IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2018 0675

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 63(1) of the Coroners Act 2008

Deceased:	Kai Wesley Wu
Delivered on:	21 December 2022
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing dates:	Inquest: 19 August 2021
Findings of:	Coroner Paresa Antoniadis Spanos
Counsel assisting the coroner:	Leading Senior Constable King Taylor from the Police Coronial Support Unit
Representation:	Ms Debra Foy of Counsel on behalf of The Alfred Hospital
Catchwords:	Psychotic illness, compulsory patient, escorted leave, requirement for supervision

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INTRODUCTION[1]

1. Kai Wesley Wu (Kai) was a 23-year-old single man who resided with his mother Yan Wu (Mrs Wu) and his father Wen Liu (Mr Liu) in South Yarra. Kai is survived by his parents and an older brother who is a medical practitioner.

2. According to his family, Kai reached normal developmental milestones, experienced some bullying at school related to severe acne and was somewhat socially isolated from Year 9 onwards. Nevertheless, Kai completed Year 12 achieving a high ATAR score and commenced university studies in Information Technology/Commerce in 2016. However, he struggled with the transition to university and changed his enrolment to part-time studies for an Arts degree in 2017, undertaking two subjects and doing reasonably well academically, before deferring his studies when he became unwell.

3. Kai had no significant medical history, apart from obsessive compulsive disorder diagnosed in 2013. Kai had no other history of mental illness and certainly no known psychotic illness prior to 2017.

4. In October 2017, Kai travelled to Sydney, New South Wales. His parents thought he was travelling with friends. Kai was reportedly acting irrationally at the airport and attracted the attention of the Australian Federal Police.[2] He was subsequently taken to the Royal Prince Alfred Hospital (**RPA**) for assessment. Kai presented as floridly psychotic and was admitted as an involuntary patient on 11 October 2017 and nursed in the High Dependency Unit (**HDU**).

5. Over a 22-day admission, Kai improved with treatment with the antipsychotic olanzapine.[3] However, he continued to experience auditory hallucinations including some of the command type; believed he deserved to die; and expressed a wish to suicide. Kai's medications were

[1] This section is a summary of background and personal circumstances and uncontentious circumstances that provide a context for those circumstances in which the death occurred.
[2] Kai presented with paranoid and grandiose themes, including that he went to Sydney after voices told him to avoid paedophile hunters who were going to kill him; that he was being tracked and bullied on Facebook; that staff were members of government intelligence agencies; and that he was the smartest person in the universe and could read people's thoughts. Apart from obsessive compulsive disorder, RPA clinicians documented a report of gender dysphoria which was noted but not confirmed. Gender dysphoria is a difference between one's experience of expressed gender and assigned gender and its diagnosis involved the application of strict criteria.
[3] Olanzapine is a second-generation antipsychotic indicated in the treatment of schizophrenia, acute exacerbations of schizoaffective disorder and bipolar disorder, available in oral and slow-release depot injection.

changed to paliperidone[4] and benztropine[5] and he appeared to improve but was also noted to hide medication intermittently. During his admission to RPA, Kai was diagnosed with first presentation psychosis.[6]

6. On 6 November 2017, Kai was assessed as stable enough for transfer and discharged into the care of his mother who accompanied him on the flight back to Melbourne from Sydney escorted by a senior RPA nurse. Once in Melbourne, Kai was taken directly to The Alfred Hospital (**the Alfred**).

CIRCUMSTANCES PROXIMATE TO DEATH

7. On arrival at the Alfred, Kai underwent a comprehensive medical and psychiatric assessment, during which he was assessed as floridly psychotic and grossly disorganised. Kai was admitted to the inpatient unit (**the unit**) as a compulsory patient pursuant to the *Mental Health Act 2014* (**MHA**).[7] Kai had systematized paranoid and persecutory thinking about the FBI, paedophile hunters, that he was a girl trapped in a man's body and that he heard God's voice. Clinicians thought he was responding to internal stimuli and had some depressive features. Kai wanted to be discharged from the unit.

8. On 27 November 2017, Kai was diagnosed with schizophrenia and clinicians discussed the diagnosis with Kai and his family. However, Kai had a poor understanding of the diagnosis because of impaired judgement and insight. It was also noted that Kai had periods of non-compliance with medications and required close supervision while in the unit to ensure he was taking medications as prescribed.

9. On 30 November 2017, the Mental Health Tribunal (**MHT**) approved an Inpatient Treatment Order (**ITO**) of 26 weeks' duration. Kai was nursed in both the HDU and the low dependence unit (**LDU**) at times during the remainder of this admission. The assessments, multidisciplinary

[4] Paliperidone is an antipsychotic indicated in the treatment of schizophrenia, acute exacerbations of schizoaffective disorder and bipolar disorder, available in oral and slow-release depot injection.
[5] Benztropine is used to treat symptoms of Parkinson's disease or involuntary movements due to the side effects of certain psychiatric drugs (including antipsychotics such as chlorpromazine/haloperidol).
[6] First presentation or first episode psychosis refers to the first onset of a psychotic disorder in the lifetime of an individual.
[7] The criteria to be met for compulsory treatment under section 5 of the MHA are: (a) the person has mental illness, (b) because the person has mental illness the person needs immediate treatment to prevent (i) serious deterioration in the person's mental or physical health or (ii) serious harm to the person or another person, (c) the immediate treatment will be provided to the person inf the person is subject to a temporary treatment order, and (d) there is no less restrictive means reasonably available to enable the person to be immediately treated.

treatment planning, family engagement and carer supports were comprehensive.[8] Kai was reluctant to engage with staff but did improve and responded to graduated leave.

10. During the admission, Kai did not respond to an adequate trial of olanzapine and paliperidone (both antipsychotic medications) but did respond well to haloperidol, an older antipsychotic medication. His mental state improved significantly when he was on a 14mg dose of haloperidol although he still had some residual delusions. Unfortunately, Kai experienced some extra pyramidal side-effects[9] of the medication including Parkinsonism and urinary retention.[10]

11. On 10 January 2018, after his mother returned from overseas, Kai was discharged from the unit on a Community Treatment Order (**CTO**). He was referred to "headspace" mobile assessment and treatment team (**MATT**) for follow up including twice daily medication supervision and dispensing of medications in a Webster pack which commenced on the day of discharge. The discharge plan was mindful of Kai's ongoing vulnerability and the risk associated with acting on psychotic instructions which he continued to experience.

12. The referral to MATT occurred well before Kai was discharged and MATT clinicians had become involved in his care while he was still an inpatient.[11] On 10 January 2018, a MATT clinician visited Kai at home. He remained unwell and he and his family agreed to twice daily visits for medication supervision. At this time, Kai's medications were 14mg haloperidol and 1mg benztropine daily. He was noted by the MATT clinician to have EPSE but said he was not bothered by them.

13. Kai was seen again by a MATT clinician on the morning of 11 January 2018 for medication supervision. Prior to the home visit, Mrs Wu had texted concerns that Kai might be spitting out his medication and needed longer supervision to address this and that he had not slept overnight.

[8] I asked clinicians from the Coroners Prevention Unit, in this case a fully qualified and experienced psychiatric nurse, to review the medical records from Kai's admission and to advise as to the adequacy of clinical management and care provided. This was her appraisal. As will be seen below, the overall adequacy of the clinical management and care provided to Kai was not the focus of the inquest.
[9] Extrapyrimidal side-effects (**EPSE**) is an umbrella term used to describe a wide variety of movement disorders. They can be divided into acute syndromes (those that develop generally within hours or days of treatment) and chronic or tardive syndromes (those that develop after a sustained period of exposure). Acute EPSE include acute dystonia, akathisia and parkinsonism, whereas tardive dyskinesia is perhaps the most common late occurring movement disorder.
[10] Exhibit "A", statement of consultant psychiatrist Dr Jianyi Zhang dated10 July 2019, at page 39 of the brief.
[11] Amply demonstrated by the MATT's "Psychiatry Community Progress Notes" at pages 70-228 of the brief.

The MATT clinician planned to discuss Kai's medications with the MATT consultant psychiatrist and advise any changes.

14. During the evening home visit on 11 January 2018, Kai was given 2mg diazepam which he took immediately and was advised that his new medication regime would be 2mg haloperidol, 20 mg escitalopram and 0.5mg benztropine in the morning; 11.5mg haloperidol in the evening; and ½ to one tablet diazepam up to three times a day as needed. Kai remained reluctant to take medication but was still agreeable to the changes and took his reduced dose of 11.5mg haloperidol. Kai reported feeling really bad physically due to the side-effects he was experiencing, and his tremor and stiffness were evident. The plan was for Kai to be taken to the emergency department if his presentation should worsen so his physical health could be assessed. MATT clinicians planned to reassess the situation in the morning.

15. On the morning of 12 January 2018, two MATT clinicians returned to find Kai was not at home, having left suddenly when informed by his mother that they were on their way. According to Mrs Wu, Kai had been extremely distressed overnight, restless and pacing while struggling to sleep. Kai returned home a short time later after responding to a phone call from his mother. He presented in significant distress, with stiff movements, ongoing concerns about not being able to urinate and restlessness that meant he struggled to sit. Despite his distress, there was no overt deterioration in Kai's mental state. He was refusing treatment due to the side-effects but agreed to return to hospital for management of his current issues. The CTO was varied to an ITO and the MATT clinicians drove Kai and his mother to the Alfred where he was re-admitted.

16. The clinical management and care provided to Kai after his re-admission will be discussed in some detail below as it provides the context for the main focus of the coronial investigation which was the management of Kai's leave from the inpatient unit. Suffice for present purposes to note that Kai had enjoyed a graduated program of leave both escorted by staff members or family and unescorted leave for some weeks before 10 February 2018 when he left the inpatient unit on escorted leave with his father at about 11.45am.

17. A short time later, while at home, Mr Lui gave Kai $50.00 to buy some lollies and allowed him to go alone. Kai would usually go to a local store to buy lollies and return home. On this occasion he did not return. When Mrs Wu realised Kai was alone, she called the inpatient unit at

1.00pm to advise that he had absconded while on leave. As a result, the inpatient unit's Absent Without Leave procedures were activated.

18. At 12.30pm, CCTV footage at South Yarra Railway Station captured Kai at the entrance at the top of the platforms for a short time before walking towards platform 5 and then onto the platform where he left a black backpack before jumping onto the track and into the path of a train running express through the station.

19. Emergency services were called, and multiple Victoria Police units responded as well as Ambulance Victoria (**AV**) paramedics who verified that Kai was deceased at 12.45pm.

INVESTIGATION AND SOURCES OF EVIDENCE

20. This finding is based on the totality of the material the product of the coronial investigation of Kai's death. That is, the brief of evidence compiled by Senior Constable Liam Rennie Rob Hamilton from Camberwell Police, reconfigured for the inquest by Leading Senior Constable King Taylor 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.

21. All of this material, together with the inquest transcript, will remain on the coronial file.[12] 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

22. The purpose of a coronial investigation of a *reportable death*[13] is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which the death occurred.[14] Generally, reportable death are deaths that appear to be unexpected, unnatural or violent or appear to have resulted directly or indirectly from an accident or injury.[15] Kai's death

[12] 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.
[13] 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)).
[14] Section 67(1) of the Act.
[15] See section 4 for the definition of "reportable death", especially section 4(2)(a).

was reportable, irrespective of the cause, as he was immediately before death a patient within the meaning of the MHA.[16]

23. 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 that are sufficiently proximate and causally relevant to the death, and not all circumstances which might form part of a narrative culminating in death.[17]

24. 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.'[18]

25. 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.[19] These are effectively the vehicles by which the Coroner's prevention role can be advanced.[20]

26. 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.[21]

[16] See section 4(2)(d) of the Act.
[17] 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).
[18] 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'.
[19] See sections 72(1), 67(3) and 72(2) of the Act regarding reports, comments and recommendations respectively.
[20] 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.

IDENTITY

27. On 15 February 2018, Coroner Jacqui Hawkins (as she then was) made a formal determination identifying the deceased as Kai Wesley Wu, born 29 November 1994, based on expert evidence of DNA comparison analysis.

28. Kai's identity was not in issue and required no further investigation.

MEDICAL CAUSE OF DEATH

29. Senior forensic pathologist Dr Matthew Lynch, from the Victorian Institute of Forensic Medicine (**VIFM**), reviewed the circumstances of Kai'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 Kai's body in the mortuary.

30. Having done so, Dr Lynch provided a written report of his findings. He noted extensive traumatic head and abdominal injuries and multiple abrasions to the limbs. Review of the PMCT showed fractures of the skull and maxilla, pneumocranium and intracranial haemorrhage.

31. Routine toxicological analysis of post-mortem specimens detected diazepam at a level of ~0.1mg/L, quetiapine at ~0.2mg/L and haloperidol at ~0.004mg/L consistent with the drugs being prescribed to Kai at the time of his death but no alcohol or other commonly encountered drugs or poisons.

32. Dr Lynch concluded by advising that it would be reasonable to attribute Kai's death to *1(a) Injuries sustained when struck by train,* without the need for autopsy.

33. I accept Dr Lynch's opinion as to the cause of Kai's death.

FOCUS OF THE CORONIAL INVESTIGATION

34. The main focus of the coronial investigation and inquest into Kai's death was on the clinical management and care provided to him after this re-admission, specifically, on (1) the guidelines and practice around leave for compulsory inpatients; (2) communication with families about what is expected of them whilst escorting a patient on leave; and, (3) what was said to Kai's father on the last or any previous occasions when he escorted Kai on leave.

35. Kai was quite unwell and had a long admission by any measure having been subject to compulsory psychiatric treatment as an inpatient for almost four months across two campuses – RPA and the Alfred.[22] The clinical management and care provided to him during this period provides important context within which to consider the issues pertaining to leave, in particular after his re-admission to the Alfred on 12 January 2018.

36. Apart from the primary medical records which were provided to the court, the clinical management and care provided to Kai after his re-admission is set out in the statement of Dr Jianyi Zhang, the consultant psychiatrist overseeing his care who also gave evidence at the inquest.[23] According to Dr Zhang, Kai was re-admitted as he had responded to the medication side-effects in a hysterical manner and was thought to be at risk of absconding from home. Kai's main complaint was of urinary retention, but he also complained of stiffness and restlessness. However, his mental state was settled without active psychotic features at the time of readmission.[24]

37. According to Dr Zhang, following Kai's readmission, treatment options were discussed with him and his family, including a trial of Clozapine which he described as a very effective antipsychotic used in patients with a treatment-resistant schizophrenia. As the family preferred not to trial Clozapine and were also against the use of electro-convulsive therapy (**ECT**) which was explored as an option, the plan was to find alternative medication which could effectively treat Kai's psychosis without the EPSE which he was finding so distressing.[25]

38. Kai was accordingly weaned off haloperidol, thought to be the cause of the EPSE, he was gradually weaned off haloperidol and changed over to quetiapine titrated up to a daily dose of 650mg. Unfortunately, within a matter of days, Kai became floridly psychotic again. In response to this clinical deterioration and with the family's agreement, haloperidol was reintroduced at a

[22] This was uncontentious at inquest. See transcript page 87 where Ms Sonmez states that the average length of stay at an inpatient unit was approximately 16-17 days and that even for first episode psychosis, Kai's admission was longer that she would expect.
[23] Exhibit A is the statement of Dr Jianyi Zhang dated 10 July 2019 at pages 38-43 of the brief and his evidence is at transcript pages 9-45.
[24] Exhibit A at page 40 of the brief, Inpatient Progress Notes at page 248 of the brief and transcript page33 and 44.
[25] Exhibit A at page 40 and transcript pages 11-13. Note that Clozapine is not without its difficulties being associated with weight gain, over-sedation, metabolic syndrome, elevated cholesterolaemia and blood sugar levels.

low dose of 8mg and found to be effective in combination with quetiapine in treating Kai's psychosis and, while there were some side effects, they were manageable.[26]

39. There was no serious suggestion that Kai should not be granted leave when it was clinically appropriate. Dr Zhang explained that the primary goals of treatment for Kai were a reduction of symptoms generally by use of antipsychotics; a reduction in the stress due to psychosis generally by use of psychological approaches and activities; and a restoration of normality by for example re-connecting him with his family, community and pursuits. Leave fell within the latter and was helpful in reducing his level of distress, and avoiding the pitfalls associated with a structured inpatient environment and the surrender of autonomy.[27]

40. Despite Kai's tragic death, it is appropriate to note that part of the context in which the "leave issue" unfolded is the general clinical understanding that suicide and/or self-harm was not a significant feature of his illness. Kai had a history of absconding, and this risk was recognised. However, while he had threatened self-harm on occasions, Dr Zhang's characterisation was that Kai made conditional threats to ensure his needs were being met or to indicate the extent of his distress about the EPSE he was experiencing, rather than indicative of an intention to self-harm.[28]

41. From the date of his re-admission, Kai was approved for escorted leave had periods of leave at home with his parents.[29] From 17 January 2018, Kai was approved for short periods of unescorted leave. However, leave was cancelled altogether on occasions because of concerns about Kai's mental state. For example, on 17 January 2018 leave was cancelled on the basis of information provided by Mrs Wu about Kai's behaviour while on leave. After review by Dr Zhang who assessed Kai as agitated with an unsettled mental state but not psychotic, leave was reinstated on 18 January 2018.[30]

[26]Exhibit A at page 40 and transcript page 14.
[27] Transcript pages 35-37. Note that at the material time, February 2018, the applicable Alfred Health guideline was entitled "Inpatient Leave from Wards" with an approval date of March 2014 and appears at pages 51-57 of the brief.
[28] Dr Zhang's opinion to this effect is in Exhibit A at page 41 of the brief and transcript pages 29-31. See also NUM Sonmez's evidence at pages 86-87.
[29] Changes to Kai's leave regime can be tracked via the Clinical Risk Assessment and Revised Clinical Risk Assessment pro forma documents completed from time to time by psychiatrists, psychiatric registrars, hospital medical officers. These were not included in the brief but tendered at inquest in a batch as Exhibit D and covered the whole of Kai's admission from 6 November 2017 until 10 February 2018. See page 20 of 641 where the changes made on 9 February 2018 are documented.
[30] Inpatient Progress Notes at page 264 of the brief. See also transcript pages 38-41 where Dr Zhang explains the rationale for graduated leave generally and by reference to the applicable Alfred Health guideline at pages 51-57 of the brief.

42. Kai's leave was cancelled again on 20 January 2018 when he returned from leave in a 'floridly psychotic state, responding to auditory hallucinations' and Mrs Wu told staff she did not feel safe taking her son out on leave. Over the next few days, Kai was increasingly distressed and disclosed thoughts with varied delusional content.[31] He was also verbally and physically aggressive to clinicians which was attributed to the reduction of haloperidol and introduction of quetiapine at the time.

43. Dr Zhang reviewed Kai regularly in the ensuing period when he remained in the unit without benefit of leave. On 25 January 2018, Dr Zhang approved Kai for staff-only escorted leave but as he continued to deteriorate, he was transferred to the HDU and prescribed regular lorazepam.[32] The plan was for continuation of the same medications with the use of PRN (as needed) benzodiazepines instead of increasing antipsychotics and risking any associated adverse side-effects.[33]

44. Kai settled over the next few days and on 2 February 2018 was assessed by Dr Zhang as well enough for transfer to the LDU, initially with no approved leave.[34]

45. On 5 February 2018, Kai was reviewed by Dr Zhang and a psychiatric registrar. He was assessed as no longer psychotic and more settled. Kai was approved for staff escorted leave for 20-minute periods and for one-hour escorted leave with family members. In the evening, Kai went on leave with his father and no issues were reported to nursing staff on his return.

46. Leave went well on 6 February 2018 and was extended by Dr Zhang after his review of Kai on 7 February 2018 to three 30-minute periods of unescorted leave and escorted leave with family for two hours each day, with a plan for discharge on Monday 12 February 2018.[35]

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[31] Inpatient Progress Notes at pages 269-273 of the brief. The notes appear to be out of chronological sequence but relevant entries are dated from 20-22 January 2018 and include the following 'Kai insists his impromptu vocal outbursts are 'praying', 'Some bizarre delusional content expressed about being Tu Pac', 'expressing delusions, overheard discussing bizarre sexualised themes', overheard expressing multitude of delusional themes eg about paedophiles, slaves, vampires, communism, political leaders, religion & child pornography, attempting to use ward phone to contact the United Nations, staging "it's an emergency"…

[32] Inpatient Progress Notes dated 25 January 2018 at pages 278-279 of the brief. Lorazepam is used for the management of anxiety disorders or for the short-term relief of the symptoms of anxiety or anxiety associated with depressive symptoms and alcohol withdrawal.

[33] Inpatient Progress Notes dated 26 January 2018 at pages 282-284 of the brief.

[34] Inpatient Progress Notes dated 2 February 2018 at page 301 of the brief.

[35] Inpatient Progress Notes at pages 305-309 of the brief.

47. However, later on 7 February 2018, Kai was agitated, panicky and believed he had a chip implanted in his head. He was more settled the following day but reported auditory hallucinations that told him to harm himself. When reviewed by a psychiatric registrar the following day, 8 February 2018, Kai reiterated that he had a microchip in his brain placed there by paedophile hunters because he had once watched child pornography. He said felt safe in the unit and did not feel a need to hurt anyone or himself but was a little frightened about the paedophile hunters.[36]

48. On Friday 9 February 2018, Kai was reviewed again by Dr Zhang and a psychiatric registrar. He had told his mother than he felt he was being tortured and was feeling suicidal. Dr Zhang reviewed Kai twice that day, and he was seen again by a senior registrar in the late afternoon. During these reviews, Kai reported symptoms of akathisia[37] and said he spoke about suicide out of frustration, rather than because he had any intention to self-harm. Dr Zhang felt that Kai was still very much future-oriented and looking forward to the pending discharge the following Monday.[38]

49. Kai was given a low dose of diazepam for akathisia to which he appeared to respond well. During the subsequent review by Dr Zhang and the senior registrar, he was more settled. Nevertheless, unescorted leave was cancelled due to concerns about his exaggerated response to akathisia. As escorted leave with the family had been very therapeutic and often relaxed him, escorted leave was to continue, and Kai had a few hours of escorted leave on the night of 9 February 2018 with his parents without incident.[39]

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[36] Inpatient Progress Notes at pages 310-312 of the brief.

[37] Akathisia is a frequent and common adverse effect of treatment with antipsychotic (neuroleptic) drugs. Akathisia consists of subjective components (like feeling inner restlessness and the urge to move) as well as objective components (like rocking while standing or sitting, lifting feet as if marching on the spot and crossing and uncrossing the legs while sitting). Antipsychotic-induced akathisia can be classified according to the time of onset during antipsychotic treatment (acute, tardive, withdrawal and chronic akathisia). Reported prevalence rates vary widely between 5% and 36.8%. See also footnote 9 above.

[38] Exhibit A at page 40 of the brief.

[39] Exhibit A at page 40 of the brief. Inpatient Progress Notes date/time 9 February 2018 at 1700 hours at page 315-316 of the brief. Note the documented reference to 'had thoughts about killing self because of akathisia by jumping in front of train, guaranteed safety on ward as no way to kill myself here'. Exhibit F is an expert report from consultant psychiatrist Dr Malcolm Hopwood dated 15 October 2020 provided on behalf of Alfred Health and was not required to attend the inquest. Among other things, Dr Hopwood expresses the *"opinion that the decision to proceed with escorted leave on the 10th of February 2018 is consistent with the expected standard of care for the reasons outlined above. I would further add that in my opinion the hospital did act in accordance with widely accepted peer professional practice in its assessment, investigation and management of Mr Wu."*

50. On the morning of 10 February 2018, Kai's allocated nurse for the morning shift was Registered Psychiatric Nurse Nicola Hammond (**RPN Hammond**).[40] According to RPN Hammond, Kai was reasonably settled that morning. [41]

51. However, as RPN Hammond was off site escorting another patient when Mr Liu arrived to take his son on escorted leave, he approached another nurse, Psychiatric Nurse Jessica Potter (**PN Potter**) at the Nurse's Station. PN Potter checked the current Clinical Risk Assessment to confirm that the psychiatrist had sanctioned leave by checking Kai's medical records and discussed the conditions of escorted leave with both Kai and his father.[42] Specifically, PN Potter testified that she told them that Kai was to stay with his father at all times while on leave. They both verbally agreed and she gave Mr Liu a "ward card" with the ward's contact number in case he needed to call.[43] PN Potter also completed a Mental State Examination prior to him leaving the unit. She assessed him as mentally stable at the time.[44]

52. As Mr Liu's understanding of what was expected of him when escorting Kai on leave was in issue, PN Potter was questioned about this at inquest. She had not dealt with Mr Liu around leave previously but had seen him in the unit. PN Potter felt Mr Liu understood what she was telling him about leave, looked as though he agreed, and she knew this was not the first time he had taken Kai on leave.

53. In response to questions from Ms Foy, PN Potter said she 'explained the guidelines of escorted leave, just to make sure they both understood how long they were going to be going for and that he needed to be with Kai at all times and they both verbally agreed.'[45] Again, in answer to a question from counsel assisting, PN Potter stated that 'her understanding of escorted leave, the carer's role, in this instance, is for Kai's father to be with him at all times while he was out of the ward and to adhere to the agreed times' and that she thought he understood her.[46]

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[40] RPN Hammond provided a statement but was not required to give evidence at the inquest. Her statement dated 11 July 2017 is at pages 44-45 of the brief.
[41] Inpatient Progress Notes of RPN Hammond date/time 10 February 2018 at 1500 hours at page 316 of the brief.
[42] See footnote 28 above and Exhibit D.
[43] Exhibit B is the statement of PN Potter dated 1 August 2019 at pages 46-47 of the brief and transcript pages 49-55. The applicable Alfred Health guideline stipulated that *"A ward business card must be given to the patient with the ward details, contact numbers and agreed return time for all leave outside the hospital precinct."* The guideline is at page 51 and following of the brief and the relevant page is page 55.
[44] Exhibit B and transcript pages 54-55. Note that PN Potter had nursed Kai before and was familiar with his usual presentation and so could assess him against a baseline.
[45] Transcript page 64.
[46] Transcript page 66.

54. Taken in combination, the evidence of RPN Hammond and PN Potter is that PN Potter discussed the conditions of leave with Kai and Mr Liu and conducted a mental state examination of Kai prior to their departure on escorted leave shortly before midday on 10 February 2018; that this was the subject of a verbal handover between PN Potter and RPN Hammond a short time later; and, that the Pre Leave Checklist was completed by RPN Hammond and signed and dated 10 February 2018 at 1200 hours was based on PN Potter's handover not her own observations of Kai.[47]

55. Gamze Sonmez, Psychiatry Nurse Unit Manager, Alfred Health (**NUM Sonmez**) provided a statement and gave evidence at inquest. NUM Sonmez's statement was based on a review of the medical records pertaining to Kai's admission and not her own direct involvement in his care. The statement sets out those progress notes relevant to Kai's leave that support her opinion that he was granted and frequently utilised leave throughout his admission when he was not being nursed in the HDU; that leave was either escorted or unescorted depending on his assessed needs; and was always negotiated with the family, specifically with Mrs Wu who was the main point of contact for staff and seen as the primary carer.[48] While most of the communication with the family was with Mrs Wu, her son Leo was contacted when she was overseas and not available, and on one occasion it was documented that Mr Liu participated in a family meeting.[49]

56. At inquest, NUM Sonmez was questioned about PRN Hammond's and PN Potter's evidence that information pertaining to Kai's leave on 10 February 2018 was handed over verbally by the latter and then documented by the former. NUM Sonmez testified that the Pre-Leave Checklist stamp is a convenient/abbreviated tool meant to make it easy for staff to document that they have done certain things before a patient commences leave. It was not a requirement that staff slavishly comply with the stamp on each occasion but could chose to write a progress note

[47] Inpatient Progress Notes of RPN Hammond at page 316 of the brief. Note that the Pre-Leave Checklist is in the form of a stamp and that RPN Hammond also made her own notes of Kai's progress during the shift at the same time.
[48] Exhibit C is the statement of Gamze Sonmez dated 15 July 2019 at pages 48-50 of the brief and transcript page 73.
[49] This was on 28 November 2017 and led to NUM Sonmez's request to amend paragraph 10 of her statement. See Transcript pages 70-71. I note that the Inpatient Progress Notes replicated in the brief cover the period from 30 Dec 2017 until 11 February 2018. The earlier Inpatient Progress Notes were provided by Alfred Health and the notes pertaining to the family meeting of 28 November 2017 were reviewed by me at the time of writing of this finding. According to the note written by psychiatric registrar Dr Chuah, the participants were Dr Zhang, Dr Chuah, the parents, Vanessa and Connie from Headspace, Kai's case manager and social worker respectively. It is apparent that the father was an active participant enquiring about the possibility of neurosurgery on one occasion and about the side effects of ECT on another. See also transcript page 19 and following for Dr Zhang's evidence in this regard.

instead. This was a matter of substance rather than form, and she would not be critical of staff who did not use the stamp format.[50]

57. NUM Sonmez did concede that 'ideally best practice' would have been for PN Potter as the nurse who conducted the mental state examination/risk assessment to have made her own entry in the Inpatient Progress Notes as well as RPN Hammond as the allocated or contact nurse during that shift.[51] That way, the Inpatient Progress Notes would give a clearer picture to anyone looking at the medical records of the people involved with a patient, without the benefit of witness accounts made some time after the event.

58. At inquest, NUM Sonmez was also asked what was considered adequate communication by nursing staff of their expectations of family members or carers who are about to take a patient on leave. Her response was that she would expect nursing staff to make the carer aware of the duration of leave; of the conditions attaching to the leave which might vary from patient to patient but could include an abstinence condition or a prohibition on driving; advice to contact the unit if anything goes wrong or if there are concerns that the patient is deteriorating; and finally, to ensure the carer was comfortable with these expectations.[52]

59. In terms of the documentation of such discussions between nursing staff and carers, NUM Sonmez testified that it would be sufficient if the nurse documented the fact that they had communicated their expectations to the carer in the Inpatient Progress Notes, that is the fact this was done, rather than a verbatim account of the discussion.[53]

60. It is important to note the context within which nursing staff undertake their assessment of the mental state of the patient immediately before their departure from the unit on escorted (or unescorted) leave. While nursing staff do not have the authority to grant or initiate leave – this falls within the remit of the psychiatrist/registrar/hospital medical officer – theirs is likely to be the more current assessment of the patient's mental state and they are empowered to restrict,

[50] Note that counsel assisting me put it to NUM Sonmez that he only found three occasions on which the pre-Leave Checklist stamp had been used in the Inpatient Progress Notes from 30 December 2017 to 11 February 2018 which were included in the brief.
[51] Transcript pages 73-75. NUM Sonmez described the current system (at least as at the date of the inquest) for recording progress notes electronically so that there are now links and pop ups that prompt clinical staff to do certain things superseding the Pre-Leave Checklist stamp.
[52] Transcript page 77.
[53] Transcript page 78

reduce or even cancel leave altogether if it appears necessary given the patient's current state.[54] In responding to a question from Ms Foy, NUM Sonmez agreed that it is implicit in the nurse's decision to allow leave, that the patient's mental state was stable.[55]

61. In response to a request for a summary and any recommendations or comments included in the Alfred Health internal review of Kai's death, I received a statement from consultant psychiatrist Dr Nicky Zigouris. The statement sets out the process which the internal review followed as well as its outcomes. Suffice for present purposes to note that Kai's death was a sentinel event, and the review utilised a Root Cause Analysis methodology and included an external member. The review acknowledged that his was a complex presentation with a high level of family and consultant involvement throughout.[56]

62. While no specific root cause was identified in relation to Kai's death, the review did identify issues with processes, systems or clinical practices that while not materially contributing to the sentinel event, provided important learnings and an opportunity for improvement in healthcare service delivery. As a result, recommendations were made that Alfred Health:

    (a) Develop a "First Episode Psychosis Pathway" inclusive of strategies for working with a young person to support clinical decision making. This has been completed and a copy of the guideline approval date October 2019 was provided by Minter Ellinson on behalf of Alfred Health immediately after the conclusion of the inquest.

    (b) Define and develop a multidisciplinary team clinical review process inclusive of a "length of stay" review process. I was advised that this has been done and that there is no written process in this regard.

    (c) Review the leave pathway for the inpatient unit that implements processes in line with the Office of the Chief Psychiatrist's Guideline and new electronic medical record. I was advised that this review remains ongoing and that a new leave brochure has been developed for provision to patients and carers regarding leave.

[54] Transcript pages 83.
[55] Transcript page 84.
[56] Dr Zigouris' statement dated 24 July 2019 is at pages 34-37 of the brief. Dr Zigouris was not required to give evidence at inquest.

FINDINGS/CONCLUSIONS

63. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the *Briginshaw* gloss or explications.[57]

64. Moreover, the effect of the authorities is that Coroners should not make adverse comments or findings against individuals in their professional capacity 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. Any departure from standards must be established strictly without the benefit of hindsight, on the basis of what was known or should have been known at the time, and not from the privileged position of knowing the outcome and perceiving patterns or trajectories that were not reasonable apparent at the time.

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

(a) The deceased is Kai Wesley Wu, born on 29 November 1994.

(b) Kai died on 10 February 2018 at South Yarra Railway Station.

(c) The cause of Kai's death is injuries sustained when struck by train.

(d) Kai's death resulted from an act of self-harm in the sense that he placed himself in the path of the train when he knew or should have known that impact with the train was inevitable.

(e) However, the available evidence does not support a finding that Kai deliberately and intentionally ended his life. Rather, it supports a finding that his judgement was likely impaired by mental illness such that he was incapable of forming intent.

(f) There was no want of clinical management or care on the part of the staff of Alfred Health that were involved with Kai during his admission that caused or contributed to

[57] *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…*"

his death. On the contrary, the clinical management and care provided to Kai, including by Headspace MATT, was responsive, comprehensive and of a high standard.

(g) The weight of evidence supports a finding that Kai's family, his mother in particular, were well engaged and appropriately consulted by the treating team throughout Kai's treatment at the Alfred and aware of the expectation that they would ensure Kai was supervised at all times while on escorted leave.

(h) While it is clear that most communication between the treating team and the family was with Mrs Wu, in the absence of direct evidence from Mr Liu to the contrary, the only reasonable inference is that he was aware of the expectation that Kai should be supervised at all times while on escorted leave.

(i) The weight of evidence does not enable me to determine why Kai was left alone during escorted leave on 10 February 2018 and thereby provided with the opportunity to end his life, or to determine if Kai's death was otherwise preventable.

PUBLICATION OF FINDING

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

DISTRIBUTION OF FINDING

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

Kai's parents, Yan Wu and Wen Liu

Alfred Health

Office of the Chief Psychiatrist

Senior Constable Liam Rennie (#40641) c/o O.I.C. Police Transit Safety Division

Signature:

Coroner Paresa Antoniadis Spanos

Date: 21 December 2022

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an inquest. 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.