IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2018 000597

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Paul Lawrie
Deceased:	Abdurrahman Coskun
Date of birth:	03 April 1964
Date of death:	06 February 2018
Cause of death:	1(a) NECK COMPRESSION IN THE CIRCUMSTANCES OF HANGING
Place of death:	2 Akita Court, Keysborough, Victoria, 3173
Keywords:	Suicide; mental health services

INTRODUCTION

1. On 6 February 2018, Abdurrahman Coskun was 53 years old when he was found deceased at his home. At the time of his death, Mr Coskun lived at 2 Alita Court, Keysborough with his wife and three adult children.

THE CORONIAL INVESTIGATION

2. Mr Coskun'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.

3. 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.

4. 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.

5. Coroner John Olle originally held carriage of this investigation. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Mr Coskun's death. The Coroner's Investigator conducted inquiries on Coroner Olle's behalf, including taking statements from witnesses – such as family members, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

6. I took carriage of this matter in October 2022 for the purposes of finalising the investigation and this finding.

7. This finding draws on the totality of the coronial investigation into the death of Mr Coskun 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.[1]

BACKGROUND

8. Mr Coskun was born on 3 April 1964 in Ankara, Turkey. He had two younger sisters and one younger brother.

9. Mr Coskun immigrated to Australia with his family in 1970 when he was six years old. His family initially lived in Western Australia, and Mr Coskun completed primary school in Fremantle. He did not attend secondary school.

10. Mr Coskun moved to Melbourne in his late teenage years. In 1984, he commenced a relationship with Aynur Kasicki (**Mrs Coskun**) and they were married in 1985. Following the wedding, Mr and Mrs Coskun lived together with Mr Coskun's parents in Dandenong South.

11. Mr and Mrs Coskun had three children together, all of whom were adults at the time of Mr Coskun's death. Following the birth of their second child in 1987, Mr and Mrs Coskun moved into their own home in Dandenong South.

12. In 1998, Mr Coskun's younger brother passed away from a heroin overdose. His nephew also passed away at a young age from a meningococcal infection. These events had a significant impact on Mr Coskun.

13. In 2000, Mr Coskun and his family moved to 2 Akita Court, Keysborough.

14. In 2014, Mr Coskun's niece ran away from home and travelled to Syria to become a member of the Islamic State of Iraq and Syria (**ISIS**). Mrs Coskun reported that this appeared to have a significant impact on her husband.

15. During his career, Mr Coskun worked in various manufacturing jobs including as a machine operator in the textile industry, manufacturing soap products, and manufacturing food products for General Mills.

[1] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

16. In 2017, Mr Coskun was made redundant from his role at General Mills, where he had worked for 15 years. He was given approximately eight months' notice of the redundancy.

17. Mrs Coskun stated that Mr Coskun saw the redundancy in a positive light. He was reportedly looking forward to being made redundant as it would enable him to retire early and he planned to use his free time to travel and repaint their house. Mrs Coskun reported that they were not experiencing financial stress.

18. In October 2017, Mrs Coskun received news that her father, who lived in Turkey, was unwell. Mrs Coskun travelled to Turkey and stayed for approximately one month to assist him. She maintained regular contact with Mr Coskun during this time.

19. Mrs Coskun stated that, after she returned home, Mr Coskun initially appeared 'really good'. However, approximately five days after her return she noticed a change in his demeanour. He told Mrs Coskun that he felt 'empty inside' and like 'something bad was about to happen'. Mr Coskun stopped eating and reduced his interactions with family members.

20. On 11 December 2017, Mrs Coskun took Mr Coskun to visit their local General Practitioner (**GP**), Dr Jim Demirtzoglou, at the Modern Medical Clinic in Dandenong. Mr Coskun reported feeling flat, lethargic, and depressed but he was unable to point to a specific trigger for this. He had experienced a similar episode seven years earlier, in 2011, for which he was prescribed duloxetine. However, he ceased this medication after a period of sporadic compliance. Further medical testing at that time had revealed that Mr Coskun suffered from a blood disorder, monoclonal gammopathy, together with painful peripheral neuropathy. This was managed with gabapentin and prednisolone in addition to the duloxetine.

21. On 19 December 2017, Mr Coskun had a further appointment with Dr Demirtzoglou. He reported that he was still feeling depressed, suffering from anxiety, and that he had started to experience suicidal ideation. Dr Demirtzoglou referred Mr Coskun for thyroid and blood tests, which returned normal results, and referred him to the Dandenong Crisis Assessment and Treatment Team (**CATT**).

22. Mr Coskun's symptoms did not improve, and so on 24 December 2017, Mrs Coskun contacted the Monash Health Psychiatric Triage Service (**PTS**). They spoke with Mr Coskun, who reported experiencing low mood for the preceding four weeks, withdrawing from family, hopelessness, helplessness, anhedonia[2], poor sleep, poor concentration, reduced appetite with

[2] The inability to feel pleasure from usually pleasurable activities.

associated weight loss of eight kilograms in three weeks, reduced energy, and suicidal ideation with a recent increase in the frequency. Monash Health PTS made an appointment for Mr Coskun to be visited by the Dandenong Mental Health Hospital in the Home (**HITH**) team the following day.

23. On 25 December 2017, Mr Coskun was visited by two nurses from HITH. He presented with suicidal ideation that had increased over the previous week. He reported several vague plans which included hanging, gassing himself in the car, walking into traffic, and driving his car off a cliff, but no intent to act on these. He also reported the same symptoms he had disclosed to Monash Health PTS the day before. Mr Coskun reported that the onset of his depression was sudden, and he was again unable to identify any acute stressors or precipitating event. He had good insight into his presentation and wished to engage in treatment.

24. The HITH team facilitated a review with a psychiatry registrar the same afternoon. During this review, Mr Coskun reported experiencing depressive symptoms for one month which were noted to include 'low mood, hopelessness, poor sleep, lack of energy, lack of motivation, poor appetite and one week of suicidal ideation with vague plan without intent'. He was reportedly unable to identify a trigger for his deterioration and although he disclosed having recently ceased employment, he was adamant that this did not trigger his symptoms. Mr Coskun was commenced on 7.5mg mirtazapine with a plan for him to be seen daily by the HITH team over the next five days. He was also referred for a computed tomography (**CT**) scan of his brain and copies of his recent blood test results were obtained by the HITH team. Mr Coskun was also contacted by a HITH social worker twice that evening with no concerns noted.

25. Mr Coskun was visited by different members of the HITH team between 26 to 29 December 2017.

26. On 26 December 2017, Mr Coskun attended the Dandenong Hospital and was reviewed by a consultant psychiatrist, Dr Marlies Lagerberg, a psychiatric hospital medical officer (**HMO**), Dr Dean Whitty, and a HITH nurse, Liz Van Diemen. During this appointment Mr Coskun disclosed ongoing depressive symptoms. Mrs Coskun was present during this appointment and stated that Mr Coskun spoke openly about 'how he felt empty, hopeless and felt like a burden to his family. [Mr Coskun] told her that he has no joy and wants to kill himself'. She stated that Mr Coskun also described his planned method of suicide.

27. An impression of moderate to severe depression with low to moderate risk of harm to self was documented. Mr Coskun's mirtazapine dosage was increased to 15mg to assist with his depressive symptoms and sleep, with a plan to increase the dosage further after three days. Mr Coskun was also commenced on diazepam, to assist with anxiety, and temazepam, to assist with sleep. Education was also provided to Mr Coskun in relation to depression and treatment. Mr Coskun was encouraged to see his GP and arrange a Mental Health Care Plan (**MHCP**). Both he and his family were encouraged to contact the CATT or HITH team in between HITH reviews if required.

28. On 27 December 2017, HITH assessed Mr Coskun in his home. He reported feeling less stressed, with a decrease in the intensity and frequency of his suicidal ideation, although he continued to experience fleeting suicidal thoughts with no plan or intent. He continued to be low in mood with anhedonia, poor motivation, and low energy. Education regarding depression and treatment was again provided.

29. At a subsequent HITH assessment on 28 December 2017, Mr Coskun reported he had been ruminating on suicidal thoughts, although he did not have a plan, because he felt useless and had only slept for three hours the previous night. He continued to experience anhedonia, poor motivation and energy, poor appetite, anxiety, hopelessness, and helplessness.

30. Dr Whitty assessed Mr Coskun during a HITH visit on 29 December 2017. At this assessment, Mr Coskun reported that his symptoms were unchanged, although he had experienced 'moments of happiness' the previous day. He also reported ongoing difficulty with sleeping, having only slept for four hours the previous night. Mr Coskun reported ongoing suicidal ideation, but denied intent, citing his family as a strong protective factor. It was noted that investigations of potential physical contributors, specifically blood tests and CTs of his brain, chest, pelvis, and abdomen, produced results that were largely unremarkable. Mr Coskun was informed about the delayed response time of antidepressant treatment, and his mirtazapine prescription was increased to 30mg at night. His care was transferred to the CATT with a plan to ultimately discharge him to his GP the following week.

31. Between 30 December 2017 and 11 January 2018, the CATT had frequent (almost daily) contact with Mr Coskun, either via telephone or in person.

32. During a CATT review on 31 December 2017, Mrs Coskun reported that Mr Coskun's mental state appeared to be improving, he was engaging more with his family and had attended a wedding the previous day. However, Mr Coskun disagreed, stating that he felt the same, had

noticed no improvement, and had found it extremely difficult to attend the wedding. He continued to experience ongoing suicidal ideation with no plan or intent. Further education was provided to Mr and Mrs Coskun about treatment for depression, including medication and engaging in usual activities.

33. During an assessment with the CATT on 3 January 2018, Mr Coskun reported that he felt his mood had deteriorated and he was currently more depressed than he had ever been. He continued to experience fleeting suicidal ideation with no plan or intent and was continuing to experience poor sleep which had not improved with the diazepam and temazepam. He reported not experiencing any side effects from the mirtazapine. He also advised that he had ceased taking temazepam. His mirtazapine prescription was increased to 45mg. The same day, he also saw Dr Demirtzoglou but no further changes were made to his treatment.

34. On 4 January 2018, Mr Coskun was assessed by the CATT via telephone. He was noted to sound tired and frustrated and reported the same symptoms, with no improvement. He reported fleeting thoughts to hang himself or walk in front of a train but denied any intent to act on these thoughts. He stated he had not slept well the previous night.

35. On 5 January 2018, Mr Coskun reported similar symptoms at his CATT assessment. He continued to experience poor sleep, despite the increase in his mirtazapine and taking temazepam. He was given information about sleep hygiene.

36. Mr Coskun reported no improvement at a CATT assessment on 8 January 2018. It was noted that his risk at that time appeared higher than when he had first presented.

37. On 9 January 2018, Dr Whitty visited Mr Coskun at his home and conducted a mental health assessment. Mr Coskun again reported no improvement in his mental state. He reported low mood, low energy, poor motivation, poor concentration, poor sleep (aside from one evening of good sleep two nights prior), fleeting suicidal ideation without plan or intent, and themes of hopelessness. His judgment was deemed to be poor due to a lack of motivation.

38. Mr Coskun's wife and son said they felt Mr Coskun's mood had improved slightly over the preceding fortnight.

39. Dr Whitty discussed the option of electroconvulsive therapy (**ECT**) with Mr Coskun if the mirtazapine did not lead to an improvement. Dr Whitty considered that Mr Coskun was experiencing major depressive disorder with a slight improvement in symptoms and a low risk of self-harm. A plan was developed for the CATT to review him two days later and to

discharge him to his GP, with whom he had an appointment the following day (10 January 2018).

40. Dr Whitty stated that Mr Coskun and his wife were agreeable with the plan for him to be discharged from the CATT and to follow up with his GP and psychologist. They were advised to contact 000 or the psychiatry triage number or attend the Emergency Department in the event of a crisis or if they had concerns. Dr Whitty also discussed this plan with Dr Demirtzoglou.

41. On 10 January 2018, Dr Demirtzoglou completed a MHCP with Mr Coskun and referred him to psychologist, Dr Mark Saltar. Mr Coskun's progress and mental state were not recorded for this appointment.

42. On 11 January 2018, Mr Coskun was reviewed at home by the CATT. He reported no change in his mental state and that he continued to experience suicidal ideation with no plan or intent, low mood, and hopelessness. Mrs Coskun said that his mood had improved 'slightly'. Mr Coskun told the CATT he had left messages with three private psychologists and a CATT clinician assisted him to make an appointment with psychologist, Shirley Wilson, for 3.30pm the following day.

43. On 12 January and 23 January 2018, Mr Coskun attended upon Ms Wilson. The primary focus of these sessions was on exploring Mr Coskun's life, major life events, and the emotional impact of these, rather than exploring his current mental state and recent depression. Ms Wilson's assessment identified several negative themes that were evident throughout Mr Coskun's life and she developed a plan to explore these further at their next session. There is no evidence that Mr Coskun expressed suicidal ideation during these sessions or that Ms Wilson inquired. The referral from Dr Demirtzoglou to Ms Wilson indicated that Mr Coskun was experiencing 'depressed mood' and 'depression, anxiety, acute onset' and that he had 'nil' ideation/thoughts of suicide.

44. On 1 February 2018, Mr Coskun attended another appointment with Dr Demirtzoglou. He presented with no improvement to his depressive symptoms. Dr Demirtzoglou continued Mr Coskun on his existing dosage of 45mg mirtazapine and planned for a further review two weeks later.

45. Mrs Coskun recalled that after this appointment, Mr Coskun appeared to have more energy and 'appeared to be a little better'. She stated 'he was interacting with me and our kids' and he had told her that he 'was looking forward to having grandkids'.

46. On 2 February 2018, Mr Coskun attended Friday prayers at a mosque in Keysborough. Mrs Coskun stated that he normally attended the mosque for three hours, however on this occasion he returned home after approximately one hour. Mr Coskun told her that he had felt as though everyone was looking at him and that they all knew something was wrong with him. Mrs Coskun stated that Mr Coskun was 'very sweaty and in a panicked state'.

47. Later the same day, Mr Coskun visited his sister and they spoke about mental health issues.

48. Mrs Coskun recalled that over the next few days Mr Coskun appeared to be doing well. He attended a family outing and was helping with planning for an upcoming family wedding.

49. On 4 February 2018, Mr and Mrs Coskun were cleaning the garage at their home when Mr Coskun picked up a box of rope and said to Mrs Coskun words to the effect of, 'if you give a man enough rope, he will hang himself'. She noted that during the preceding weeks he had told her of several different ways he could suicide, but this was the first time he had mentioned hanging.

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

Circumstances in which the death occurred

50. At 7.30am on 6 February 2018, Mr Coskun and his daughter collected Mrs Coskun from work, and they all walked home together. After they returned home, the children left to attend work. Mrs Coskun spoke to Mr Coskun for a period and asked him to attend to some errands. She then went to bed to have a short sleep.

51. Mrs Coskun woke at approximately 11.00am. She did not see Mr Coskun inside the house but noticed that his car was still parked outside. She began searching for him and went to the garage at the rear of their property. When she entered the garage, she observed Mr Coskun hanging by his neck from a boxing bag stand. An electrical cable was tied around his neck. Mr Coskun did not appear to be moving or breathing.

52. Mrs Coskun cut Mr Coskun down and contacted her eldest son, asking him to come home immediately. She then contacted emergency services and followed their instructions to commence cardiopulmonary resuscitation.

53. Ambulance Victoria paramedics arrived shortly afterwards. They observed that Mr Coskun was unconscious, unresponsive, and apnoeic with no pulse in cardiac arrest. Attempts at resuscitation were unsuccessful and Mr Coskun was declared deceased at the scene.

54. Victoria Police members also attended and conducted an examination of the scene. They determined that there were no suspicious circumstances related to the death.

Identity of the deceased

55. On 6 February 2018, Abdurrahman Coskun, born 3 April 1964, was visually identified by his son, Aliosman Coskun.

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

Medical cause of death

57. Forensic Pathologist, Dr Victoria Francis from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination on 7 February 2018 and provided a written report of her findings dated 9 February 2018.

58. The post-mortem examination revealed that Mr Coskun had ligature marks showing features consistent with the electrical cable. A post-mortem CT scan showed no obvious laryngeal injury.

59. Toxicological analysis of post-mortem samples identified the presence of mirtazapine in levels consistent with therapeutic use.

60. Dr Francis provided an opinion that the medical cause of death was 1 (a) NECK COMPRESSION IN THE CIRCUMSTANCES OF HANGING.

61. I accept Dr Francis' opinion.

FAMILY CONCERNS

62. In August 2018, Mr Coskun's family submitted a statement to the court, outlining their concerns with respect to the mental health care provided to Mr Coskun. They suggested that the mental health system had failed Mr Coskun and that, despite his repeated attempts to seek help, he was not provided with appropriate assistance.

63. The family detailed a range of specific concerns, including that:

a) Mr Coskun was never admitted to hospital, despite his repeated requests.

b) The clinicians who visited Mr Coskun in the home were always different, and Mr Coskun was unhappy that he had to explain the same things over and over again to different people. He told family members that he felt like he was not being listened to and expressed frustration and confusion regarding this lack of continuity.

c) Mr Coskun was never alone for any of his appointments or reviews.

d) Mr Coskun's treating practitioners did not involve Mr Coskun's family members in his treatment and did not offer them any guidance or support. They were not provided with information regarding his treatment or other potential treatment options and were not advised that he required close monitoring. They were also not provided with information about possible warning signs. They noted that they had private health cover and had the means to pay for alternate treatment options, such as a private psychiatric clinic or hospital, had this been presented as an option.

e) Mr Coskun was discharged from the CATT to the care of his GP and psychologist, despite showing no improvement in his symptoms at the time of discharge. Further, a psychiatrist was not included in this discharge plan, and Mr Coskun was not directly referred to a psychiatrist at this time.

f) After Mr Coskun completed a MHCP with his GP, he was asked to return in one week for a referral to a psychologist. Mr Coskun's family suggested that he should have been referred to a psychologist immediately given his recent history.

g) At Mr Coskun's final appointment with his GP on 1 February 2018, he reported no improvement in his mental health, that he was still experiencing suicidal ideation and that he wished to be admitted to hospital. Despite this, the GP did not organise any follow up appointments, or notify Mrs Coskun of the change in Mr Coskun's prescription which potentially required that he be more actively supervised.

h) Mr Coskun was continued on mirtazapine despite reporting no improvement when on this medication. It was unclear whether alternate medications were considered.

FURTHER INVESTIGATIONS

64. In light of the concerns raised by Mr Coskun's family, Coroner Olle referred this matter to the Coroner's Prevention Unit (**CPU**)[3] Mental Health and Disability Team for a review of the care provided to Mr Coskun prior to his death. The court requested an expert opinion from Dr Ling Chua[4] and further statements were obtained from, and provided by, Monash Health including statements from Dr Bharat Saluja[5], Dr Akshay Ilango[6], and Associate Professor Ilan Rauchberger[7]. An expert opinion completed by Dr Michael Giuffrida[8] was also submitted to the court by lawyers representing Mr Coskun's family.

Communication with Mr Coskun's family

65. Dr Giuffrida suggested that the HITH and CATT failed to engage appropriately with Mr Coskun's family, and that they should have been advised, educated, and provided with a plan as to how to supervise and monitor Mr Coskun to keep him safe, but this did not occur.

66. Dr Chua noted that the involvement of Mr Coskun's family in his care was beneficial as a support for him, and he appeared to have had some positive response to their encouragement. Dr Chua noted that the discharge planning could have involved more collaboration with Mr Coskun's family and suggested that this would have ensured a more comprehensive treatment plan overall.

67. In particular, Dr Chua noted that Mr Coskun's family were unaware of the options of pursuing further mental health care privately, despite having private health insurance. Dr Chua suggested that a family meeting to provide further psychoeducation concerning Mr Coskun's condition, including alternate mental health treatment options, would have been useful.

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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] Consultant Psychiatrist; Lead Psychiatrist for the Consultation Liaison Psychiatry Service, Eastern Health; course unit coordinator and senior lecturer for the Masters of Psychiatry, Faculty of Medicine, Nursing and Health Sciences, Monash University.

[5] Consultant psychiatrist, Monash Health.

[6] Acting Program Director of the Mental Health Program, Monash Health.

[7] Consultant Psychiatrist; Unit Head of Adult Acute Inpatient Psychiatric Unit of Alfred Mental and Addiction Health, Alfred Hospital; Adjunct Associate Professor, Swinburne University; Adjunct Senior Lecturer (Practice), Monash University.

[8] Forensic psychiatrist.

68. The CPU noted that there was evidence in Mr Coskun's medical records that both Mr Coskun and his family members were provided with education about depression and treatment on multiple occasions, including on 31 December 2017 and 9 January 2018. On these occasions, the time for antidepressants to take effect was discussed. Mrs Coskun was also present when ECT was discussed as a potential option.

69. Dr Whitty stated that Mr and Mrs Coskun were both agreeable with the plan for Mr Coskun to be discharged from the CATT and receive follow-up from his GP and a private psychologist. Mr Coskun's family were advised that they could contact the CATT, Monash Health PTS, or present to an emergency department if required.

70. Dr Ilango noted that Mr Coskun's family were present for many of the HITH and CATT reviews and were consulted throughout the episode of care and in relation to the discharge plan. Associate Professor Rauchberger also noted this and considered that there was a reasonable delivery of education and support for Mr Coskun's family during the episode of care.

71. However, Dr Ilango also acknowledged the views of Mr Coskun's family that they could have received more comprehensive communication concerning Mr Coskun's condition and treatment options, including private health treatment, and noted that Monash Health has taken this feedback on board and is in the process of reviewing its Patient Experience Strategy.

Continuity of care

72. It is apparent that Mr Coskun was not seen by the same clinicians consistently throughout his care with the HITH team and the CATT, although Dr Whitty was involved in two of the three psychiatric reviews conducted with him.

73. The CPU noted that, due to the intensive nature of CATT treatment, it is impractical for patients to always be reviewed by the same clinician. In order to provide staff across multiple shifts, seven days per week, whilst simultaneously complying with workplace conditions, patients may be seen by multiple clinicians. This is particularly the case during the Christmas/New Year period when staff availability is lower.

74. The CPU also noted that it can often appear that clinicians are not aware of previous contacts with other clinicians, as the same questions and topics may be discussed. However, a comprehensive mental state assessment and risk assessment requires clinicians to ask the same questions over time to determine whether the patient's presentation or risks have changed.

75. Mr Coskun's medical records indicate that appropriate records were made during his assessments. These included progress notes, which were completed the same day as each review, and detailed a plan for the following review. A clinical review meeting was also conducted on 3 January 2018, which included Dr Whitty and several clinicians who saw Mr Coskun between 25 December 2017 and 11 January 2018. This meeting allowed all staff involved in Mr Coskun's care to discuss his presentation, risks, and treatment plan.

76. Records from the clinical review meeting were consistent with the progress notes and demonstrated that effective communication was occurring within the team. The records also indicate that Mr Coskun was being provided with treatment consistent with the documented treatment plans and was being given consistent messages regarding his treatment from all clinicians involved.

77. It was the opinion of the CPU that the records of the treating clinicians were appropriate and allowed for effective communication of Mr Coskun's situation to other clinicians. They noted that having multiple staff review a patient often provides a more robust clinical picture, given that individual staff members have different levels of experience, and different professional and clinical backgrounds. Accordingly, the CPU considered that the review of Mr Coskun by multiple clinicians was reasonable. I accept this conclusion.

Documented treatment plans

78. The CPU noted that a clear treatment plan was evident in the medical records. This plan outlined the treatment goals for Mr Coskun and the interventions being undertaken. Treatment plan documentation indicated that discussions had occurred with Mr Coskun and his family about the plan, although Mr Coskun had not signed it.

79. Treatment plans were documented after Mr Coskun's initial contact with Monash Health PTS, after his initial intake assessment, at a clinical review meeting on 3 January 2018, and in progress notes after most of the reviews conducted by clinicians and psychiatrists.

80. On 25 December 2017, Mr Coskun signed a consent form that outlined his proposed treatment, which included regular reviews by the psychiatrist and medical officer, as well as daily reviews by mental health clinicians.

81. The primary treatment goal was to improve Mr Coskun's depressive symptoms and monitor his suicide risk. This was pursued through antidepressant medication and psychotherapy, including sleep hygiene and behavioural activation. The medical records reveal that Mr

Coskun advised clinicians when his current treatment was apparently ineffective and engaged in discussion regarding alternatives, such as ECT.

Medication and alternate treatment options

Medication

82. Mr Coskun was treated with mirtazapine throughout his care with the HITH and CATT, and after his discharge. On 25 December 2017 he was started on 7.5mg per day and this was gradually increased over the following weeks until he was taking 45mg daily. When Mr Coskun was discharged from the CATT, he had been taking mirtazapine for a total of 17 days, and his most recent therapeutic dose of 45mg for eight days.

83. Mirtazapine is a first line antidepressant that is often chosen when a person's depressive symptoms include insomnia, circadian disruption, weight loss and/or reduced appetite. The starting dose for adults is 15mg, the usual maintenance dose is 30-45mg, and the maximum dose is 60mg. Medication guidance suggests that the dose should be gradually increased as indicated until the lowest possible dose to relieve symptoms has been achieved.[9]

84. Dr Giuffrida suggested that the commencement of Mr Coskun on a sub-therapeutic dose of mirtazapine, which was only very gradually increased, was inappropriate and 'the dose should have been pushed much more urgently and earlier in the course of treatment to 60mg per day'. Dr Giuffrida also suggested that the deterioration in Mr Coskun's depression ought to have prompted the consideration of augmentation of the mirtazapine or additional strategies for treatment, such as mood stabilising anti-psychotic medications or an alternative group of antidepressants.

85. Dr Chua considered that Mr Coskun's initial antidepressant medication was appropriate and that the titration of this medication was timely and clinically indicated. Dr Chua did however agree with Dr Giuffrida concerning augmentation of the mirtazapine, suggesting it should have been augmented with an additional second-generation antipsychotic agent such as olanzapine. Dr Chua also suggested a switch in antidepressant medications could have been considered after two weeks of poor response, at Mr Coskun's review on 9 January 2018.

86. The CPU noted that a response to antidepressant medication is normally discernible within the first two weeks of treatment, but in some instances may take longer. The Royal Australian

[9] Mims Online, "Mirtazapine", revised August 2018.

and New Zealand College of Psychiatrists (**RANZCP**) clinical practice guidelines for mood disorders notes that an adequate trial of antidepressant therapy for major depressive disorder should be a minimum of three weeks at the recommended therapeutic dose.[10] The CPU were of the opinion that the prescription of mirtazapine to Mr Coskun was appropriate. Given he had not yet been taking this medication for three weeks at the time of his discharge from the CATT, they suggested it was appropriate that his prescription was not changed or augmented with another medication at that time.

87. The CPU also observed that, due to the increased risk of adverse reactions and side effects (especially serotonin syndrome) with combination antidepressants, the introduction of a second antidepressant should not be considered until there is sufficient evidence that the patient does not respond to the single drug therapy.

88. Dr Ilango stated that it can take four to six weeks at the correct dosage of antidepressant to see clinical improvement in symptoms of depression and mood improvement. He also noted that a change in antidepressant medication can be associated with side effects and further time would be required for a new medication to take effect. Accordingly, Dr Ilango suggested it was reasonable to allow further time to assess the efficacy of the mirtazapine and a change in Mr Coskun's medication was not indicated as at 9 January 2018.

89. Dr Ilango conceded that it was an option to prescribe an antipsychotic but suggested that 'it was not required at that time and therefore it was reasonable not to prescribe an antipsychotic'.

90. Associate Professor Rauchberger opined that the initial dosage and incremental increases in mirtazapine were therapeutic and reasonable. He also suggested it was reasonable to wait for a longer period before exploring whether to trial Mr Coskun on an alternate antidepressant.

91. Associate Professor Rauchberger noted that there was no indication of psychotic symptoms evident in Mr Coskun's medical records and that Mr Coskun's presentation was consistent with Major Depressive Disorder. Whilst he conceded that antipsychotic medication can be prescribed 'off-label' for Major Depressive Disorder, and it would not have been unreasonable to prescribe an antipsychotic agent or consider a change in anti-depressant medication at this point, he considered that neither was required at the time of Mr Coskun's discharge from the CATT.

[10] Royal Australian and New Zealand College of Psychiatrists (RANZCP), *Clinical Practice Guidelines for Mood Disorders*, 2015, page 33.

Electroconvulsive therapy

92. At an assessment with Dr Whitty on 9 January 2018, the option of ECT was discussed with Mr Coskun. However, pursuit of this option did not proceed further.

93. Dr Giuffrida suggested that Mr Coskun's risk was 'so high' in December and early January that 'any reasonable assessment of him at that time would have more than justified a trial of [ECT]', whilst Dr Chua suggested that the option of ECT should have been considered further prior to Mr Coskun's discharge from the CATT.

94. Dr Ilango stated that, at the time of this assessment, Dr Whitty considered the indications for ECT were not met, and he discussed this with Mr Coskun, noting that this option could be considered in the future if he did not respond to the mirtazapine or a trial of another antidepressant. Dr Ilango submitted that this plan was 'considered, patient centred and reasonable'. Associate Professor Rauchberger also agreed that the indications for ECT therapy did not appear to have been met at this point of time.

Discharge from the Dandenong CATT

Appropriateness of discharge

95. When Mr Coskun was discharged from the CATT on 11 January 2018, he had completed a MHCP with Dr Demirtzoglou and had an appointment to see a psychologist on 12 January 2018.

96. At the time of his discharge, Mr Coskun had reported no improvement in his mental state and had not perceived any benefit from the mirtazapine. Mr Coskun's symptoms, as recorded at his last review with Dr Whitty on 9 January 2018 and last CATT review on 11 January 2018, were consistent with the symptoms present at his original referral to Monash Health PTS on 24 December 2017, and throughout his period of treatment with the HITH and CATT.

97. Despite this, Dr Bharat Saluja and Dr Ilango from Monash Health noted that the treating team considered that Mr Coskun's condition was stable at the time of his discharge. Dr Saluja stated that:

> *the treating team's view was that the longer recovery phase of Mr Coskun's depressive disorder, which could be many months, could be adequately managed within the community setting with the networks that Mr Coskun had already established, including his GP and with the Psychology services that were*

> *arranged. Mr Coskun's treatment plan was discussed and agreed by his GP and the ability to step up services was flagged with Mr Coskun, indicating escalation to PTS or* [an Emergency Department] *if required…*
>
> *Mr Coskun did not present with any additional needs that a continuing care team would usually provide assistance with, such as social needs, case management needs, drug and alcohol or financial support. He had a supportive family, stable housing and the onset of his depressive episode was relatively recent, and not viewed as an enduring mental health illness.*

98. Dr Saluja noted that Mr Coskun's stabilisation was confirmed via regular clinical risk assessments, documentation, and outcome measures, and that the treating team assessed the efficacy of the mirtazapine by interpreting the clinical information obtained from Mr Coskun and his family during face-to-face appointments, telephone contact and mental state examinations. Dr Saluja also noted that mirtazapine is known to take several weeks to reach clinical efficacy, particularly for mood improvement.

99. Dr Saluja stated that, after discharge from the CATT, Mr Coskun's mood and medication was to be monitored by his GP in line with the aim of the medication reaching clinical efficacy over the following weeks.

100. This last statement appears to confirm that Mr Coskun's medication had not reached clinical efficacy at the time of his discharge from the CATT, and that Mr Coskun had not experienced the desired effect from the mirtazapine at this time. It is difficult to reconcile with Dr Saluja's opinion that the acute episode had stabilised at the time of Mr Coskun's discharge. It is also difficult to reconcile with Mr Coskun's reports of having experienced no improvement in his mental state, his family's reports of minimal improvement, and the discussion regarding ECT occurring two days before discharge.

101. Dr Ilango submitted that the discharge plan for Mr Coskun was reasonable and appropriate in the circumstances, noting that it would be considered 'fairly standard practice across Victorian Mental Health Services'. Dr Ilango noted that it was not feasible for acute short-term services like the CATT to take charge of a patient for four to six weeks, particularly when there are reasonable alternatives available.

102. Associate Professor Rauchberger agreed that the discharge from CATT was appropriate, and that the discharge plan was reasonable.

103. In contrast, Dr Giuffrida stated that 'the notes repeatedly described symptoms of major depression with suicidal ideation and plans as to how [Mr Coskun] would act upon them'. He

noted that Mr Coskun's suicide risk ought to have been assessed as high, and the discharge of Mr Coskun in the context of his heightened risk of suicide and ongoing symptoms 'represented a straight-out abandonment of the care and treatment of a patient which is one of the most egregious failings for medical practitioners and clinical staff in all of medicine'.

104. Dr Giuffrida asserted that Mr Coskun required ongoing urgent medical care at the time of his discharge and suggested that Mr Coskun should have 'urgently been admitted to Monash Hospital for a review of his treatment by a senior psychiatrist with a view to augmenting strategies of a pharmaceutical nature but more likely going straight on to a trial of [ECT]'.

105. The CPU also suggested that Mr Coskun's discharge from the CATT was not appropriate, particularly in circumstances where sufficient monitoring had not been arranged. Whilst they did not indicate that Mr Coskun required hospitalisation, they suggested it would have been reasonable for Mr Coskun's mental health to be closely monitored until a significant improvement was noted and that this could have been achieved through a public mental health service (such as a CATT or community mental health team) or regular reviews by a private psychiatrist.

106. The CPU noted that, at the time of Mr Coskun's discharge from the CATT, he had not taken mirtazapine for sufficient time to gain therapeutic benefit, he had a known history of poor compliance with antidepressant therapy (in reference to his previous therapy in 2011), he had ongoing suicidal ideation, and he had not yet had his first appointment with his psychologist. In fact, three days prior to discharge his mental state was documented to be worse than when he had initially presented to services two weeks earlier. Furthermore, two days before Mr Coskun's discharge, Dr Whitty had discussed the possibility of ECT if mirtazapine continued to be ineffective.

107. Dr Chua considered that the discharge plan would have been adequate if Mr Coskun had experienced some response to treatment, however this was not the case. Dr Chua also noted that the 'subsequent discharge and reduced contact with his care providers may have contributed to a sense of hopelessness in this situation, thus increasing his suicidal thoughts and intent'.

108. Dr Chua suggested that, following Mr Coskun's meeting with Dr Whitty on 9 January 2018, it would have been appropriate for him to have been assessed by a consultant psychiatrist. Dr Chua stated that this 'would have provided additional options of medication treatment, including the review of the efficacy of the current medication or augmentation of his

antidepressant medication'. Dr Chua also noted that alternative treatment avenues were not actively explored, and the option of engagement with a private psychiatrist or having an admission into a private inpatient psychiatry unit should have been explored with Mr Coskun and his family.

109. Dr Ilango accepted that it 'would have been optimal practice for a consultant psychiatrist to have reviewed Mr Coskun in person prior to his discharge' but noted that it was not possible to say whether such a review would have resulted in a change to medication management or the discharge plan. Associate Professor Rauchberger also agreed that it would have been optimal practice for a consultant psychiatrist to review Mr Coskun prior to his discharge but stated that, if that had occurred, it was likely the path that was followed in relation to his treatment and discharge would have remained the same.

110. Dr Ilango and Associate Professor Rauchberger both agreed that it would have been reasonable for the CATT to discuss the option of engagement with a private psychiatrist or admission to a private inpatient psychiatry unit with Mr Coskun and his family. However, they also noted it was reasonable for the CATT to allow a further period of time to monitor the efficacy of the mirtazapine, and that Dr Demirtzoglou could have then referred him to a private psychiatrist if necessary.

Handover to Dr Demirtzoglou and post-discharge treatment

111. Dr Ilango suggested that critical communication between Mr Coskun's treating clinicians and Dr Demirtzoglou occurred following discharge. Dr Sajula noted that the discharge summary provided to referrers, such as Dr Demirtzoglou, did not contain information on the level of monitoring required at the time of discharge. However, he also noted that 'there is a conversation with the GP to confirm the follow-up management plan and, in Mr Coskun's case, his treatment plan was discussed and agreed with his GP'.

112. The CPU suggested that the level of monitoring facilitated by the CATT upon Mr Coskun's discharge was inconsistent with Mr Coskun's clinical presentation. They noted that there was no evidence that Dr Demirtzoglou was given advice by the CATT to closely monitor the efficacy of Mr Coskun's mirtazapine, medication compliance, or risks. The CATT also provided no information regarding the level of monitoring they recommended, the frequency with which Mr Coskun had been seen by the CATT, the dates on which the mirtazapine had been commenced and increased, how long he should continue the mirtazapine to determine its efficacy, or what to do if the mirtazapine continued to be ineffective. They also did not

advise Dr Demirtzoglou to refer Mr Coskun to a psychiatrist if no improvements (or limited improvements) were noted. This meant there was no plan for ongoing involvement of a psychiatrist after Mr Coskun's discharge from the CATT.

113. The CPU suggest that the absence of this critical clinical information undermined the safe transition of Mr Coskun to Dr Demirtzoglou during a high-risk period.

114. Consequently, Dr Demirtzoglou only had one appointment with Mr Coskun three weeks after his discharge and then scheduled another for two weeks after that. This was a significant decrease in the frequency of monitoring of Mr Coskun's mental state and the efficacy of medication, compared to the monitoring under the care of the CATT.

115. This absence of information also appears to have contributed to Dr Demirtzoglou misunderstanding the length of time that Mr Coskun had been taking mirtazapine. When Dr Demirtzoglou last saw Mr Coskun, he noted that Mr Coskun had been taking mirtazapine for two weeks when he had actually been taking it for over five weeks and had been on his most recent dosage for four weeks.

116. The RANZCP note that generally only one third of patients will experience remission from depressive symptoms with initial antidepressant treatment. Treatment non-response is therefore a significant issue in managing depression. RANZCP further suggests that, when patients have a poor response to pharmacological treatment, assessing the ongoing morbidity and associated disability assists in monitoring suicide risk, which may worsen with failure to respond, and will also guide decisions about continuing outpatient management or admitting the patient to hospital.[11]

117. The CPU suggested that it would have been reasonable for Mr Coskun to be under the care of a treating psychiatrist until it was known whether the mirtazapine was effective. They suggested that in cases where a patient presents with low risks, such care may be provided by a GP. However, Mr Coskun had been experiencing suicidal ideation for one to two months which was not consistent with his usual presentation and indicated a significant deterioration in his mental state. He also demonstrated increasing frustration with his lack of response to treatment and lack of progress. Mr Coskun's risks and the possibility he may require ECT

[11] Royal Australian and New Zealand College of Psychiatrists (RANZCP), *Clinical Practice Guidelines for Mood Disorders*, 2015, page 50-51.

were a further indication that he should be treated by a psychiatrist, as neither a GP nor a psychologist can facilitate ECT.

118. The CPU also suggested that keeping Mr Coskun under the care of public mental health services (where a psychiatrist is a member of the treating team) or asking Mr Coskun's GP to refer him to a private psychiatrist, would have been appropriate actions to ensure that his mental state and the efficacy of his medication were being appropriately monitored.

119. Dr Giuffrida suggested Dr Demirtzoglou ought to have referred Mr Coskun to a private psychiatrist. However, the CPU observed that, as the CATT had discharged Mr Coskun back to Dr Demirtzoglou, it would have been reasonable for Dr Demirtzoglou to assume that the CATT did not feel that ongoing monitoring by a psychiatrist was required at that time. I accept the opinion of the CPU in this regard.

RELEVANT REVIEWS, CHANGES, AND IMPROVEMENTS

Monash Health Internal Review

120. Following Mr Coskun's death, an internal review was conducted by the Monash Health Mental Health Program. This review recognised that there was 'scope for improvement by the CATT, including in the timing and staff attendance at handover meetings and in the nature of the information being handed over'. Dr Sajula noted the CATT were reviewing their team handover process as a result of this review, in order to streamline handover and facilitate further discussion and management planning. The importance of appropriate escalation to the consultant level was also recognised. Monash Health also reviewed Mr Coskun's case with the CATT involved and provided them with further familiarisation concerning the procedures associated with clinical risk assessment and escalation.

121. Dr Ilango also advised that Monash Health had implemented other improvements, particularly:

> *Monash Health have implemented a GP Psychiatrist Advisory Service in collaboration with the South Eastern Melbourne Primary Health Network (**SEMPHN**). This service is available to GP's within the Monash Health and SEMPHN catchment. GP's can contact the psychiatrist advisory service during business hours for free telephone advice in relation to diagnostic issues, medication options, developing safety plans and general management.*
>
> *Monash Health's CATT is now referred to as ACIS (Acute Crisis Intervention Service). Monash Health has in place a procedure titled 'Clinical handover patient*

discharge or transfer (Mental Health)' dated 14 October 2022… which includes the following:

- *The discharge of a patient must be approved by a consultant.*
- *The treating/clinical staff will include the patient, family/carer and/or nominated person in discussions regarding the discharge/transfer plan.*
- *In the case of discharge to a general practitioner, the treating clinical staff will refer to a general practitioner mental health liaison officer where available or contact general practitioner directly to provide handover. (Note – the general practitioner mental health liaison officer is a role within the Monash Health community mental health teams and not applicable in a situation of discharge from CATT team directly to a general practitioner.)*
- *The patient, family/carers are to be provided with key information including follow up plans; service contact details and how to re-access services if required.*
- *Where discharge has occurred to an external service provider, the hospital should make every effort to contact the patient within seven days to complete the post discharge contact and record in medical record/CMI database.*

Monash Health has produced written information for consumers and families/carers regarding its mental health services.

The Royal Commission into Victoria's Mental Health System

122. I note that since the death of Mr Coskun, the Victorian Government has held a Royal Commission into Victoria's Mental Health System (**the Royal Commission**). The final report of the Royal Commission was delivered on 3 February 2021 and made 65 recommendations targeted at improving the mental health service system in Victoria. [12]

123. The Royal Commission identified substantial gaps in the comprehensiveness of treatment, care and support delivered by community mental health services, including to those consumers who access services. The Royal Commission made a range of recommendations targeted toward expanding and improving community mental health services. This includes ensuring that, in future, such services are resourced to provide shared care between a mental health specialist and a GP or psychologist.

124. The Royal Commission also highlighted the importance of involving families in care and recovery, making a range of recommendations to ensure that the inclusion of families becomes

[12] State of Victoria, *Royal Commission into Victoria's Mental Health System*, Final report (2021).

standard practice for all services. The Royal Commission also recommended that families have access to dedicated support through eight family and carer led centres to be established across Victoria.

125. The Royal Commission also recommended the establishment of a Suicide Prevention and Response office in the Department of Health, which will be responsible for establishing a system-based response to suicide prevention.

126. Dr Ilango confirmed that Monash Health is reviewing their services to incorporate the recommendations of the Royal Commission. He stated that:

> *Monash Health is currently undertaking a broad review of delivery of mental health services and the models of care, including the CATT/ACIS model. This has been a long term project. The review is in the process of considering the findings of the Royal Commission into Victoria's Mental Health System to ensure that the relevant recommendations are incorporated into any redesign.*
>
> *Monash Health is also reviewing its approach to consumer and family/carer experience following the Royal Commission into Victoria's Mental Health system. In addition, Monash Health's Deteriorating Patient Governance Committee has established a subcommittee to review policies and procedures around family escalation of care processes and we are in the process of finalising a Patient Experience Strategy aimed at putting consumer choice front and centre of all decisions. These are ongoing projects.*

FINDINGS AND CONCLUSION

127. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the overlay of caution required by *Briginshaw v Briginshaw*.[13] 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.

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

[13] *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…'.

a) the identity of the deceased was Abdurrahman Coskun, born 03 April 1964;

b) the death occurred on 06 February 2018 at 2 Akita Court, Keysborough, Victoria, 3173, from neck compression in the circumstances of hanging; and

c) the death occurred in the circumstances described above.

129. Having considered all the evidence, I am satisfied that Mr Coskun's family members were provided with a level of education about Mr Coskun's depression and treatment which was reasonable and appropriate. However, the assertion by Mr Coskun's family that they were not provided with adequate information and support indicates that more could have been done to ensure they felt sufficiently equipped to assist Mr Coskun. I accept the opinion of Dr Chua that more proactive communication and collaboration with Mr Coskun's family, particularly in relation to his discharge planning, would have assisted the family and ensured a more comprehensive treatment plan overall.

130. I accept that Mr Coskun's family should have been provided with information regarding their option to access mental health services via a private hospital or private psychiatrist.

131. I am satisfied that appropriate steps have been taken by Monash Health to ensure greater family involvement, education and support occurs in future. I note the recommendations of the Royal Commission in this regard, and the statement of Monash Health that they have reviewed their Patient Experience Strategy. In particular, families will now be provided with key information including follow up plans, service contact details and how to re-access services if required.

132. A lack of continuity in the treating clinicians was a clear source of frustration for Mr Coskun. However, I accept that it was not practicable for Mr Coskun to be seen by the same clinician for every assessment whilst he was under the care of HITH and the CATT. I am satisfied that the documentation completed by the clinicians who engaged with Mr Coskun throughout this episode of care was sufficiently detailed to ensure continuity of care across these services in circumstances where it was necessary for multiple clinicians to be involved.

133. I am also satisfied that Mr Coskun had a clear treatment plan which was documented in the medical record throughout his treatment. This plan included trialling mirtazapine, which was a reasonable and appropriate choice of medication.

134. I accept that an antipsychotic medication or alternative anti-depressant medication could have been prescribed to Mr Coskun when the mirtazapine continued to be ineffective, and it would have been reasonable for this to have been commenced prior to his discharge. However, I am also satisfied that it was reasonable for the CATT to allow further time to assess the efficacy of the mirtazapine before implementing alternative or additional treatment options, particularly given that Mr Coskun had been taking the mirtazapine for less than three weeks and had not yet reached the recommended maximum dosage for this medication at the time of his discharge.

135. ECT may have been an appropriate alternate treatment option if the mirtazapine continued to be ineffective. However, I also accept that the indications for ECT were not met at the time of Mr Coskun's discharge from the CATT.

136. I am satisfied that the discharge of Mr Coskun from the CATT to his GP and a psychologist, in circumstances where he had experienced no apparent improvement in his condition, and his medication regime had not yet demonstrated any efficacy, was not appropriate. I accept the opinion of the CPU that Mr Coskun should have been monitored more closely by public mental health services or referred to a private psychiatrist to ensure that his mental state and the efficacy of his medication were being appropriately monitored. I am also satisfied that Mr Coskun should have been reviewed by a consultant psychiatrist prior to his discharge from the CATT.

137. The handover provided by the CATT to Dr Demirtzoglou was inadequate and did not contain critical information regarding the history of Mr Coskun's treatment on mirtazapine, the ongoing need to monitor the efficacy of his medication, and alternative options that could be considered if the mirtazapine continued to be ineffective.

138. I acknowledge that subsequent improvements have been implemented by Monash Health to improve support for GP's following and during handover. These include the establishment of a GP Psychiatrist Advisory Service, the requirement that patient discharges are now approved by a consultant, that direct contact is made with GPs to provide handover, and post-discharge contact occurs within seven days of discharge. These actions are to be commended and I am satisfied they are significant improvements to ensure the adequacy of handover to GPs in future.

139. However, it is important to ensure that the discharge handover includes sufficiently detailed information to ensure continuity of care. I note that the National Safety and Quality Health

Service (**NSQHS**) Communicating for Safety Standard provides useful guidance in this area. This standard aims to ensure timely, purpose-driven and effective communication and documentation to support continuous, co-ordinated and safe care for patients. The criteria for this standard includes:

a) having processes for structured clinical handover to effectively communicate about the health care of patients and thereby reduce communication errors,

b) having systems to effectively communicate critical information and risks to the appropriate person(s) when they emerge or change, and

c) documenting essential information in the healthcare record to ensure that relevant, accurate, complete and up-to-date information about the patient's care is documented and clinicians have access to the right information to make safe clinical decisions and deliver safe, high quality care[14].

140. Additionally, the standard includes a criterion regarding continuity of medication management and particularly, the provision of a medication list, noting that the medication list should include:

a) essential elements of the medicines list and an explanation of any changes made to therapy during the episode of care, and

b) clear instructions for ongoing care and follow-up requirements, if relevant[15].

[14] Australian Commission on Safety and Quality in Health Care, NSQHS Standards: Communicating for Safety Standard, https://www.safetyandquality.gov.au/standards/nsqhs-standards/communicating-safety-standard, accessed 4 July 2019.
[15] Ibid.

RECOMMENDATIONS

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

Recommendation One

In line with the National Safety and Quality Health Service (NSQHS) Communicating for Safety Standard, that the Monash Health Crisis Assessment and Treatment Team (CATT)/Acute Crisis Intervention Service (ACIS) review their process for communicating critical clinical information on discharge to the accepting practitioner to ensure it includes:

a. a detailed and current medication list including details of commencement date and dates of dose changes;

b. suggested frequency of monitoring the patient's mental state; and

c. clear indications of when a patient requires re-referral to a specialist mental health service and information on how to re-engage.

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

Pursuant to section 73(1A) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

Aynur Coskun, Senior Next of Kin

Katie Murphy, Maurice Blackburn, on behalf of Mrs Coskun

Alice Smith, K&L Gates, on behalf of Monash Health

Anya Tovey, Australian Health Practitioner Regulation Agency

Dr Neil Coventry, Chief Psychiatrist for Victoria

Sergeant Matthew Kille, Coroner's Investigator

Signature:

Coroner Paul Lawrie

Date : 10 October 2023

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.