Rule 63(1)

IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2016 5972

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 63(1)

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

Inquest into the death of: CHRISTOPHER JOHN PETER DEWHURST

Findings of:	AUDREY JAMIESON, CORONER
Delivered On:	28 May 2021
Delivered At:	65 Kavanagh Street, Southbank 3006
Hearing Dates:	23 June 2020 – 25 June 2020
Appearances:	Ms Naomi Hodgson of Counsel instructed by Lander & Rogers Lawyers on behalf of Mercy Health
Police Coronial Support Unit:	Senior Constable (SC) James Kett, Assisting the Coroner and assisted by Leading SC Duncan McKenzie

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I, AUDREY JAMIESON, Coroner having investigated the death of CHRISTOPHER JOHN PETER DEWHURST

AND having held an Inquest in relation to this death on 23 June 2020 - 25 June 2020

at the Coroners Court of Victoria at Southbank

find that the identity of the deceased was CHRISTOPHER JOHN PETER DEWHURST

born on 19 October 1989

died on 16 December 2016

at Hoppers Crossing Railway Station, Hoppers Crossing Victoria 3029

from:

1 (a) MULTIPLE INJURIES – STRUCK BY A TRAIN

In the following summary of circumstances:

Christopher John Peter Dewhurst was a compulsory patient at Werribee Mercy Health Psychiatric Unit and was subject to a Temporary Treatment Order under the *Mental Health Act 2014* (Vic). He was granted ground leave but absconded from the facility and placed himself in the path of a train. His death was reportable pursuant to section 4 of the *Coroners Act 2008* (the Act) and an Inquest mandated pursuant to section 52(2) of the Act.

BACKGROUND CIRCUMSTANCES

1. Christopher John Peter Dewhurst[1] was 27 years of age at the time of his death. His early years were spent with his parents and sister, between Casterton and Melbourne. In 1997, they moved to Cairns to enable Christopher's mother to receive treatment for breast cancer with which she had been diagnosed during the previous year. Christopher's mother died from her illness in 2001 and her death had a significant impact on Christopher's mental wellbeing. He became poorly motivated at school, increasingly getting into trouble with resultant implications to his academic record. Notwithstanding these effects, he moved to Brisbane in 2007 to attend University to study Engineering. It was at University that he was believed to have been "introduced"

[1] With the consent of Christopher Dewhurst's father, Dr Timothy Dewhurst, he was referred to as "Christopher" during the course of the Inquest. For consistency, save where formality requires, I have also only referred to him as Christopher throughout the Finding.

to alcohol and illicit drugs. Christopher left University after three years without completing his course and he became a bus driver.

2. In July 2013, at approximately 24 years of age, Christopher experienced his first episode of psychosis. His father, Dr Timothy Dewhurst (Dr Dewhurst), flew to Brisbane to take Christopher back to Cairns. In the following two weeks, Christopher's mental health deteriorated, he assaulted his father and he was subsequently admitted to hospital under the relevant Queensland Mental Health Act provisions. He was hospitalised and commenced on antipsychotic medication and he moved into halfway accommodation until January 2014. However, he continued to abuse drugs resulting in periods of drug-induced psychoses and further admissions to hospital. Overtime, Christopher's diagnoses included recurrent drug induced psychosis, chronic substance dependence with amphetamines and cannabinoids, as well as florid antisocial and borderline personality disorder with a history of impulsivity.

3. Towards the end of January 2014, Dr Dewhurst brought Christopher to Melbourne and Christopher was admitted to Odyssey House for rehabilitation purposes. He remained there for approximately four months. For the remainder of 2014 and leading into 2015, Christopher's mental health remained stable – he returned to work driving buses and found stable accommodation.

4. In 2015, Christopher experienced severe psychosis following a dental procedure, necessitating prolonged admission to the Melbourne Clinic under the care of Consultant Psychiatrist, Dr Rowan McIntosh (Dr McIntosh). Dr McIntosh said that Christopher had a myriad of personality and substance dependence issues. He described Christopher as '*naïve with regard to the profoundly detrimental effects of 'ice' and marijuana,*' and referred to his '*unpredictability and impulsivity and indifference to the longer-term consequences of his risk taking/drug taking*'. After he was discharged, Christopher returned to driving buses.

5. In approximately July 2016, Christopher was readmitted to the Melbourne Clinic following a drug overdose. Dr Dewhurst spoke to Christopher about entering a drug rehabilitation program and Christopher responded with threats to kill himself. He was scheduled to commence a rehabilitation program on 29 August 2019. Christopher subsequently became violent and kicked a door down at Dr Dewhurst's home. He was

initially conveyed to Box Hill Hospital under the *Mental Health Act 2014* (Vic) before being transferred to the Melbourne Clinic. He remained at the clinic under the care of Dr McIntosh until 5 September 2016. On 7 September 2016 a further overdose resulted in an admission to Geelong University Hospital for a few days. On discharge, Christopher went to live with an Aunt in Werribee but in October 2016 he was asked to leave due to his behaviour.

6. On 3 December 2016, Christopher was living in a shared house in Altona Meadows when he had an argument with a housemate over the supply of drugs. He had been using cannabis and methamphetamines. Christopher stabbed himself in the arm in an apparent attempt to commit suicide resulting in his presentation to Werribee Mercy Hospital, Emergency Department (ED). Christopher remained in the ED and was permitted to leave the building to smoke.

SURROUNDING CIRCUMSTANCES

7. On 4 December 2016, Christopher was reviewed by Psychiatric Registrar Dr Ovami Oveleya. He was noted to have low mood, with ongoing suicidal ideation but no plans. The impression was of suicidal ideation with psychosocial stressors, past diagnoses of depression with current drug abuse, homelessness, and cluster B personality traits[2].

8. Christopher wanted a private admission but attempts to get him a bed in a private facility were unsuccessful and instead, on 5 December 2016, Christopher was admitted as a voluntary patient to the Werribee Mercy Mental Health Psychiatric Unit, Clare Moore Building. He was prescribed Pristiq 100 milligrams (mgs) daily, Subpraxi 5 mgs twice a day (bd) and Valium as required. Amphetamine withdrawal scale charting was put in place.

9. Soon after admission Christopher asked for "ground leave" which is where a patient is permitted to leave the ward to access hospital facilities but remains on the hospital grounds. His request at this time was refused due to his suicidal thoughts and safety issues. Christopher became angry and impulsive, and broke the door of the ward to get out. He was reviewed and placed on an Assessment Order under the *Mental Health Act 2014* (Vic).

[2] Cluster B is an American Diagnostic Statistical Manual term, is not a diagnosis but is characterised by dramatic, overly emotional, or unpredictable thinking or behaviour.

10. On 6 December 2016, Christopher was placed on a Temporary Treatment Order under the *Mental Health Act 2014* (Vic)[3] by Consultant Psychiatrist Dr Sharmila Lawrence due to Christopher's suicidal ideation.

11. On 7 December 2016, a review of Christopher by Consultant Psychiatrist Dr Ashok Kumar Singh (Dr Singh) lead to an increase in his medication doses – Pristiq increased to 150 mgs daily and Olanzapine 5 mgs bd was added. Dr Singh contacted Dr Dewhurst. Christopher sent his father a text message stating, '*When I kill myself just remember it wasn't the drugs like you like to blame. It's the situation I'm in.*' Dr McIntosh was contacted, and he reported Christopher had a personality disorder with polysubstance abuse and a vulnerability towards psychosis. Dr McIntosh was on six weeks leave at that time. Christopher was also reviewed by the Substance Use and Mental Illness Team (SUMIT) on the same day.

12. At a further review on 9 December 2016, Christopher denied any suicidal thoughts but advised that he had no intention of giving up cannabinoids or amphetamines. Dr Singh decided to start Christopher on supervised trials from the high dependency area of the Unit to the low dependency area, under the supervision of a staff member.

13. The supervised trials went well and following a review by Dr Singh on 12 December 2016, Christopher's transfer to the low dependency area was approved. Dr Singh observed that Christopher was more settled.

14. On 14 December 2016, Christopher sent another text message to Dr Dewhurst which said, '*I feel the same on and off drugs. I want you to know that it wasn't the drugs that made me kill myself*'.

15. Christopher was reviewed by Dr Singh and Psychiatric Registrar Dr Lalitha Balasubramanian (Dr Balasubramanian), on 14 and 16 December 2016. On both occasions he was noted to have presented well and denied any suicidal thoughts.

16. Between 14 December 2016 and 16 December 2016, Christopher had been on ground leave on several occasions without incident. On 15 December 2016, Christopher was approved for escorted leave to collect his belongings and wallet from his housemate.

[3] Rendering Christopher a compulsory/involuntary patient.

IMMEDIATE SURROUNDING CIRCUMSTANCES

17. On 16 December 2016 at 1.00pm, clinicians at Werribee Mercy Psychiatric Unit held a family meeting with Christopher, his father, and the treating team to discuss plans for discharge.

18. During that morning, Christopher's contact nurse was Registered Psychiatric Nurse (RPN) Thomas Kelly. Christopher was granted four hours of unaccompanied leave to attend an appointment at 8.15am with Yarra Housing with the aim of finding him accommodation.[4] Christopher presented as calm, polite, co-operative, with no reported irritability, anxiety, or suicidal thinking.

19. At 12.00pm, Christopher had not returned to the Unit at the required time and RPN Kelly telephoned him. Christopher said he was on his way back to the Unit and returned at 12.25pm and was calm and polite.

20. At 1.00pm, Dr Singh, Dr Balasubramanian, and Intern Dr Edward Fearon met with Dr Dewhurst at the Werribee Mental Health Psychiatric Unit where they discussed Christopher's post discharge follow-up, including linking him to community psychiatric team in the short term, to private psychiatrist in the longer term and a drug and alcohol program. Christopher and RPN Kelly later attended the meeting.

21. The discussions at the meeting revolved around encouraging Christopher to find alternative accommodation for his discharge to occur and plans for the future. Christopher became emotionally heightened during the meeting and rude towards his father, his treating team and was generally ambivalent about his future. He said that he had no intention of giving up amphetamines and cannabis. Dr Singh advised that if accommodation was available Christopher would be discharged on Monday 19 December 2016. However, Christopher had already refused the accommodation option offered earlier in the day by Yarra Housing.

22. The family meeting concluded at approximately 2.00pm. Dr Dewhurst said goodbye to Christopher who replied, '*you can go fuck yourself*'. Dr Dewhurst then told Christopher

[4] See p 223 Coronial Brief – Dr Singh has granted unaccompanied leave to Christopher to look for accommodation between the dates 16 – 20 December 2016 (*Mental Health Act 2014*, s64 – leave of absence for a compulsory patient).

to keep himself safe to which he replied '*never*'. RPN Kelly escorted Christopher back to the ward at the conclusion of the meeting.

23. At some stage after Christopher had left the meeting and before Dr Dewhurst had left the facility, Christopher attempted to telephone his father, who did not answer the calls. Dr Dewhurst stated that this was because Dr Singh had told him not to answer these calls, as his son was in a distressed state but would calm down in 24 hours.

24. At approximately 2.05pm, Christopher approached RPN Kelly to request ground leave. RPN Kelly stated that Christopher was calmer than he had been during the meeting; he was polite while negotiating the length of time for ground leave. Christopher said he was okay and that he would not do anything to harm himself when he was outside the Unit. RPN Kelly noted that there had been no prior issues with Christopher's leave. Ultimately, he permitted Christopher ground leave for 15 minutes.

25. At approximately 2.10pm, Christopher left the Unit on his approved leave. At 2.18pm, Christopher sent his father a text message which said "Goodbye". He sent his sister a similar text message.

26. At 2.25pm, Christopher had not returned from his ground leave and he could not be located on the grounds of the facility. He did not answer calls to his mobile telephone from the Unit.

27. At approximately 2.30pm, Christopher was observed walking onto the train tracks near Hoppers Crossing Railway Station. The 2.30pm Werribee to Flinders Street train TD 6470 was approaching the station. The train driver saw a male come out from the left-hand side of the track, and sprint toward the train. Christopher was observed turning to face the oncoming train and lowered his head. The train driver applied the emergency brake and sounded the whistle but was unable to avoid colliding with Christopher. Metrol was contacted who in turn contacted Emergency Services.

28. Metropolitan Fire Brigade members, Ambulance Victoria paramedics, State Emergency Services members and Victoria Police members attended shortly afterwards however, it was apparent that Christopher had sustained immediate and fatal injuries and died at the scene.

29. At approximately 2.35pm, RPN Kelly initiated an *Absent Without Leave* procedure, requiring notification of a patient's absence to Victoria Police and next of kin. He

telephoned Dr Dewhurst to ask if he had heard from Christopher and was advised of the "Goodbye" text message. At approximately 2.40pm, RPN Kelly contacted Police. He lodged a missing person's report at 2.45pm. He filled out an MHA 124 *Apprehension of Patient Absent Without Leave* form, which included a description of Christopher, and faxed it to Werribee Police Station at approximately 2.50pm. Shortly thereafter, Victoria Police contacted RPN Kelly to indicate that a recently deceased person matched Christopher's description.

JURISDICTION

30. The death of Christopher John Peter Dewhurst was a reportable death under section 4 of the Coroners Act 2008 ('the Act'), because it occurred in Victoria, and was considered unexpected, unnatural or to have resulted, directly or indirectly, from an accident or injury. In addition, at the time of his death, Christopher John Peter Dewhurst was subject to a Temporary Treatment Order under the *Mental Health Act 2014* (Vic) – he was a compulsory patient and as such his death was reportable, as he was "person placed in care" as is defined in the Act.

PURPOSE OF THE CORONIAL INVESTIGATION

31. The Coroners Court of Victoria is an inquisitorial jurisdiction.[5] The purpose of a coronial investigation is to independently investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[6] The cause of death refers to the medical cause of death, incorporating where possible the mode or mechanism of death. For coronial purposes, the circumstances in which death occurred refers to the context or background and surrounding circumstances but is confined to those circumstances sufficiently proximate and causally relevant to the death and not merely all circumstances which might form part of a narrative culminating in death. [7]

32. The broader purpose of coronial investigations is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making

[5] Section 89(4) Coroners Act 2008.

[6] Section 67(1) of the *Coroners Act 2008*.

[7] See for example *Harmsworth v The State Coroner* [1989] VR 989; *Clancy v West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J).

of recommendations by Coroners, generally referred to as the 'prevention' role.[8] Coroners are also empowered to report to the Attorney-General on 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 or safety or the administration of justice.[9] These are effectively the vehicles by which the prevention role may be advanced.[10]

33. It is not the Coroner's role to determine criminal or civil liability arising from the death under investigation. Nor is it the Coroner's role to determine disciplinary matters.

34. Section 52(2) of the Act provides that it is mandatory for a Coroner to hold an Inquest into a death if the death or cause of death occurred in Victoria and a Coroner suspects the death was as a result of homicide, or the deceased was, immediately before death, a person placed in custody or care, or the identity of the deceased is unknown. Christopher's "in care" status mandated the holding of an Inquest pursuant to section 52(2)(b) of the Act.

35. This finding draws on the totality of the material; the product of the Coronial Investigation into the death of Christopher. That is, the court records maintained during the Coronial Investigation, the Coronial Brief and further material sought and obtained by the Court, the evidence adduced during the Inquest as well closing submissions from Counsel Assisting and Counsel representing Mercy Health.

STANDARD OF PROOF

36. All coronial findings must be made based on proof of relevant facts on the balance of probabilities. In determining whether a matter is proven to that standard, I should give effect to the principles enunciated in *Briginshaw v Briginshaw*.[11] These principles state

[8] The "prevention" role is explicitly articulated in the Preamble and Purposes of the Act.

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

[10] See also sections 73(1) and 72(5) of the Act which requires 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.

that in deciding whether a matter is proven on the balance of probabilities, in considering the weight of the evidence, I should bear in mind:

- the nature and consequence of the facts to be proved;
- the seriousness of any allegations made;
- the inherent unlikelihood of the occurrence alleged;
- the gravity of the consequences flowing from an adverse finding; and
- if the allegation involves conduct of a criminal nature, weight must be given to the presumption of innocence, and the court should not be satisfied by inexact proofs, indefinite testimony or indirect inferences.

37. The effect of the authorities is that Coroners should not make adverse findings against or comments about individuals, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

INVESTIGATIONS PRECEDING THE INQUEST

38. Upon attending the site of the collision, police located a note which provided Christopher's father's telephone number and the password to his computer.

39. The train driver completed a preliminary breath test, which was negative for alcohol.

Identity

40. The identity of Christopher John Peter Dewhurst was facilitated by DNA comparison evidence from a sample provided by Dr Timothy Dewhurst. A Form 8 Rule 32 *Determination by Coroner of Identity of Deceased* was completed by me on 21 December 2016.

41. The identity of Christopher was not in dispute and required no further investigation.

Medical Cause of Death

42. Dr Paul Bedford, Forensic Pathologist at the Victorian Institute of Forensic Medicine (VIFM) performed an external examination upon the body of Christopher, reviewed a post mortem computed tomography (CT) scan and referred to the Victoria Police Report of Death, Form 83.

Post mortem examination

43. Dr Bedford reported that anatomical findings were consistent with the known mechanism of injury.

Toxicology

44. Toxicological analysis of Christopher's post mortem blood detected diazepam and its metabolite nordiazepam,[12] aripiprazole,[13] olanzapine[14] and desmethylvenlafaxine.[15]

Forensic pathology opinion

45. Dr Bedford ascribed the cause of Christopher's death to multiple injuries sustained after being struck by a train.

Conduct of my Investigation

46. First Constable (FC) Christopher Paul Jeffery,[16] the nominated coroner's investigator,[17] investigated the circumstances surrounding Christopher's death, at my direction, including the preparation of the coronial brief. The coronial brief contained *inter alia*, statements from Christopher's father Dr Timothy Dewhurst, Werribee Mercy Health Consultant Psychiatrist Dr Ashok Kumar Singh and registered psychiatric nurse Nurse Thomas Kelly, private Psychiatrist at the Melbourne Clinic Dr Rowan McIntosh, general practitioner Dr Alan Kwong, the train driver and two witnesses to the collision.[18]

[12] Diazepam is a sedative/hypnotic drug of the benzodiazepines class.

[13] Aripiprazole is an anti-psychotic drug indicated for the treatment of schizophrenia.

[14] Olanzapine is indicated for the treatment of schizophrenia and related psychoses. It can also be used for mood stabilisation and as an anti-manic drug.

[15] Venlafaxine is indicated for the treatment of depression.

[16] Now a Senior Constable.

[17] A coroner's investigator is a police officer nominated by the Chief Commissioner of Police or any other person nominated by the coroner to assist with his/her investigation into a reportable death. The coroner's investigator takes instructions direction from a coroner and carries out the role subject to the direction of a coroner.

[18] The statements in the coronial brief informed the depiction of the Background and Surrounding Circumstances.

Metro Trains Melbourne Investigation

47. Metro Trains Melbourne (MTM) provided a detailed incident investigation report, prepared by Investigator Hannah Fitchett, for inclusion in the coronial brief.

48. The report indicated that Closed Circuit Television footage from Hoppers Crossing Railway Station, was obtained of the incident. The train's data logger device was analysed, and evinced that the train travelled approximately 118 metres, after the driver hit the emergency brakes. Since departing the previous station, Werribee Station, the train's maximum speed reached was 83km/h, which is below the maximum speed of 115km/h. Investigator Fitchett reported that she was satisfied the train was being driven appropriately, within the rules and operating procedures. Following Christopher's death, the Old Geelong Road level crossing, which is adjacent to Hoppers Crossing Railway Station, was examined. The level crossing was considered to be working as designed. Investigator Fitchett concluded that Christopher had crossed Old Geelong Road once the boom barriers had lowered and placed himself in the path of the train. No follow up actions were taken after the investigation.

Chief Psychiatrist Guidelines

49. The Chief Psychiatrist 2009 and 2018 *Leave of absence from a mental health inpatient unit* guidelines include expectations for completed risk assessments, communication of leave and special conditions for compulsory and voluntary inpatients, carers and leave arrangements.

50. The 2009 guidelines state: *'It is not appropriate to automatically allow a decision to grant leave that has been made some days previously without consideration of the patient's current mental state'*.

51. The 2018 guidelines state: *'It is not appropriate to proceed with leave that was approved some days before without considering the current situation.'*

INQUEST

Direction Hearing/s

52. In light of the issues raised in my preliminary investigation, I directed that a Directions Hearing be held with a view to scoping the issues for Inquest.

53. A Directions Hearing was held on 19 August 2019. I was assisted by Leading Senior Constable (LSC) Tracey Ramsay from the Police Coronial Support Unit (PCSU). The scope of the Inquest was discussed.

Inquest

54. At the Inquest I was assisted by Senior Constable (SC) James Kett from the PCSU who in turn received assistance from LSC Duncan McKenzie, PCSU. Mercy Health was represented by Ms Naomi Hodgson of Counsel.

55. The Inquest was conducted via Cisco WebEx due to social distancing limitations which were imposed due to the COVID-19 pandemic. SC Kett, LSC McKenzie and the Bench Clerk were present in Court with me and all other participants appeared remotely.

56. SC Kett read a summary of the known circumstances surrounding Christopher's death and delineated my determination that the scope of the Inquest was to include:

- Policies in place at the time of Christopher's death relating to the granting of leave;
- The immediate surrounding circumstances to Christopher's death on 16 December 2016 including the planned family meeting;
- Matters that occurred at that meeting; and
- Decisions made after the meeting enabling Christopher to take leave.[19]

Viva Voce Evidence at the Inquest

57. Viva voce evidence was obtained from the following witnesses:

- Dr Timothy Dewhurst[20]
- Thomas Kelly, Registered Psychiatric Nurse
- Dr Lalitha Balasubramanian, Psychiatric Registrar/Hospital Medical Officer
- Dr Ashok Kumar Singh, Consultant Psychiatrist, Mercy Health

[19] Transcript of proceedings (**T**) @ p 10.

[20] Dr Dewhurst is a general medical practitioner with a interest and experience in mental health – he describes himself as a *generalist mental health practitioner.* (T @ p 15).

- Associate Professor Dean Stevenson, Consultant Psychiatrist, Clinical Director of Mental Health Services, Mercy Health

The family meeting

Organisation

58. Dr Dewhurst said that he did not know how much contact his son wanted with him after Christopher had been admitted to Mercy Health. At certain times, Dr Dewhurst attempted to heed Christopher's perceived desire for limited contact; he thought he might be '*inflaming the situation by having contact'*.[21]

59. Dr Balasubramanian stated that it was common practice for the treating team to discuss family or support person meetings with every in-patient; the treating team would explain that the purpose of the meetings was to determine how participants could be supported upon patient-discharge. Dr Singh gave similar evidence.[22]

60. Dr Dewhurst said that members of Christopher's treating team had contacted him on three or four occasions during his son's admission to the unit.[23] Dr Balasubramanian stated that it was a common practice for a treating team to discuss potential family or support person(s) meetings with every in-patient.

61. On 7 December 2016, Christopher began consulting Dr Singh. Dr Singh stated that Christopher was clear that he wanted a family meeting from the outset of their consultations, a request that he reiterated on 9 December 2016. On that date, Christopher's treating team began to determine *'the future management plan, discharge process* (and) *future support'*[24] that was going to be offered to Christopher, as well as the type of support that would be provided by his family when he was discharged from

[21] T @ p 26.

[22] T @ p 237, 238, 239.

[23] T @ p 28.

[24] T @ p 232.

hospital.[25] Consequently, Dr Singh requested that his Team to arrange a meeting at the convenience of Dr Dewhurst on that date.[26]

62. On Wednesday 14 December 2016, Dr Dewhurst received a text message from Christopher which said: *'I feel the same on and off the drugs. I want you to know that it wasn't the drugs that made me kill myself.'*[27] Dr Dewhurst could not recall if he had informed any of Christopher's treating team about the text message.

63. Around this time, Dr Dewhurst said that Christopher confirmed that he wanted his father to attend a family meeting on 16 December 2016.[28] Dr Dewhurst said that he could not recall ever being informed of a family meeting scheduled on 12 December 2016. He also said that his wife had never intended to participate due to an active Family Violence Intervention Order against Christopher.[29]

64. Dr Dewhurst recalled that Dr Singh contacted him directly to confirm a family meeting for 16 December 2016. However, Dr Dewhurst said that he did not understand that the family meeting was a pre-discharge meeting. He did not know its precise purpose but believed it was about family contact and for the treating team to discover more about his relationship with Christopher.[30] Dr Dewhurst anticipated discussing their ongoing contact, in circumstances where Christopher was not able to live with him and his wife.[31]

65. Dr Singh said that he and his Team was aware that Christopher and his father had had a difficult relationship in the past. Dr Dewhurst told Dr Singh that his son had been physically abusive toward him. Dr Dewhurst had also told Dr Singh that he loved his son and wanted to support him.[32] Dr Singh said that the broader implications of their

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[25] T @ p 234.

[26] T @ p 232.

[27] Exhibit 1, Statement of Timothy David Dewhurst, dated 2 April 2017, p 4.

[28] T @ p 27.

[29] T @ p 27.

[30] T @ pp 31 – 32, 40.

[31] T @ p 31.

[32] T @ pp 235 – 236.

complex relationship was considered. However, they were eager to meet and therefore Dr Singh considered a family meeting to be the right platform to work out a future plan.[33]

66. Dr Balasubramanian also said that treating team were aware that the relationship between Dr Dewhurst and Christopher was '*not the best'*[34] – they had conflict/differences of opinion. She said that Dr Dewhurst did his best to support Christopher, but his perception of support was his father giving him money when he asked for it.[35] Dr Dewhurst had concerns about Christopher using any money he gave him for drugs whereas Christopher denied that the drug use was an issue for him.[36] But regardless of this known conflict between Christopher and his father, Dr Balasubramanian said that Christopher would still contact Dr Dewhurst for support. He identified his father *'as the person that would be supportive of him or would try to assist him in times of need*.'[37]

67. RPN Kelly stated that, according to the notes in Christopher's medical records, the purpose of the family meeting was dependent on the outcome of Christopher's appointment with Yarra Housing earlier the same morning. The file notes indicated that the meeting was to discuss Christopher's "progress to date and the plan moving forward", including discharge dates.[38] RPN Kelly said that he reminded Christopher of the meeting but that he did not really discuss it with him.

16 December 2016

68. On 16 December 2016, Dr Dewhurst arrived shortly before the scheduled meeting time of 1.00pm. After a short wait, he was taken to the meeting room; Christopher had not

[33] T @ p 236.

[34] T @ p 175.

[35] T @ p 175.

[36] T @ p 175.

[37] T @ p 176.

[38] T @ pp 98 – 100.

yet arrived. Dr Singh was present and Dr Dewhurst believed that one or two other doctors were also present.[39]

69. Dr Singh recalled that he introduced himself to Dr Dewhurst as this was the first time that they had met face to face. He stated that they had a friendly chat which lasted no more than four minutes before Christopher joined the meeting.[40]

70. Dr Dewhurst stated that they discussed his son's diagnoses during this time. He said that Dr Singh spoke about Christopher's diagnosis of anti-social personality disorder/Cluster B personality disorder.[41] Dr Dewhurst believed that he questioned Dr Singh about this diagnosis, querying alternate diagnoses of Schizophrenia or complex PTSD, stemming from childhood trauma. Dr Dewhurst also recalled that Dr Singh specifically disagreed with a diagnosis of schizophrenia.[42] Dr Dewhurst said that they may have started to talk about accommodation options for Christopher before he joined the meeting.

71. When Christopher joined the meeting, Dr Dewhurst thought that his son's *'demeanour was unsettled'*. He felt that, despite Dr Singh's persistent attempts, Christopher was not engaging in the discussion.[43] Dr Dewhurst thought that his son was agreeing with the things that were being said for the sake of finishing the conversation and the meeting. When Dr Singh posed a question to Christopher about being proud of his father,[44] Dr Dewhurst said that Christopher became *'quite defiant'*.[45] Overall, Dr Dewhurst felt that his son was, throughout the meeting, '*still quite stressed, still quite depressed and still possibly suicidal.'*[46]

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[39] Identified as being Dr Lalitha Balasubramanian and Dr Edward Feeran.

[40] T @ p 240.

[41] T @ p 35.

[42] T @ p 39.

[43] T @ p 41, 42.

[44] T @ pp 46 -47 – Dr Dewhurst corrected this to be that Dr Ashok Singh stated that a parent would want to be proud of their child.

[45] T @ p 43, 44.

[46] T @ p 45.

72. RPN Kelly's recollection of the family meeting was that Christopher was quite provocative and sarcastic when he was talking to his father.[47] He said that the treating team did not respond or react to Christopher's provocative statements. They let Christopher continue speaking except when he spoke about death or suicide, then the treating team would talk to him about his current suicide risk.[48]

73. Dr Balasubramanian said that Christopher had his '*ups and downs*' in the meeting – he was shouting and abusive and at other times responding appropriately to questions.[49] Dr Balasubramanian recalled that Christopher disagreed with his father about the support Dr Dewhurst provided and that Christopher became irritable and verbally abusive towards his father.[50] Dr Balasubramanian did not recall specific comments, threats nor allegations made by Christopher. She did recall that the topic of the disagreement was payments for Christopher's car.[51] Dr Balasubramanian stated that Dr Singh asked Christopher to calm down and that Christopher complied. Dr Balasubramanian did not recall hearing Christopher make any comments about death[52] and she did not recall that the meeting was cut short but rather that it ended because '*the discussions that were meant to be heard were heard'*.[53]

74. Dr Singh described Christopher's behaviour in the meeting as '*quite dramatic and he was quite demanding…. angry…using very foul and bad words towards his father'.* However, he said that this behaviour only lasted for a few minutes and then Christopher calmed down.[54] Dr Singh also said that, although they were not expecting this initial behaviour from Christopher, it can be a part of the behaviours they see with people suffering from Cluster B personality traits: *'they easily come up with a high demand, high expectation, but once their demand*s *are not met they usually settle down and it*

[47] T @ p 100 and T @ p 102.

[48] T @ p 101.

[49] T @ p 182, 184.

[50] T @ p 181.

[51] T @ p 188.

[52] T @ p 190.

[53] T @ p 191, 196, 197.

[54] T @ pp 242 – 243.

does not take some time – long time."[55] Dr Singh had no recollection of Christopher being threatening towards his treating team.[56]

75. At approximately 2.00pm, the meeting concluded and as Christopher said goodbye to his father as he left to return to the ward with RPN Kelly. Dr Dewhurst replied, '*keep safe*'. According to Dr Dewhurst, Christopher responded by saying '*never*'.[5758] Christopher made other '*sarcastic comments*' as he was leaving the meeting including, '*I only wanted to kill myself because you wouldn't give me money to fix my car'* and *'I have no friends or family*'.[59] Dr Dewhurst said that, at this point, Christopher appeared agitated.

76. Dr Singh said that Christopher was settled at the conclusion of the meeting. He stated that Christopher appeared to understand that he was going to be supported with all aspects of a future management plan.[60] Dr Singh said that he saw no reason to review or revoke Christopher's leave protocol; he had used his leave appropriately during the previous three or four days and he had been out on leave that morning for three and half hours without incident.[61] He was of the same view in relation to Christopher's right to ground leave.

Events after the family meeting

77. After RPN Kelly and Christopher left the meeting room to return to the ward, RPN Kelly described Christopher's demeanour as '*quite calm…composed*.'[62] As soon as they arrived back at the ward, Christopher asked to go on ground leave to smoke a cigarette. However, RPN Kelly stated that he told Christopher to take a five minutes as '*there*

[55] T @ pp 247 – 248.

[56] T @ pp 243-244, 257, 258.

[57] T @ p 48, 59 (Dr Dewhurst at this stage stated that Christopher had "yelled" the word never at him).

[58] During the family meeting RPN Kelly also conceded/recalled Christopher responding with '*never*' to his father's request to 'look after [him]self' (transcript at page 104, line 8).

[59] T @ pp 54-55.

[60] T @ p 246.

[61] T @ p 249.

[62] T @ p 103.

were some topics (discussed in the family meeting) *that could possibly have brought up some feelings…*'[63]

78. RPN Kelly said he did not have any immediate concerns for Christopher. When Christopher returned to pursue his request for ground leave, RPN Kelly said that he asked him if '*he was feeling safe… if he was having thoughts around feeling hopeless or helpless, any suicidal thoughts'*.[64] During this conversation RPN Kelly said that he was assessing how Christopher was engaging with him. He noted that Christopher was making eye contact, there was reactivity in his affect and there was no prominent distress.[65] Having satisfied himself that nothing arose in that conversation '*that left any implication that there was a risk'*[66] and having not received any communication from the psychiatrists involved in the family meeting that Christopher's leave entitlements should be reviewed/cancelled,[67] RPN Kelly granted the ground leave to Christopher.

79. Dr Dewhurst remained in the meeting room with the doctors after Christopher and RPN Kelly had left. Dr Balasubramanian said Dr Dewhurst was upset by some of the words used by Christopher and that the treating team provided support to him and reiterated that Christopher would not be discharged until he had secured suitable accommodation.[68] While still in the meeting room Dr Dewhurst received a telephone call from Christopher. He recalled that Dr Singh advised him not to answer the call from Christopher because he was in a distressed state and that he would calm down in 24 hours. Dr Dewhurst said that he tended to agree with Dr Singh's advice. [69]

80. Dr Dewhurst said that he did not want to influence Christopher's treating team but wanted to convey to them that he was present to try to help if he could but he went onto

[63] T @ p. 103, 128.

[64] T @ p 107.

[65] T @ p 116, 117, 129, 133.

[66] T @ p 109, 117.

[67] T @ p 132.

[68] T @ p 197.

[69] T @ pp 57-58.

to say that '*they could see that the interaction between the two of us wasn't necessarily the best one, and so I wasn't going to be too involved afterwards.*'[70]

81. When Dr Balasubramanian left the meeting room, she sought out the hospital social worker about securing Christopher's accommodation, so that he could be discharged. She did not go to the ward to review Christopher as she did not have concerns about his mental state; she did not consider him to be at an increased risk.[71] Similarly, Dr Singh did not see or review Christopher after the family meeting because he had no concerns for Christopher's wellbeing.[72]

82. At 2.18pm, after Dr Dewhurst had left the hospital building and had walked back to his car,[73] he received a text message from Christopher which said "goodbye". Similarly, Dr Dewhurst did not respond to this message. He believed that '*saying goodbye in a text wasn't an unusual thing.*'[74]

83. A short time later, RPN Kelly telephoned Dr Dewhurst and asked if Christopher was with him, explaining that Christopher had not returned from his approved ground leave. Dr Dewhurst told the nurse that his son was not with him and passed on the content of the text message that he had just received from Christopher.

84. RPN Kelly concluded that Christopher was absent without leave after he had unsuccessfully attempted to contact and locate him. He completed the appropriate documentation MHA124,[75] advising Victoria Police that a patient was missing/absent without leave and requesting that police officers apprehend the patient.

<u>Retrospective Documentation</u>

85. RPN Kelly did not complete a contemporaneous entry in the medical records of his involvement with Christopher on 16 December 2016. He was still on duty when he was

[70] T @ p 61.

[71] T @ pp 209 - 211

[72] T @ p 279.

[73] T @ p 84.

[74] T @ p 80.

[75] See p 88 Coronial Brief.

informed that Christopher had died and I accept that this would have had a deleterious impact on his wellbeing. RPN Kelly informed me that he was given leave from work after attending a debriefing. He said that he made some notes on a "scrap bit of paper" on the following day and that he transcribed these notes into the medical record upon his return to work on 25 December 2016. RPN Kelly appropriately indicated in the record that his notes were a retrospective entry. I commend him in this regard.

86. On 25 December 2016, RPN Kelly retrospectively completed three risk assessments with reliance on his notes made during his leave. He had not documented any risk assessment as he undertook it or immediately thereafter; he informed me that he had completed them "mentally" on the day. RPN Kelly further informed me that he does not hold the Mental Health Routine Risk Assessment form "in his hand" while undertaking any risk assessment because '*as a nurse, you're aware of what risk you're assessing for.*'[76] According to RPN Kelly, documentation of these risk assessments would ordinarily eventuate retrospectively but before the end of the nurse's shift.

87. The retrospective risk assessments are all dated 25 December 2016, and each have the same time recorded on them. RPN Kelly could not explain why the times were documented in that way. He said that the actual time of the risk assessments would have been at:

    a. 8.00am, when he assessed Christopher prior to him going on day leave;

    b. approximately 12.30pm, when Christopher retuned from that leave, and

    c. approximately 2.05pm, prior to the ground leave from which Christopher did not return.

<u>Application of the Chief Psychiatrist's Guidelines</u>

88. In his *viva voce* evidence, Associate Professor Dean Stevenson (AP Stevenson), Clinical Services Director of Mental Health Services at Mercy Hospitals Victoria Limited (Mercy Health), said that when the Office of the Chief Psychiatrist releases new guidelines, Mercy Health review them and will update their own procedures to reflect the guidelines if needed. The guidelines from the Office of the Chief Psychiatrist

[76] T @ p 122.

come as recommendations relevant to service provision[77] but each Area Mental Health Service develops its own procedures based on the guidelines. Staff are expected to be aware of the services procedures relevant to the area in which they work, although they can access all Mercy Health policies and procedures through an online portal/Mercy Intranet.

89. AP Stevenson said that any review or updates of policy specific to inpatient leave entitlements was undertaken by the Quality Committee. The Committee is comprised of the:

    a. program director;

    b. deputy program directors from the four divisions of the service;

    c. deputy clinical service directors from those parts of the service;

    d. senior nurse, and

    e. consumer / area representatives.[78]

90. Staff authorised to grant leave to an inpatient depends on the status of the patient at the time leave is being considered/requested. If the patient has been admitted under the *Mental Health Act 2014* as an involuntary patient and is subject to a Treatment Order or Temporary Treatment Order, leave from the hospital grounds must be authorised by the treating Psychiatrist.[79] "Ground leave", that is permission to leave the in-patient Unit and go onto the grounds of the facility – usually for the purposes of smoking – requires no such formal process.

91. Christopher's death was considered a sentinel event. Under the auspices of the Department of Health and Human Services (DHHS),[80] a Root Cause Analysis (RCA) was conducted by Mercy Health. This RCA was referred to as a "cluster review"[81] by

[77] T @ p 287.

[78] T @ pp 295 – 296.

[79] T @ p 296.

[80] On 1 February 2021, the Department of Health and Human Services (DHHS) was separated into two departments: the Department of Health (DH) and the Department of Families, Fairness and Housing (DFFH).

[81] T @ P 302.

AP Stevenson; it also dealt with another sentinel event of a patient of the Clare Moore Building that had occurred one week earlier.[82] According to AP Stevenson, these deaths occurred in similar circumstances. The RCA made no finding - no root cause(s) established that Christopher was at an increased risk when his ground leave was granted. However, the RCA yielded a number of recommendations:

a. Recommendations 1 and 2 were relevant to the circumstances of Christopher's death.

b. Recommendation 2 of the RCA related to the use of a patient-leave register by the nurse facilitating patient ground leave. The register was already in place at the time of Christopher's death. However, according to AP Stevenson, it was not being used '*as robust(ly) as we would have wanted it to be.'*[83]

c. Recommendation 4 was written in reference to the other death. However, AP Stevenson conceded that it was also pertinent to Christopher's death.[84, 85] It arose from Mercy Mental Health identifying that the service '*needed to tighten up the granting of ground leave',*[86] it read:

   Before each period of ground leave, a risk assessment is to be conducted and documented. Access to ground leave will be deferred if the patient presents with a significant increase in risk.[87]

   i. In response to this recommendation, Mercy Mental Health determined that only one assessment must be conducted and documented prior to the first occasion of patient leave on each nursing shift. This was to ensure that an '*inordinate number*' of assessments were not conducted.[88] The health

[82] Coroners Court of Victoria reference – COR 2016 5834.

[83] T @ p 337.

[84] Coronial Brief @ p 73.

[85] T @ p 307.

[86] T @ p 305.

[87] Exhibit 9, *Statement of Associate Professor Dean Stevenson,* dated 25 October 2019, p 3 of 5.

[88] Ibid.

service amended the *Mental Health Planning and Management of Leave of Absence Procedure* to reflect this response.[89]

92. Mercy Mental Health had no policies that related specifically to conducting family meetings. AP Stevenson stated that he was not aware of other services having such a policy.[90] Dr Singh gave similar evidence. Further, AP Stevenson stated that he did not believe a specific policy around family meetings would have any positive effects on the process – '*I see it as a part of a standard of care…which we are expected to provide in services*.'[91] He did not believe that one could layout in a procedure '*every possible reaction that one might get in a meeting'* without reducing the frequency of the meetings. He was of the opinion that staff were sufficiently trained to manage the multiple scenarios that may present in family meetings.[92] He did not consider that a formal risk assessment post a family meeting would have '*much positive influence on the scenario',* as although the family meeting is not a pure risk assessment process, clinicians holding the meeting are conducting ongoing assessment of the patient throughout the meeting.[93]

93. Mercy Mental Health's policies in relation to leave have been reviewed since Christopher's death. According to AP Stevenson's evidence, the review included:

    a. clarifying precisely what "leave" is;

    b. obliging the admitting nurse to provide clear information to patients about the expectations of leave, and

    c. providing a taking of leave brochure to the new patient.

93. At the time of the Inquest, a proposal to deny leave within the first 24 hours of admission was still under review. The proposed policy was an attempt to ensure that new patients' level of risk was well understood prior to granting any leave.

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[89] T @ p 327.

[90] T @ p 323

[91] T @ p 325.

[92] T @ p 326.

[93] T @ pp 330 - 331.

COMMENTS

Pursuant to section 67(3) of the Coroners Act 2008, I make the following comments connected with the death:

Dr Dewhurst's Evidence

1. Dr Dewhurst was in the unenviable position of giving evidence at his son's Inquest. Giving evidence about his contemporaneous contact with Christopher before his violent death is not an easy task and had he indicated his preference not to give evidence, I would have understood and accepted his position. An additional hurdle I perceived for Dr Dewhurst was the impossible task for him to detach himself from his own professional expertise. He had to provide evidence based on his observations and knowledge of his son as a father and as participant in a Family Meeting, without attempting to diagnostically analyse Christopher's words and actions in retrospect. My impression was that he struggled to separate the two as he reflected on the events leading up to Christopher's death. I do not believe that he purposely embellished his recollection nor do I make any other criticism of him.
2. I acknowledge and greatly appreciate that Dr Dewhurst reflected on his own son's sad trajectory of decline from his use of methylamphetamine and mental health issues to articulate that he was not pointing blame at anyone for Christopher's death but that he was wanting to increase awareness and find ways of helping men like his son without '*putting them in a diagnostic category of mad or bad*.'[94] He said that, in particular, he wanted something to be done about "ice". Dr Dewhurst identified that although Christopher did not think it was doing him any harm, it was clear his mental health was continuing to decline with ongoing use.

Werribee Mercy Psychiatric Unit – Risk Assessment & Documentation

3. Prior to the family meeting, there appears to have been appropriate application of the leave of absence procedures, both in relation to his leave of absence from the unit (see for example Exhibit 4) and the procedure related to ground leave.[95] By all accounts, Christopher was always compliant with his leave requirements prior to the date of his

[94] T @ p 64.

[95] Inquest Brief, p 331.

death. However, RPN Kelly considered the general risk of heightened agitation following a family meeting, but it did not ultimately influence his decision to grant ground leave. Additionally, Christopher's agitation during the family meeting did not prompt medical staff who were present to review the appropriateness of his prior-approved leave.

4. AP Stevenson informed me that shorter leave periods on or off "grounds" do not reduce the risks associated with unescorted leave from an inpatient psychiatric unit; patients with Cluster B personalities tend to have elevated long term risk, that the person's impulsivity can colour that risk at any time and as such, risk assessment is particularly challenging in this group of patients.[96] According to AP Stevenson, people with Cluster B personalities have a thought and there is an action and that there is no time to modulate the response. He opined that this is what had happened with Christopher.[97]

5. The evidence does not indicate that the unique challenges of risk assessments for patients with Cluster B personality traits were considered by those assessing Christopher's risk proximate to the Family Meeting. But I cannot dismiss the possibility that they did, as they were all experienced clinicians in the mental health field. In order to accept AP Stevenson's proposition that "thought, action, no time to modify" was typical of this cohort, I would have to conclude that Christopher only made the decision to end his life spontaneously once he had gone on ground leave, as opposed to planning his actions beforehand. I am not convinced of this chain of events to the requisite standard but ultimately, it is not necessary for me to make this analysis for the purposes of my Findings.

6. The 2018 Chief Psychiatrist Guideline requires a review of a patient prior to granting leave. However, the Guideline does not identify the person responsible for the review, nor does it encourage escalation of decision-making about the appropriateness of leave in such circumstances. It does not specifically reference family meetings.

7. Meetings with a psychiatric patient's support network – including those people that may be able to assist the patient after discharge – are to be commended. However, there is always the potential that the meeting will become emotive and distressing for the

[96] T @ p 312.

[97] T @ p 312.

patient, their support network, and/or the treating team. The mere risk of this potential being realised should prompt a reassessment of previous leave arrangements by the treating medical team and as such would act as a contemporaneous risk assessment to inform and support the nursing staff who enact the leave arrangements.

8. RPN Kelly accepted that I had no contemporaneous documentation which reflected that Christopher had any requisite risk assessment on the Ward on 16 December 2016. Furthermore, there was no required form to complete to facilitate ground leave at that time. I accept that RPN Kelly's progress notes were incomplete due to the events that unfolded during that afternoon. If it were a singular issue, I would have also accepted the same lapse in contemporaneous documentation of Christopher's ground leave risk assessment. However, the evidence indicates that there was a lackadaisical practice or system of documentation of patient risk assessment: the fundamental tool used by healthcare providers in the delivery of mental health services. It is critical that a patient's records are kept as up to date as possible to ensure the provision of appropriate and quality healthcare and treatment. Medical documentation must also be completed contemporaneously to the documented event to be reliable and persuasive in the legal setting. I cannot accept that "best practice" is allowing nursing staff to complete their documentation at the end of their shift, based on their memory.

9. Mercy Health have informed me that the health service now use an electronic medical record (EMR). However, there is no evidence to suggest that the practice of retrospective note taking has been eliminated or fully addressed.

RECOMMENDATIONS

Pursuant to section 72(2) of the Coroners Act 2008, I make the following recommendation(s) connected with the death:

1. With the aim of promoting public health and safety and preventing like deaths, I recommend that the Chief Psychiatrist review the Guidelines related to Leave (*Leave of absence from a mental health inpatient unit guidelines)* to specifically reference Family Meetings and recommend that the patient's leave entitlements be suspended until a review of the patient's risk to taking leave – escorted, unescorted, on grounds, off grounds; by the patient's Consultant Psychiatrist can be made.

2. With the aim of promoting public health and safety and preventing like deaths, I recommend that Mercy Health review its own policies and procedures[98] related to Leave to specifically reference Family Meetings and require that the patient's leave entitlements be suspended until a review of the patient's risk to taking leave – escorted, unescorted, on grounds, off grounds; by the patient's Consultant Psychiatrist can be made.

3. With the aim of promoting public health and safety and encouraging best practice in the clinical setting, I recommend that Mercy Mental Health take steps to discourage the practice of completing retrospective documentation particularly in respect of risk assessments by providing training, that is repeated periodically, on the principles that contemporaneous documentation in the health care setting should be an effective means of communication, should act as an *aide memoire* to the clinician of the contemporaneous circumstances and of their importance emphasised as they are a legal document.

FINDINGS

1. I find that Christopher John Peter Dewhurst born 19 October 1989 died on 16 December 2016 at Hoppers Crossing Railway Station, Hoppers Crossing, Victoria 3029.

2. I find that at the time of his death Christopher John Peter Dewhurst was an inpatient at Werribee Mercy Hospital Psychiatric Unit, Clare Moore Building and subject to a Temporary Treatment Order under the *Mental Health Act 2014* (Vic).

3. I find that there was a clear and documented association between Christopher John Peter Dewhurst's polysubstance abuse and his mental ill health however, there is no evidence of a causal connection between his polysubstance abuse and his death.

4. I accept and adopt the cause of death as ascribed by Forensic Pathologist, Dr Paul Bedford and I find that Christopher John Peter Dewhurst died from multiple injuries from being struck by a train in circumstances where I find that he intended to take his own life.

[98] Mental Health Planning and Management of Leave of Absence Procedure.

5. I am not able to determine all of the contributing factors leading Christopher John Peter Dewhurst to end his own life. However, in the absence of any other intervening, significant event, I find that his participation and discussions as they unfolded in the Family Meeting at Werribee Mercy Psychiatric Unit were contributing factors to his decision making.

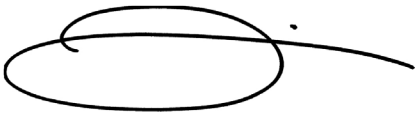
6. I find that Werribee Mercy Psychiatric Unit was making significant attempts to facilitate the discharge of Christopher John Peter Dewhurst and to support his transition back into the community including arranging a Family Meeting.

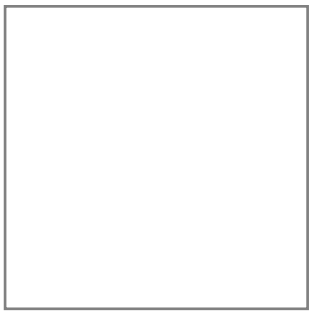
7. I find that the risk to Christopher John Peter Dewhurst was not identified at the conclusion of the Family Meeting and/or at the time he was granted ground leave on 16 December 2016.

8. I am unable to say with any degree of certainty that Christopher John Peter Dewhurst's death was preventable. However, I find that there were missed opportunities to intervene in the course of events preceding and leading to Christopher John Peter Dewhurst's death.

To enable compliance with section 73(1) of the Coroners Act 2008 (Vic), I direct that the Findings will be published on the internet.

I direct that a copy of this Finding be provided to the following:
Dr Timothy Dewhurst
Kate Mellier, Lander & Rogers Lawyers on behalf of Mercy Health
Office of the Chief Psychiatrist
Senior Constable Christopher Jeffery





AUDREY JAMIESON
CORONER
Date: 28 May 2021