug-induced or not); aware that he had

[45] Transcript pages 160-161.
[46] Medical records at page 169 of the inquest brief. Unsurprisingly, Dr Tan had a vague recollection of events and the notes he made in the medical records assisted his recollection of matters discussed at inquest – transcript page 194. See also transcript pages 209-210 for Dr Tan's evidence that Christopher insisted on taking his discharge despite all encouragement to remain as a voluntary patient.
[47] Transcript page 236. An organic screen refers to set of blood tests and brain imaging normally done when a patient presents with first episode psychosis to exclude the possibility of a physiological or organic cause of the presenting condition which might be reversible. Dr Tan explained that he made this request out of an abundance of caution as he saw no evidence that an organic screen had been undertaken when Christopher had experienced psychosis.
[48] The next entry on page 169 of the inquest brief is a nursing note that confirms Christopher's discharge at 1450 hours; confirms that scripts for discharge medications Zyban and olanzapine were given; and notes that deliberate self-harm and suicide was denied (presumably by Christopher). This is consistent with the Medical Discharge Form completed by Dr Tan, appearing at page 133 of the inquest brief and deciphered by him in Exhibit J.
[49] Exhibit A, Mr Hunter's statement dated 23 September 2015, is at pages 6-14 of the inquest brief and his evidence at transcript pages 10-57. Exhibit B, Ms French's statement dated 12 September 2019, is at pages 19-21 of the inquest brief and her evidence at transcript pages 57-99.

commenced taking an antidepressant and was to commence taking an antipsychotic drug; and aware of the need to make an early appointment with Dr Varma for review.

51. During the discussion with Dr Tan, Mr Hunter and Ms French had to take in information of great import about their son's mental health. Not only was the diagnosis of paranoid schizophrenia news to them and shocking, but they had no lived experience of mental illness themselves or within their family and were naive to the workings of the mental health system. At the same time, although there are differing accounts of the precise words used by Dr Tan, Christopher's parents' concerns for their son were heightened when they were also advised of a risk of suicidality and a need to be mindful of that risk.[50]

52. As regards the involvement of the St Vincent's Health Crisis Assessment and Treatment Service (**CATS**), Mr Hunter understood that the CATS was to be contacted if there was a need to escalate Christopher's medication compliance and/or if he was feeling suicidal.[51] Mr French's evidence was that Dr Tan told them that if they decided or needed to get the CATS, Christopher's Delmont file would be sent to the CATS.[52] She also understood that they should contact the CATS if they felt Christopher was suicidal, but had no idea where that point was. According to Ms French, they were floundering pretty much from the time Christopher got home.[53]

53. At inquest, Dr Tan was questioned at length about the adequacy of this plan and what else could or should have been arranged for Christopher following his precipitous discharge.

54. Dr Tan nominated three programs available for Delmont patients each of which was, in his opinion, either unsuitable or practically unavailable for Christopher. The Community Outreach Service was a limited service, providing a home visit once a week as a maximum. Implicit in Dr Tan's statement is the belief that this was unnecessary as Christopher would be living in a supportive family environment. Dr Tan did not consider any day programs suitable as they were groups programs and Christopher was

[50] Exhibit A, page 9 of the brief – *"…The psychiatrist explained to us that when he had previously spoken to Christopher he had asked if he felt at all suicidal and that Christopher had said no, he wasn't. The psychiatrist explained to us that despite Christopher saying he did not feel suicidal it was something we needed to be aware of and to keep watch over Christopher.* Exhibit B, page 20 – *"…were given the diagnosis that Chris had drug-induced paranoid schizophrenia. This was the first time we had ever heard this diagnosis. Dr Tan also hinted that Chris may be at risk of suicide. In retrospect we can understand he was trying to warn us. We understand his reticence, but we had no skills to understand this, to cope with this or to comprehend the risks and signs."* Transcript pages 19-21, 62.
[51] Exhibit A, page 10 of the inquest brief.
[52] Transcript page 63.
[53] Transcript page 84.

still suffering from paranoia at the time of his discharge. Also, there were logistical constraints including potentially long waiting lists. The Hospital Transition to the Home Program is designed for inpatients who are on a gradual return to home trajectory and so was unsuitable for Christopher post-discharge. Moreover, these programs are designed for patients who complete their inpatient treatment and referrals are usually made by their treating consultant psychiatrist.[54]

55. Another witness able to speak to these programs was Peter Randall, Director of Nursing at Delmont. Mr Randall completed his training and has been registered as a psychiatric nurse since 1983. He has worked as a nurse unit manager in private mental health since 1986 and provided a statement setting out, among other things, follow-up and support available to Delmont patients after an inpatient admission.

56. Mr Randall testified that Christopher's discharge was in accordance with Delmont procedures and gave evidence supportive of Dr Tan's assessment that the Community Outreach Service, day programs and Hospital Transition to the Home Program were unsuitable for Christopher due to his paranoia and/or practically unavailable to due to the structure of the programs or logistical constraints.[55] He emphasised that all therapeutic interventions were designed to commence during the inpatient admission, with rapport building and skills development during the admission, and were meant to continue on those foundations after discharge.[56]

57. Another criticism of the discharge plan was Dr Tan's failure to make an actual referral to the CAT team, rather than simply providing the family with their contact details. Dr Tan conceded that while this was an option, he did not make the referral as he did not consider it necessary. Dr Tan believed there was sufficient structure in place to support Christopher as, at that point, he had agreed to take the medication and had agreed to his parents supervising its administration.[57]

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[54] Exhibit J at page 59 of the inquest brief and transcript pages 237-238, 291-293.
[55] Exhibit K, statement of Peter Anthony Randell dated April 2017 at page 62 of the inquest brief and transcript at pages 300-338. I note the following outline of the steps which Delmont can take to engage patients in active follow-up and support programs to follow on from their inpatient admission, at page 63 of the inquest brief *"This may include, but is not limited to, continued appointments with the patient's Delmont doctor; regular attendance at the Hospital Day Program Service; routine attendance at the Hospital Transition to Home Program; regular individual follow up at the patient's place of residence by the Hospital Community Outreach Service; linking the patient to appropriate local community support organisations and/or mental health professionals; re-connecting the patient to their referring General Practitioner; providing the patient with emergency follow up contact details for the hospital and community agencies; engaging the patient's carers/relatives in after hospital planning. These measures are applicable in normal and self-discharging against advice circumstances, where time and circumstances permit…" permit.*
[56] Transcript pages 312-315.
[57] Transcript page 239.

58. In Dr Tan's experience, a referral to the CAT team for medication compliance would be made for (say) a patient living alone without supports who was at risk of deteriorating but did not satisfy the requirements for compulsory treatment. However, where family members were available to help with the administration of medication, clinicians would elicit their support.[58]

59. At inquest, Dr Tan's discharge plan was endorsed (either in whole or in part) by A/Prof Varma, A/Prof Damodaran and Professor Malcolm John Hopwood, a consultant psychiatrist engaged as an expert witness by Delmont primarily to give expert evidence about matters pertaining to Delmont's interests.[59]

60. A/Prof Varma received a verbal handover from A/Prof Damodaran and was briefed about Christopher's discharge by Dr Tan when he returned to Delmont on Wednesday 11 June 2015. Dr Tan briefed him verbally during the 5.00pm daily ward round and he was comfortable with the information provided and was very happy with the discharge summary which he reviewed.[60] Similarly, A/Prof Damodaran testified that Dr Tan conducted a very comprehensive assessment and endorsed the discharge plan.[61]

61. Professor Malcolm John Hopwood (Prof Hopwood) was a consultant psychiatrist and expert witness who provided a statement on behalf of Delmont about matters pertaining to that party's interests.[62] At inquest, with some notice, I invited his opinion about broader matters, namely the correct interpretation of section 29 of the Mental Health Act 2014 and those aspects of the medical records which could have informed Dr Tan's decision to allow Christopher to take his own discharge on 9 June 2015.[63]

62. Prof Hopwood has extensive experience in psychiatry in a number of settings, including his current position at the Albert Road Clinic. This allowed him to comment about the feasibility of referring Christopher to one of Delmont's day programs post discharge. According to Prof Hopwood, the most frequent diagnostic groups targeted by day programs in private psychiatric settings are those who form the main cohort of private psychiatric patients – people with mood disorders, such as depression and bipolar disorder; anxiety disorders; and personality disorders which often present with

[58] Transcript page 290.
[59] Exhibit N, Prof Hopwood's report dated 3 April 2020 at page 101.1 of the inquest brief.
[60] Exhibit C, A/Prof Varma's statement of 8 May 2017 at page 34 of the inquest brief and transcript pages 115-117.
[61] Transcript pages 142-143 where unfortunately the last part of his answer was not transcribed and designated "indistinct" by the reporting service, and page 152.
[62] Exhibit N, Prof Hopwood's statement dated 3 April 2020 at page 101.1 of the inquest brief. See also his supplementary statement dated 18 September 2020, Exhibit O.
[63] Transcript page 339 and following.

depression and substance abuse.[64] It follows that the day programs are not designed for the kind of disorder that Christopher suffered.

63. Moreover, based on the nature of Christopher's discharge and descriptions in the clinical notes about his interactions with others, Prof Hopwood doubted that he would have engaged in group therapies such as the day programs that were available at Delmont. This arose from Christopher's psychotic symptoms and feelings of paranoia or persecution. Though not always the case, in Prof Hopwood's view, it was conceivable that Christopher would find the group format challenging, that he might misinterpret the interactions of others in the group and find participation more stressful than helpful. Prof Hopwood recognised that the programs such as they were reflected the general cohort of patients commonly treated in private psychiatric facilities and were not designed for patients with psychotic disorders.[65]

64. According to Prof Hopwood, the same considerations would suggest that hospital transition to home programs and community outreach programs available in the private setting would not have been feasible in Christopher's case. Finally, all such day programs were voluntary, could not be imposed on Christopher, and required his willingness to attend and engage, to be of any benefit.[66]

65. Prof Hopwood agreed that it was sensible to advise the family to contact the CAT team if Christopher deteriorated and he recognised that the CAT team has specific skills, training and expertise in assertive community treatment, particularly with patients proving difficult to engage in treatment. He did not go so far as to say that Christopher ought to have been referred to the CAT team for supervision of his medication compliance and general follow-up as part of the discharge plan. In part, this reflected Christopher's status as a voluntary patient and the reality that such a referral could be offered or suggested but not imposed.[67]

66. During the course of his evidence, Prof Hopwood repeatedly stressed the importance of an adequate assessment of the patient including exploration of the likelihood that the voluntary treatment plan would indeed be enacted, that the patient would accept treatment following discharge as envisaged. He described this as a difficult assessment that needed to be undertaken carefully and required subtlety. For example, a clinician would need to evaluate any assurance from a patient that they would take prescription

[64] Transcript page 345.
[65] Transcript pages 345-346, 348 and 384-385.
[66] Transcript pages 346-347.
[67] Transcript pages 348, 361, 385.

medication following discharge, factoring in their reluctance to take the medication during the admission and their desire to be discharged and potentially to say whatever was necessary to achieve that end.

67. Nevertheless, Prof Hopwood maintained throughout that, without the benefit of hindsight, he agreed with Dr Tan's decision not to invoke the compulsory treatment provisions and to allow Christopher to discharge himself against medical advice; that this was a reasonable decision based on what was known to Dr Tan at the time.[68] Prof Hopwood clarified that he was not so much endorsing Dr Tan's discharge plan such as it was, but agreed with his decision not to make an Assessment Order and commence the process of subjecting Christopher to compulsory psychiatric treatment.[69]

THE FAMILY'S APPROACHES TO ST VINCENT'S HEALTH

On 12 June 2015

68. In Ms French's appraisal, as they left Delmont on 9 June 2015, Christopher was 'now terrified and desperately ill, far sicker than when he was admitted four days earlier and they had with no clear pathway as to what to do next'.[70] On the way home, Christopher was almost lying down in the back of the car, covering himself with his hoodie and very distressed. In the days that followed, Christopher did not take the antipsychotic medication prescribed for him (olanzapine) and his parents remained on high alert.[71]

69. It was in this setting, described elsewhere as floundering, that Ms French called psychiatric triage on 12 June 2015 wanting information about CATS, how the service worked and what support they could provide. She found her interaction with the psychiatric triage clinician during this phone call 'pretty helpful' as they talked her through the procedure and said they would come if "we decided it was important,

[68] Transcript pages 360-377. In particular, transcript page 376 where Prof Hopwood stated – *"…the assessment that would occur around the time of discharge against medical advice is a nuanced one that has to take all of that into account. I accept that fully. And yes, including the issues that would need to be taken into account is the very fact that it is a discharge against medical advice and yes, it would be appropriate as a clinician to examine carefully how clear – well I think the easiest that this treatment plan is going to work. It is somewhat subjective art, it needs to be acknowledged sadly, and that's very challenging, clinically and for everyone concerned... but those factors absolutely should be taken into account."*

[69] Transcript page 377.

[70] Exhibit B, page 20 of the inquest brief and transcript page 65.

[71] This is my paraphrase of their state of mind. Neither Mr Hunter nor Ms French were challenged about their evidence that Christopher deteriorated once at home and they were at a loss about what to do. See for example transcript page 25 where Mr Hunter testified that – *"…he was deteriorating. That the paranoia was something that was appearing to become more and more intense, especially concern about anything and everything. There was no other sort of friends or other people to turn to and that seemed to be something that was just happening day by day…"* Also, transcript page 83 where Ms French testified that – *"…your evidence this afternoon has been that there was a deterioration between 9 and 12 July [sic]?---Yes, there was - he – hard to say deterioration but things weren't going well ---He was coming back a very sick boy and --- there was no – no evidence that he was making any progress following coming home from Delmont."*

urgent or whatever".[72] It is apparent from Ms French's evidence that the dilemma she and her husband found themselves in was knowing when Christopher's risk was heightened or when his mental state deteriorated to the extent that they should seek CATS intervention, and how to achieve this without damaging the their son's trust.

70. The clinician who took Ms French's call was described as a Social Worker (Grade 3) working as part of the Psychiatric Triage team recorded the salient details on a Screening Register.[73] It is apparent that the call was treated as a request for information about how the CATS could assist when and if required, not a referral or request for intervention at that time. When the contents of the Screening Register were put to Ms French during cross-examination by Ms Hodgson, she agreed with their accuracy.[74]

71. In particular, Ms French agreed that she said Christopher was a very private person and she would prefer that he not know that she had called, and that if CATS needed to be involved in the future, she would prefer that either their private psychiatrist or Delmont make the referral as she was worried that a referral by the family would impact their trusting relationship with Christopher.[75]

72. Consultant Psychiatrist Dr William James Leahey holds a part-time appointment at St Vincent's Hospital (**SVHM**) where he is the Clinical Director of Psychiatric Triage, Emergency Department Mental Health and the **CATS.** In his first statement for the inquest brief, Dr Leahey provided a narrative account of the interactions between CATS and Christopher's parents between 12 and 20 June 2015 based on his review of the medical records rather than any direct or indirect clinical input at the time of the events described.[76] Dr Leahey's endorsement of the CATS clinician's response to the approach from Ms French on 12 June 2015 was implicit in his first statement and explicit in his testimony at inquest.[77]

On 17 June 2015

73. One of the outcomes of Ms French's contact with psychiatric triage on 12 June 2015 was that Christopher was placed on Triage Alert. This is a local process within SVHM whereby if a triage clinician identifies that it is highly likely that there will be further contact about a consumer, as an aid in providing a timely response, the consumer's

[72] Transcript page 65.
[73] Pages 186-187 of the inquest brief. As a result of this contact, Christopher was placed on "Triage Alert" - See Screening Register re subsequent contact dated 17 June 2015 at page 184 of the inquest brief.
[74] Transcript pages 86-87.
[75] Ibid.
[76] Exhibit S is Dr Leahey's statement dated 4 October 2017, at pages 73-82 of the inquest brief.
[77] Exhibit S at page 76 of the inquest brief and transcript pages 595-597.

name is placed on a whiteboard and a period of time is denoted for the alert to remain active. Commonly this is a two-week period, but it depends entirely on the clinician's judgement and/or specific information provided by the referrer, for example the expected duration of a particular stressor. This was described as a passive process flagging further contact from outside SVHM about a particular consumer not signifying that psychiatric triage (or the broader mental health service) will take further action by way of follow-up or otherwise.[78]

74. Ms French made a second call to psychiatric triage on 17 June 2015 in response to the family's heightened concern about Christopher and his deteriorating mental state.[79] The triage clinician, a different one from the one Ms French spoke to on 12 June 2015, described as a Psychiatric Registered Nurse (Grade 3), completed a Screening Register with information provided by Ms French including the basis of her concerns about Christopher's deteriorating mental state which included increasing social withdrawal, no longer leaving the house, pervasive paranoia, feeling pressured to make amends for perceived mistakes and previous wrongs, preoccupation with social media and people criticising him.[80] It is apparent on the face of this Screening Registrar that the clinician completing it was aware that Christopher was on Triage Alert.[81]

75. Ms French said she did not believe that Christopher would be cooperative with CATS intervention but was amenable to the clinician speaking to Christopher on the phone. Having done so, the clinician documented that Christopher was initially wary, but rapport was established. He gave a history consistent with the concerns communicated by Ms French about his deteriorating mental state. He denied thoughts to harm himself or others; confirmed his family were supportive and protective and that home is a 'safe place'; and indicated that he believed he was suffering from depression and anxiety but did not believe he had a psychotic illness and 'does not like antipsychotics'.

76. Relevantly, Christopher was initially resistive to CATS contact and felt that it 'is all too fast' and he did not want to be 'bombed out' with medication, but then indicated he was accepting of further CATS contact.[82] The outcome of the family's interaction with triage

[78] See Statement of Mr Bryan Gibson Bowditch, Manager of the Crisis Assessment and Treatment Service, Psychiatric Triage and Emergency Department Mental Health programme at SVMH dated 3 October 2017, at pages 72 of the inquest brief. See also transcript page 594 where Dr Leahey explains the triage alert in similar terms.
[79] Transcript page 89.
[80] Screening Register dated 17 June 2015 at pages 184-185 of the inquest brief. See Exhibit S pages 76-77 of the inquest brief where Dr Leahey provides a fuller narrative account of the discussion between the triage clinician and Ms French based on the Screening Register.
[81] Screening Register dated 17 June 2015, at page 184 of the inquest brief.
[82] A fuller account of their discussion is in the Screening Register dated 17 June 2015, at page 185 of the inquest brief and a narrative account is in Exhibit S, Dr Leahey's first statement at pages 76-77 of the inquest brief. Note that

on 17 June 2015 was that telephone contact would follow to arrange an assessment of Christopher by the CATS.[83]

77. In response to cross-examination at inquest, by Ms Hodgson who represented St Vincent's Health, Dr Leahey was asked to appraise the outcome of the call and plan arrived at on 17 June 2015. His evidence was that the plan was completely adequate and appropriate.[84] He inferred that the clinician who took the call felt it was better, all things considered, that the CATS conduct a home visit the next day when everyone would be fresh and when psychiatric registrar Dr Mark Robertson, could be one of the CATS clinicians attending thus facilitating Christopher's commencement on appropriate antipsychotic medication if he could be persuaded.[85]

THE CLINICAL ASSESSMENT OF CHRISTOPHER ON 18 JUNE 2015

78. The CATS team who conducted a home visit with Christopher and his parents on 18 June 2015 comprised Dr Mark Peter Robertson, then a fifth-year psychiatric registrar, working as a Senior Registrar with the CATS[86] and a registered psychiatric nurse (**RPN**), described during the inquest as a very experienced and very senior mental health clinician.[87]

79. Dr Robertson provided a statement and gave evidence at inquest. While he recalled his attendance and interaction with Christopher on 18 June 2015, Dr Robertson stated that he relied on his clinical note made later that day[88] and that prior to undertaking the home visit he *would have* referred to the screening register made by the CATS clinician on 17 June 2015. It is entirely understandable and unexceptional that he did so in both respects.

80. Dr Robertson's statement is a narrative account with explication of the clinical note which I will not repeat here in its entirety. However, relevantly, Dr Robertson recalled difficulty in establishing rapport with Christopher, who was guarded and reluctant to

although clearly reluctant to take antipsychotics, Christopher had been persuaded by his father to take one 5mg tablet of olanzapine the day before.

[83] Ibid.

[84] Transcript page 599.

[85] Ibid.

[86] As at the date he made his statement, Dr Robertson was a consultant psychiatrist practising in Melbourne, having obtained his Fellowship of the Royal Australian and New Zealand College of Psychiatrists in August 2018 and was working as a Consultation-Liaison psychiatrist at the Peter MacCallum Cancer centre. When he gave evidence at inquest, he was a consultant psychiatrist at the Royal Women's Hospital.

[87] Transcript pages 599

[88] Exhibit R, Dr Robertson's clinical notes entitled CMHPN Doctor/Progress Notes, dated 18 June 2015, at pages191-192 of the inquest brief. See transcript pages 555 and following for Dr Robertson's evidence about when he made these clinical notes.

share information, and repeatedly indicated his preference to work with his psychologist with whom he had a long-established relationship. This reluctance led Dr Robertson to orient their approach towards developing a therapeutic alliance. His clinical impression was that Christopher was likely psychotic at the time of the assessment and he *would have* presumed the inevitability of longer-term interaction between St Vincent's mental health service and Christopher. In such instances, "*operating with excessive force can have negative repercussions for the longer-term therapeutic relationship, which is important in achieving recovery."*[89]

81. Dr Robertson considered and eschewed the making of an Assessment Order as his sense was that Christopher would have railed against an enforced treatment regime which would have been detrimental to building an ongoing therapeutic relationship. In adopting an approach of forging a therapeutic alliance, Dr Robertson noted the caring home environment in which Christopher lived with supportive parents.

82. In arriving at a plan, Dr Robertson was bolstered by the knowledge that Christopher had made no prior suicide attempts and weighed any potential risks to himself against the desirability of building a therapeutic relationship. Nonetheless, the plan allowed for escalation by the family calling psychiatric triage if Christopher's presentation changed, for CATS to telephone Christopher on Saturday and Sunday (20 and 21 June respectively) with the possibility of a home visit if he was amenable and the need had arisen, liaison with Christopher's psychologist following his scheduled consultation on Friday 19 June,[90] and a review by Dr Robertson on Monday 22 June 2015.[91]

83. Dr Robertson recognised that Christopher's reluctance to engage presented the greatest impediment to his clinical management and was acutely aware that the plan they were instituting meant there would be a delay in Christopher receiving antipsychotics until (at least) Monday. Given his stated reluctance to taking antipsychotics, Dr Robertson felt that the best compromise was to allow Christopher to discuss taking antipsychotics with his psychologist, in the hopes that he could be persuaded to do so.[92]

84. Dr Robertson's evidence at inquest was consistent with and expanded on his statement and, among other things, his understanding of the paradigm shift in the MHA

[89] Exhibit Q, at page 88 of the inquest brief.
[90] See Exhibit Q at page 89 of the inquest brief where Dr Robertson described liaison with Christopher's psychologist *"as an important aspect of the plan as the quality of this interaction would have had a great bearing on determining the best manner of proceeding. In essence, if it became evidence that this therapeutic relationship had deteriorated, then the plan was to have his treatment escalated, to consideration of involuntary treatment."*
[91] See Exhibit Q, at page 90 of the inquest brief, where the plan is described in nuanced but essentially the same terms.
[92] Ibid.

particularly as applied to the provisions for compulsory treatment; what he meant when he documented *"low threshold for involuntary treatment"* in Christopher's case; and the opportunity for oversight of decision-making in the CATS operational model.[93]

85. Dr Robertson testified that the major change brought in by the MHA was the requirement for greater participation by patients in navigating the complexities of their mental illness in conjunction with mental health services, greater autonomy for patients, shared decision-making and flexibility of approach with a strong preference for treatment delivery in the least restrictive manner possible and consequently a strong preference for voluntary over compulsory treatment.[94] His evidence was that Christopher had partial insight into his illness, 'was very much aware that something was going terribly wrong for himself', which is one aspect of insight, and that under the MHA, he had both capacity and a right to be involved in decisions about treatment.[95]

86. Dr Robertson testified about the many factors that needed to be balanced in arriving at a treatment plan – the history of how the person came to be in contact with the mental health service; any available collateral history; the person's mental state;[96] the particular environment including intimate family relationships and professional relationships such as Christopher's relationship with his psychologist – and then formulating a plan geared around the over-arching principles of the MHA which required working with Christopher to become better in himself.[97]

87. In response to an invitation to comment on Professor Harvey's attribution to him of apparent discomfort about Christopher's safety, Dr Robertson testified that although he clearly documented an aspect of uncertainty, he did not regard this as discomfort about Christopher's safety, rather as reflective of the complexities required to be weighed up with a difficult presentation.[98] Later, Dr Robertson explained what he meant by having a low threshold for involuntary treatment in Christopher's case by giving a series of examples of aspects of his situation which might change or be further compromised so as to require a change in the assessment and treatment plan.[99]

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[93] Ms Hodgson, counsel representing St Vincent's Health, led Dr Robertson's evidence starting at transcript page 540.
[94] Transcript page 540-542.
[95] Transcript page 546.
[96] Transcript pages 548-549. Note that the mental state examination entails -*"all features of that particular assessment: how they present in their behaviour, their speech, their affect, their mood, how they are thinking and how they're talking and what they are talking about. Entailed in that is consideration of insight, judgement and risk."*
[97] Ibid.
[98] Transcript page 551.
[99] Transcript pages 558-561.

Oversight of clinical decision-making within CATS

88. As a registrar, Dr Robertson was working under the supervision of Dr James Leahey, the Clinical Director of the CATS and Dr Dominika Baetens, another consultant psychiatrist at St Vincent's Health, who was allocated as his formal supervisor.[100]

89. In addition, CATS decisions about management of a patient as a voluntary or compulsory patient are reviewed by a multi-disciplinary team at CATS handover meetings which take place morning and afternoon seven days a week. Christopher's assessment and plan would have been discussed at the afternoon meeting on 18 June 2015 and the meeting the following morning which is chaired by a consultant psychiatrist and is usually also attended by the CATS team manager.[101]

90. Dr Robertson was aware and reassured by this overview and did not consider that Christopher's case presented a level of risk that required any escalation beyond the usual practice such as calling Dr Leahey to discuss the plan outside of established review processes.[102] Moreover, Dr Leahey's evidence at inquest was that registrars are encouraged to contact the duty consultant via their mobile number which is available to them or via the SVH switchboard, if they perceive a need; and despite the tragic outcome in this case, the situation confronting Dr Robertson was a commonplace in terms of the work of CATS registrars and clinicians.[103]

91. At inquest, both Dr Robertson and Dr Leahey spoke to the CATS internal review processes. Importantly, they also spoke to robust decision-making and a flat structure within the SVH mental health service in which all clinicians are encouraged to voice any concerns they may hold about a clinical decision, irrespective of their particular discipline or role, or the status they may occupy in a more traditional hierarchical structure.[104]

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[100] Exhibit Q, at page 91 of the inquest brief.
[101] Exhibit U, Dr Leahey's statement dated 1 June 2020 at page 84.2 of the inquest brief and transcript page 592.
[102] Exhibit Q, at page 91 of the inquest brief and transcript pages 552-3, 565. It is noteworthy that staff also rotate through the various teams. As explained by Dr Leahey at transcript pages 592-593 – *"Basically in 2015, staff rotated between those three areas, so they might be on CAT one day, or for a few days, then do some shifts in triage, triage is our single point of entry into the mental health service…There's a lot of communication because…[staff are] all very familiar with each other. They consider themselves ultimately to be part of one – well, they are one team…just happen to be operating in difference roles at different times…in 2015, triage were co-located with ED mental health…there's very easy communication between the various parts of my team because they know each other very well…someone who's not in triage may have been on CAT the previous week and take a call from a consumer or carer they will be familiar with that case. And they have full access to all the notes et cetera."*
[103] Transcript page 619.
[104] For Dr Leahey's evidence in this regard see transcript pages 599 and following and Exhibit T at page 84 and Exhibit U at page 84.2 of the inquest brief respectively. Note that in the latter statement, Dr Leahey stated his belief that the RPN accompanying Dr Robertson on 18 June 2015 *"would have spoken if she had disagreed with Dr*

92. Support for the CATS team's assessment and plan made on 18 June 2015 can be found in Dr Leahey's statements where he expressed the opinion that the plan was 'in line with the principles of least restrictive care' mandated by the MHA and that the 'assessment was as comprehensive as possible under the circumstances and the plan appropriate, particularly given the principles of least restrictive management required under the MHA'.[105]

93. During cross-examination at inquest, Dr Leahey maintained this position, and went further, testifying that the plan made for Christopher was not only reasonable and appropriate within a range of possible outcomes but that it was *the right* decision, indeed was *absolutely the right decision*, in the circumstances that prevailed or were known at the time, and a decision to make an Assessment Order as the first step in the compulsory treatment process would have been the *wrong decision*.[106]

94. As the consultant psychiatrist who chaired the morning handover meeting on Friday 19 June 2015, Dr Leahey recalled that not only did he not think there was anything wrong with the plan (at that time), but that he thought it was a good example of working collaboratively with the patient and his family to ensure he got the help he needed in the least restrictive way, a way that respected his autonomy.[107]

95. At inquest, Dr Leahey went further and gave evidence that if an Assessment Order had been made on 18 June 2015, it was highly likely or extremely likely that he would have been the consultant reviewing that order in the emergency department on the morning of 19 June 2015. Presented with Christopher's history, including the environment from which he came, his supportive parents, the fact that although ill he was not expressing - and was in fact denying - suicidal ideation and was prepared to consider antipsychotic medication after speaking to his trusted psychologist, Dr Leahey testified that he would have taken Christopher off the order as being inappropriate and sent him home with CATS follow-up. Relevantly, he would have been concerned that trust and rapport building by CATS would have been detrimentally impacted in the process.[108]

Robertson and/or would have escalated her concerns to me or one of my senior colleagues. She would have done so without fear or favour."

[105] Exhibit S at page 79 and Exhibit U at page 84.2 of the inquest brief respectively.

[106] Transcript pages 605-606.

[107] Exhibit U at page 84.2 of the inquest brief.

[108] Transcript pages 608-609. For completeness, I note that in his first statement, Exhibit S at page 81 of the inquest brief, Dr Leahey advised that Christopher's case was reviewed by SVHM's

PROFESSOR HARVEY'S EVIDENCE AND THE MENTAL HEALTH ACT 2014

96. Professor Richard Harvey is a consultant psychiatrist in private practice with previous experience in the public mental health system. He was engaged by the court to provide an independent expert appraisal of the clinical management and care provided to Christopher during his last episode of care from 4-20 June 2015 based on material available at the time; to advise whether Christopher met the criteria for compulsory treatment under the MHA on 9 June 2015 or on 18 June 2015 to assess post-discharge follow-up provided by Delmont Private Hospital and give any other information of advice that may assist the coroner.[109]

97. The latter was intended and was indeed understood by Prof Harvey to be an invitation to consider any systems/systemic issues and whether the circumstances in which Christopher died provided scope for "prevention", that is an opportunity to make comments or recommendations aimed at reducing the number of preventable deaths.[110]

98. Prof Harvey was cross-examined at length at inquest about several aspects of his report where he made what appeared to be criticisms of the clinicians involved – relevantly, a failure of handover and lack of continuity of care; an apparent lack of depth in documented assessments of Christopher while an inpatient; a lack of clarity around supervision of Dr Tan; a failure to make provision for ongoing management pending review by A/Prof Varma or involvement of the CATS; and a possible lack of supervision/support of Dr Robertson.[111]

99. In the end, Prof Harvey made it clear that any criticisms in his report and evidence was aimed at the system within which Drs Tan and Robertson were training and working and not at them as individual clinicians.[112]

100. Perhaps due to the potential to have led to a changed outcome, Prof Harvey's main concerns related to the supervision of the two registrars, Drs Tan and Robertson, and his

[109] Exhibit P at pages 92-101 is Prof Harvey's reported dated 20 February 2018 which includes brief details of his formal qualifications and experience.
[110] See paragraphs 16 and 17 above.
[111] Transcript pages 398-404.
[112] For example at transcript pages 429-430 – *"Mr Halley: …I just want to go firstly to your overall analysis, and this is a classical example of a Swiss cheese model of events causing a terrible outcome, that seems to be your reasoning. Is that correct, for me to make the assumption, that it's a series of events that have coalesced to cause a tragic outcome? --- Exactly, precisely, yes. You're not really saying any one of those events, the person involved in that event, you're not apportioning blame, you're just saying in this particular case, there's been a number of events that have coalesced to cause a terrible outcome. --- Absolutely. Not in the slightest would I want any of my comments to be taken as blame by any of the practitioners who were involved. These are unfortunate things that happen, and it is the system of healthcare that sits around us ah that is there to prevent these outcomes but sometimes, ah the holes line up and the patient can pass through."*

perception that they were not adequately supervised/supported in terms of their determinations on 9 and 18 June 2015 respectively not to make Christopher the subject of an Assessment Order pursuant to section 29 of the MHA. He testified about the undue burdens placed on registrars in a very busy mental health system in which there are often unspoken and subtle impediments for junior doctors to interrupt workflow by seeking consultant input when they are unsure of the decisions they need to make.[113]

101. This gave rise to extensive cross-examination of Prof Harvey, in particular by Mr Cash on behalf of Dr Tan, about the correct application or interpretation of section 29 of the MHA,[114] especially section 29(d) which Dr Tan had identified as the criterion not met by the circumstances pertaining to Christopher on 9 June 2015.

102. That said, on a fair and objective reading of Dr Tan's evidence as a whole, it was Christopher's stated preparedness to accept treatment on a voluntary basis which led to Dr Tan's decision not to make an Assessment Order, albeit he misinterpreted that preparedness as amounting to a failure to satisfy section 29(d) of the MHA. In so doing, Dr Tan was abiding the strong preference in the MHA for treatment in the least restrictive means reasonably available and/or did not assess Christopher as needing *immediate* treatment as required by section 29(b) of the MHA.

103. Having reviewed the transcript in its entirety, the legislation as enacted, the excerpts from Hansard referred to during the inquest and counsel's submissions, I accept that Prof Harvey's interpretation of section 29(d) is correct, that is that the assessment envisaged is that of an authorised psychiatrist.[115] An assessment by A/Prof Varma, A/Prof Damodaran or any other consultant psychiatrist in private practice is not the assessment referred to in section 29(d) of the MHA. It follows that an early (or earlier) review by A/Prof Varma would not be a less restrictive means reasonably available to enable Christopher to be "assessed" and to the extent that this formed part of Dr Tan's reasoning it was flawed.

[113] Transcript pages 403-406.
[114] The text of this provision which was scrutinised at length during the inquest is as follows: "Section 29 **Criteria for an Assessment Order** The criteria for a person to be made subject to an Assessment Order are – (a) the person appears to have mental illness; and (b) because the person appears to have mental illness, the person appears to need immediate treatment to prevent – (i) serious deterioration in the person's mental or physical health; or (ii) serious harm to the person or to another person; and (c) if the person is made subject to an Assessment Order, the person can be assessed; and (d) there is no less restrictive means reasonably available to enable the person to be assessed."
[115] Transcript pages 416 and following.

104. It is important to note that while Prof Hopwood[116] appears to have misinterpreted section 29(d) of the MHA in the same way as Dr Tan, A/Prof Damodaran[117] gave evidence in keeping with the interpretation urged by Prof Harvey as regards section 29(d) of the MHA and focused, in Christopher's case, on his preparedness to accept voluntary treatment and therefore the inability to satisfy section 29(b) MHA criterion of appearing to need immediate treatment to prevent serious deterioration in his mental health.

105. Similarly, Dr Leahey focused his comments about the inability to make Christopher the subject of an Assessment Order on 18 June 2015, on section 29(b) of the MHA, expressing the opinion that the criterion for *immediate need for treatment* in section 29(b) of the MHA was not met and that while Christopher may not have been consenting to medication, at the time, he was consenting to a treatment plan which included discussing medication with his psychologist.[118]

FINDINGS/CONCLUSIONS

106. 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 explication.[119]

107. Moreover, the effect of the authorities is that Coroners should not make adverse comments or findings against individuals or institutions, unless the evidence provides a comfortable level of satisfaction that they departed materially from the standards of their profession and in so doing, caused or contributed to the death.

108. It is axiomatic that the *material departure* from applicable standards be assessed without the benefit of hindsight, on the basis of what was known or should reasonably have been known at the time, and not from the privileged position of hindsight. Patterns or trajectories that may be appreciated at a later time or may even obvious once the tragic outcome has come to pass are to be eschewed in favour of a fair assessment made

[116] Transcript pages 377 and following.
[117] Transcript pages 183-186, especially at page 186 where A/Prof Damodaran testified as follows: *"…the context if for an assessment order for compulsory treatment so if a person does not require compulsory treatment then the whole criteria doesn't apply because the person is expected to be treated in the least restrictive and the least intrusive manner…"*
[118] Transcript page 609.
[119] *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…*"

while standing in the shoes of the individual or institution whose conduct is under scrutiny.

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

(a) The deceased is Christopher David French Hunter born 11 May 1984.

(b) Christopher died on 20 June 2015 at 1/43 Faversham Road, Canterbury, Victoria.

(c) The cause of Christopher's death is hanging.

(d) While the available evidence supports a finding that no-one else was involved in Christopher's death, it also supports a finding that he was suffering from a psychotic illness at the time, and that his judgement was likely significantly impaired by that illness.

(e) It follows that evidence does not support a finding that Christopher intentionally took his own life.

(f) There was no want of clinical management or care on the part of the clinicians involved with Christopher during his last episode of care between 4-20 June 2015 that caused or contributed to his death.

(g) The weight of available evidence supports a finding that Dr Tan's assessment of Christopher on 9 June 2015 and his decision to allow him to discharge himself against medical advice was sound based on what was known by him at the time and without the benefit of hindsight.

(h) That said, Dr Tan's own evidence supports a finding that while his decision not to make an Assessment Order on 9 June 2015 is supported by the weight of evidence before me, his approach to and interpretation of the criterion in section 29(d) of the MHA 2014 was flawed. To use a colloquialism, he was right for the wrong reason.

(i) Professor Hopwood's evidence in this regard suggests there may be a broader problem with how section 29 of the MHA is being interpreted by clinicians in the field and, if so, this is disheartening.

(j) The response of SVHM's psychiatric triage service to Ms French's telephone call asking for information on 12 June 2015 was reasonable and appropriate.

(k) The response of SVHM's psychiatric triage service to Ms French's telephone call on 17 June 2015 including the telephone assessment of Christopher and the plan to conduct a home visit the following day was reasonable and appropriate.

(l) Without the benefit of hindsight, the CATS team's assessment of Christopher on 18 June 2015 and the plan for CATS follow-up was reasonable and appropriate.

(m) The weight of evidence supports a finding that there was no sound basis for making Christopher the subject of an Assessment Order on 18 June 2015.

(n) Nomenclature aside, Dr Robertson's approach to and interpretation of section 29 of the MHA was sound. His assessment and treatment of Christopher was in keeping with the legislative preference for treatment in the least restrictive means reasonably available and was likely to improve trust and rapport building and his longer-term engagement in treatment.

(o) The supervision of Drs Tan and Robertson at the material time, that is when they were involved in the clinical management and care of Christopher was in accordance with the standards applicable at the time.

COMMENTS

Pursuant to section 67(3) of the ***Coroners Act 2008,*** I make the following comments on matters connected with the death, including matters relating to public health and safety or the administration of justice:

1. Suicide remains difficult to predict on an individual basis and although risk assessment and mental state examination are core competencies for clinicians working in the mental health system, identifying those situations where suicide is an imminent risk and where "prevention" gains can be made is confounded by this difficulty.

2. Christopher was fortunate indeed to have the love and support of both his parents and other family members. His parents were integral to his access to care in the private sector and in the public mental health system during his last episode of care between 4 and his death on 20 June 2015. They were however naïve to mental illness having no lived experience and no experience of mental illness within their family to draw upon in navigating the mental health system as a whole.

3. The discharge plan pursuant to which Christopher left Delmont Hospital precipitously and against medical advice on 9 June 2015 relied heavily on Christopher's parents to monitor his mental state, supervise the taking of prescription medication and facilitate his attendance at appointments, all while trying to deal with their son's distress in the face of the debilitating symptoms of a newly diagnosed psychotic illness.

4. Mr Hunter and Ms French would have benefitted from more immediate practical support and ready access to advice in carrying the heavy burden of caring for their son when he was so unwell in the days that followed his discharge from Delmont Private Hospital on 9 June 2015. This may have helped them understand their son's illness and the mental health system as a whole and enabled them to feel more empowered to access supports such as the CATS at an earlier time with the *potential* for a different outcome.

5. Christopher's death occurred when the ***Mental Health Act 2014*** was relatively new, and clinicians were still coming to grips with its various provisions. Following the report of the Royal Commission into Victoria's Mental Health System tabled in the Victorian Parliament on 2 March 2021 and the government's acceptance of its comprehensive recommendations, Victoria is on the brink of far-reaching reforms of the mental health system which have been described as generational change.

6. A number of the recommendations of the Royal Commission address the concerns raised by Mr Hunter and Ms French during the inquest about adequate support of carers and recognition of their important role in caring for loved ones, and I hope that in time, we will see a more responsive and inclusive mental health and wellbeing system from the carers' perspective.

PUBLICATION OF FINDING

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

DISTRIBUTION OF FINDING

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

Mr Hunter and Ms French

Delmont Private Hospital

Associate Professor Shashjit Varma

Associate Professor Saji Damodaran

Dr Schuyler Tan

Dr Mark Robertson

St Vincent's Hospital Melbourne

Office of the Chief Psychiatrist

Signature:

Paresa Antoniadis Spanos

Coroner

Date: 11 August 2022

Cc: Sergeant Duncan McKenzie – Police Coronial Support Unit