Court Reference: COR 2019 4846

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 63(1)
Section 67 of the Coroners Act 2008

Deceased:	**SCOTT ADAM BROWN**
Delivered on:	12 December 2022
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing date:	12 December 2022
Findings of:	**KATHERINE LORENZ, CORONER**
Counsel assisting the Coroner:	**Dylan Rae-White, Senior Coroner's Solicitor, Coroners Court of Victoria**
Other matters:	*Person detained under the Mental Health Act*
Keywords:	Suicide; Hanging; Inpatient; Mental Health; Parkinson's Disease.

HER HONOUR:

INTRODUCTION

1. Scott Adam Brown (**Mr Brown**) was born on 1 June 1969. He died on 7 September 2019, at 50 years of age, having ended his own life while he was in the Inpatient Psychiatric Unit at Alfred Hospital. At the time of his death, he was subject to a Temporary Treatment Order under to the *Mental Health Act 2014* (Vic).

THE CORONIAL INVESTIGATION

2. Mr Brown's death was reported to the coroner as it was 'unnatural' and he was 'in care' pursuant to section 3(1) of the *Coroners Act 2008* (**the Act**) by virtue of the fact that he was a patient detained in a mental health service within the meaning of the *Mental Health Act 2014*.

3. The Act recognises that people detained in such circumstances are vulnerable and affords them protection by requiring that the circumstances of their death are investigated by a coroner, irrespective of the medical cause of death, and by mandating that as part of that investigation there should be an inquest.

4. A coroner independently investigates 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. Coroners make findings on the balance of probabilities, not proof beyond reasonable doubt.

5. Victoria Police assigned Senior Constable Lauren Kane (**SC Kane**) as the Coroner's Investigator for the investigation. SC Kane conducted inquiries on my behalf, including taking statements from witnesses and submitting a coronial brief of evidence. The brief includes statements from family members, treating physicians, the forensic pathologist who examined him and investigating officers, as well as other relevant documentation.

6. The Court also obtained Mr Brown's medical records and statements from various treating practitioners.

7. Coroner Philip Byrne directed this coronial investigation until my appointment as a coroner on 8 February 2021, when I assumed the responsibility for it.

BACKGROUND

8. Mr Brown was described by his family as having a laid-back personality and who had accumulated a huge number of friends over his lifetime. He lived in Botanic Ridge with his wife Diana, sons Jessie and Logan and his stepson, Tom. He worked as a carpet layer and was known to be always available to help friends and family. He was a great sportsman and played football and cricket.

9. In 2011, Mr Brown was diagnosed with Parkinson's disease. Over time, he began to suffer more from the effects of the illness, finding it increasingly difficult to go about his everyday life. His job as a carpet layer was physically taxing and as time went on it took longer to complete jobs. He was tired more easily, became self-conscious about his symptoms and started to feel anxious in public.

10. In 2016, Mr Brown underwent a procedure known as Deep Brain Stimulation (**DBS**). DBS is a surgical procedure whereby electrodes are placed in the brain; these wires send electrical pulses to the brain to help control some motor symptoms. The electrodes are connected to a battery-operated device (similar to a cardiac pacemaker), which usually is placed under the skin below the collarbone. This device, called a neurostimulator, delivers continuous electrical pulses through the electrodes.

11. Initially, Mr Brown's condition seemed to improve after the procedure. However, following an infection at the surgical site, the initial improvements to his condition did not continue. Although Mr Brown continued to work, his daily life became more difficult. He had difficulties with walking and controlling his body, his speech was impaired, and a lack of saliva made eating difficult.

12. In 2019, Mr Brown's condition deteriorated further. According to his nephew, Hayden Brown, Mr Brown told him he was struggling with debt and his behaviour started to change. He started sending his nephew crude text messages and reported that he couldn't sleep.

13. Between 1 August and 3 August 2019, because of Mr Brown's behaviour, including excessive spending and irritability, Diana and the children moved out of the family home over three days.

14. On 3 August 2019, Hayden Brown became concerned about Mr Brown's behaviour which included posting offensive material on Facebook. Hayden Brown contacted police and requested a welfare check, but Mr Brown was not home when police attended.

15. On 5 August 2019, Mr Brown's sister Debra Brown and Hayden Brown took him to the Alfred Hospital Emergency Department. Upon admission, he was extremely agitated and presented with severe, involuntary jerking movements. The family reported that Mr Brown had not been drinking large amounts of alcohol, had been verbally abusive to his family, had not been taking his medication as prescribed and had been overusing his DBS.

16. Mr Brown displayed some evidence of dopamine toxicity when he arrived at the hospital which included confusion and increased heart rate. These symptoms settled as the effects of the overdose wore off. This had occurred in the background of impulse control issues, including incurring financial debt and increased sex drive with reported use of dating apps and pornographic websites.

17. Mr Brown was initially admitted to the hospital under the General Medical Unit. He disclosed to the treating doctors that in the context of conflict with his wife, he had consumed alcohol and impulsively took an overdose of his Parkinson's medication, Madopar (levodopa).[1]

18. During the admission it was recognised that Mr Brown had been using larger doses of Madopar and that he had increased his use of the DBS. He had also been able to obtain testosterone and had been using it. Mr Brown was reviewed by both the Neurology Unit and the Movement Disorders team. Medical staff identified that the combination of medications and high settings on the DBS had caused Mr Brown to be more impulsive and irritable.

[1] Statement of Dr Richard Broadley.

19. During the admission Mr Brown was seen by the psychiatry registrar and denied any ongoing ideas to commit suicide. He told treating teams that he intended to cease the testosterone use, reduce his alcohol use, and follow the neurology team's directions regarding his DBS settings and medications.

20. The psychiatry registrar discussed her assessment of Mr Brown with Dr Forlano, the consultant psychiatrist. Dr Forlano felt it was unlikely that Mr Brown was presenting with a primary mood disorder. The neurology team considered that Mr Brown's disinhibition and impulsivity should improve with changes ordered to his DBS and medications. The medical team made a plan to provide medications in a "Webster pack" to limit supply. The marital stress was recognised with the psychiatry team who suggested that Mr Brown speak with his GP about a mental health plan and ongoing support.

21. On 10 August 2019, Mr Brown was discharged from hospital.

22. On 18 August 2019, Mr Brown sent Diana a message saying that he had cut his wrists. She contacted Mr Brown's brother who then contacted emergency services. Police and a Police, Ambulance and Clinician Early Response (**PACER**) clinician attended. On assessment, Mr Brown reported self-harming out of frustration that he could not work due to his Parkinson's Disease symptoms and denied suicidal intent. The PACER clinician assessed Mr Brown and deemed that he did not require transport to hospital. Mr Brown had an appointment scheduled at Alfred Hospital the following day for treatment of his Parkinson's Disease and was advised to also see his GP the next day.

23. On 19 August 2019, Mr Brown attended his scheduled neurologist appointment at Alfred Hospital. He reported multiple stressors including his marriage breakdown, financial stressors, symptoms of Parkinson's Disease, dissatisfaction with his decrease in medications and DBS, feelings of hopelessness and isolation. He denied suicidal ideation. Mr Brown reported that he continued to overuse Parkinson's Disease medications since his recent discharge from hospital and he showed clinical signs of medication overuse.

24. Mr Brown was reviewed by the Emergency Psychiatric Service (**EPS**) and reported that his self-harming behaviour was in the context of frustration with movement

difficulties and feeling as though he was being under-treated after his medications were reduced. He denied suicidal intent. Mr Brown declined a voluntary admission and was made subject to an assessment order and later a Temporary Treatment Order (**TTO**) under the *Mental Health Act 2014* (Vic) due to his impulsivity, recent suicide attempts and social isolation. He remained on the neurology ward and his Parkinson's Disease medications were reduced to the recommended dose, which he was unhappy with this as he believed this to be too low.

25. On 20 August 2019, Mr Brown was reviewed by one of the Consultation Liaison Psychiatrist and placed on a treatment order because he was still asking to leave hospital despite his functional impairment and distress. He was admitted to hospital under the Neurology Unit.

26. On review by the Movement Disorder Registrar, Mr Brown was noted to have very limited capacity to walk and was only able to shuffle a few steps. He had significant slowing and rigidity. The movement disorders team made changes to his medication and DBS to try to improve his functioning.

27. On 20 August 2019, in consideration of Mr Brown's presentation, he was placed in a single room near the nurses' station on the general medical ward and the level of nursing observations were set as visual observations every 15 minutes.

28. On 21 August 2019 at around 1:00 PM, nursing staff noticed that Mr Brown was no longer in his room. The neurology team, his family and police were notified and later that day police returned Mr Brown to the hospital. Following his return, he was admitted to the Inpatient Psychiatric Unit (**IPU**) with ongoing support from the Neurology Movement Disorders Service. The admission to the IPU was based on a variety of factors, including the following:

    (a) The ongoing display of impulsive behaviours that required further assessment and treatment.

    (b) Mr Brown's departure from the neurology ward without notice to ward staff.

    (c) The presence of psycho-social issues which required input from multidisciplinary teams which was best provided in a psychiatry unit.

(d) The need to ensure that Mr Brown was in a locked ward to ensure he did not abscond from hospital while he needed acute treatment.

29. On 22 August 2019, the treating reviewed Mr Brown's care and sought information from his family. The family reported increasing aggression including threats to assault them. Mr Brown was diagnosed with an impulse control disorder and was prescribed quetiapine. The treating doctor decided to continue the TTO and seek reviews from other multidisciplinary teams including social work and occupational therapy to review additional supports Mr Brown would need to function in the community after discharge.

30. Mr Brown remained in the IPU with documented poor sleep and some abusive outbursts. At times, he acknowledged his behaviour had been out of character and was apologetic about it. He was given short periods of unescorted leave from the IPU to go out to smoke cigarettes during the admission.

31. Overnight on 4-5 September 2019, Mr Brown appeared to have poor sleep, was irritable, verbally abusive and made several derogatory remarks towards staff. He was reviewed by the psychiatric registrar on the morning of 5 September 2019, who noted increasing impulsive behaviour, escalating quickly and volatile in a setting of frustration with containment. Another family meeting was held that day without Mr Brown being present (at the request of the family). The family expressed further concerns about Mr Brown's threats to harm them, aggressive outbursts, and their worry that he could not look after himself at home.

32. Later that day a decision was made to postpone Mr Brown's planned discharge until after the Mental Health Tribunal hearing due to the ongoing behavioural issues. Mr Brown was seen by the consultant psychiatrist in the afternoon and advised that his discharge would not progress as planned.

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

33. On 6 September 2019, Mr Brown declined to be reviewed by the psychiatrist. His risk of absconding while disgruntled was noted and therefore no leave was to be granted without Mr Brown being reviewed by the psychiatrist first.

34. On 7 September 2019, nursing staff made observations every 60 minutes. The notes indicated that Mr Brown was settled throughout the morning.

35. At 1.00pm, Nurse Mark Fraser conducted observations and saw Mr Brown face-down on the floor of his bedroom. On approaching, he saw that Mr Brown's face was slightly off the ground and suspended by a ligature. Nurse Fraser removed the ligature and activated his duress alarm. Mr Brown was unresponsive and Nurse Fraser called a Code Blue. CPR was administered, however, Mr Brown was unable to be resuscitated.

IDENTITY

36. Mr Brown's identity was not in dispute and required no investigation.

MEDICAL CAUSE OF DEATH

37. On 9 September 2019, Dr Matthew Lynch, a senior forensic pathologist practising at the Victorian Institute of Forensic Medicine, performed an examination and provided a written report of his findings dated 9 September 2019. In that report, Dr Lynch concluded that the cause of Mr Brown's death was hanging.

38. I accept and adopt Dr Lynch's opinion as to Mr Brown's medical cause of death.

FURTHER INVESTIGATIONS

39. Mr Brown's death highlights the challenges of treating patients in a psychiatric inpatient setting who have comorbid medical conditions, such as Parkinson's disease. Mr Brown's mental health deterioration and behavioural manifestations could not be adequately managed in a general hospital ward and hence he was admitted to a psychiatric inpatient unit.

40. During his admission to the IPU Mr Brown was regularly reviewed by the Movement Disorder team to further assess and fine tune the DBS settings and the medication regime for Parkinson's disease.

41. The challenges of managing Mr Brown's co-morbidities were considered in the Root Cause Analysis report prepared by Alfred Health for Safer Care Victoria dated 28

November 2019 (**RCA**) and explained further in the statement of Dr Sudeep Saraf to the Court dated 1 October 2021.

42. Recommendation 1 of the RCA was for "*Multidisciplinary Treatment Review to be completed on all patients in the IPU and documented in the EMR that reflects the presenting problem / critical thinking / plan of care and agreement of actions that include the consumer / shared with them."*

43. Alfred Health has since confirmed that this recommendation has been implemented. The implementation of this recommendation is to ensure that complex patients with significant co-morbidities, such as Mr Brown, will have a single integrated care and treatment plan rather than each specialty forming its own separate plans. This process has since highlighted the need and ability to work collaboratively between specialties to meet the needs of patients.

44. The second learning identified in the RCA was that the risk assessment was not completed in accordance with the existing mental health IPU risk assessment guidelines. In accordance with the recommendation in the RCA, Alfred Health has since confirmed that it has developed a specialist mental health tool in the electronic medical record that links risk assessment and leave orders together in response to the identified learning. The new tool is designed to trigger a review of risk at various points, including any change in presentation such as agitation or substance abuse, review of leave and transfer between wards.

45. The other learning identified in the RCA and a subject of this coronial investigation was the availability of the skipping rope in the ward, which was able to be used as a ligature. In the RCA, it was recommended that Alfred Health implement an environmental hazard sweep process across high and low dependency areas which includes the identification of possible ligatures.

46. In the statements to the court, Alfred Health did not identify how Mr Brown accessed the skipping rope used as a ligature. In his statement, Nurse Mark Fraser identified that it may have been equipment used in the exercise group run by the occupational therapists.

47. In his statement dated 1 October 2021, Dr Saraf acknowledged that this was a possibility and that prior to Mr Brown's death, there was no formalised process regarding the management of exercise equipment.

48. Dr Saraf also offered other possible explanations for how Mr Brown may have accessed the skipping rope, including the possibility that he brought the skipping rope to the ward in his personal property, that he brought the skipping rope onto the ward after a period of leave or that another patient gave him the skipping rope. Dr Saraf noted that there are processes in place to check items brought onto the ward on admission and following leave. While it is possible that Mr Brown brought the skipping rope onto the ward at admission or following leave, this is a less likely explanation given it should be identified as a ligature risk when his belongings were searched, Mr Brown only had brief periods of unescorted leave (up to 30 minutes) and this was cancelled in the days prior to his death.

49. Dr Saraf stated that while most patients admitted to mental health wards are able to ambulate, many complain about the lack of resources to keep themselves engaged and entertained during their admission and exercise is important in addressing the metabolic risks present in psychiatric patients.

50. However, the lack of process for monitoring exercise equipment brought onto the ward was an obvious risk and may have contributed to Mr Brown accessing the skipping rope. Accordingly, since Mr Brown's death, a process for monitoring exercise equipment was developed as a priority, resulting in the development of the Management of High-Risk Items in Acute IPU Guideline.

51. A copy of this guideline was provided to the Court on request, and it read "*high risk exercise equipment such as skipping ropes and therabands are no longer available for use on the inpatient unit*". Moderate risk exercise equipment (such as hand weights, hand grips and boxing gloves) must be used only under supervision and accounted for by a staff member after use. This change in process appears to mitigate the risk that may have resulted in Mr Brown accessing a skipping rope to aid in his suicide.

SUMMARY INQUEST

52. Alfred Health has taken actions to address the concerns about Mr Brown's care which were consistent with the findings in the RCA report. These actions obviated the need to hear witness evidence in open court. I determined that this matter would be appropriately finalised by way of a Form 37 Finding into Death with Inquest and to hand down my findings at the conclusion of a summary inquest.

COMMENTS

53. Pursuant to section 67(3) of the Act, I make the following comments connected with the death:

54. Mr Brown had no known mental illness prior to the onset of Parkinson's Disease and mental and behavioural symptoms that he experienced following his diagnosis of Parkinson's Disease appeared to be secondary to the Parkinson's Disease and its treatments. It was apparent that managing the balance between adequate symptom control of Parkinson's Disease and the mental and behavioural disturbances that resulted from Parkinson's Disease treatment was complex and extremely difficult. Multiple services and treatment providers were involved over time and the documentation provided to the court indicates that information transfer between services sometimes suboptimal.

55. During his final hospital admission, Mr Brown was a compulsory patient on the Alfred Health mental health ward, primarily due to the need for a secure environment to treat his Parkinson's Disease and resulting mental and behavioural disturbance. He did not have nor was being treated for a primary psychiatric illness. Due to his complex needs, Mr Brown required treatment by multiple treating teams during this admission.

56. Alfred Health has accepted the recommendation in the RCA and implemented a plan to ensure that complex patients with significant co-morbidities, such as Mr Brown, will have a single integrated care and treatment plan rather than each specialty forming its own separate plans. Accordingly, no recommendation by this Court is required.

57. All mental health services (including Alfred Health) have processes in place to identify and remove access to dangerous items on a mental health ward, including for patient searches. At the time of Mr Brown's death, there was no process for Alfred Health to monitor patient access to high-risk exercise equipment. While it is unclear how Mr Brown came to access the skipping rope, he should not have had unsupervised access with one and this should have been identified as a potential ligature. Alfred Health have since implemented a guideline which appears reasonable and I am satisfied that no further recommendation is needed regarding access to means.

FINDINGS

58. Having investigated and held an inquest into the death of Scott Adam Brown, I make the following Findings pursuant to s 67(1) of the Act:

    a) The identity of the deceased is Scott Adam Brown, who was born on 1 June 1969, and who died on 7 September 2019 at the Alfred Hospital, 22 Commercial Road, Prahran, Victoria from hanging in the circumstances set out above.

    b) Mr Brown was under a temporary treatment order pursuant to the *Mental Health Act 2014*. As such, I find that he was 'in care' immediately before his death pursuant to the definition contained within section 3 of the *Coroners Act 2008* (Vic).

59. Having considered the circumstances, I am satisfied that Mr Brown intentionally ended his own life.

60. Pursuant to section 73(1) of the Act, I order that this Finding be published on the internet.

61. I convey my sincere condolences to Mr Brown's family.

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

Ms Diana Brown, Senior Next of Kin

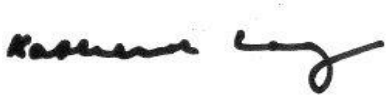
Office of the Chief Psychiatrist

Secretary, Department of Health

Alfred Health

Monash Health

Signature:



KATHERINE LORENZ

CORONER

Date: 12 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.