IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2020 0549

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
Section 67 of the ***Coroners Act 2008***

Findings of:	Sarah Gebert, Coroner
Deceased:	Mr J
Date of birth:	[redacted] 1983
Date of death:	29 January 2020
Cause of death:	*Multiple Sharp Force Injuries to Chest and Neck*
Place of death:	[redacted], Victoria

INTRODUCTION

1. Mr J[1], born on [redacted] 1983, was 36 years old at the time of his death. He is survived by his parents [redacted] and [redacted], and his sister [redacted].

2. Mr J lived by himself in an apartment in Wantirna South. He completed a certificate in Animal Studies with aspirations to become a veterinary nurse and volunteered at the [redacted] Animal shelter.

3. On 29 January 2020, Mr J was located by his mother in the bathroom of the family home in [redacted] with multiple injuries and, despite medical treatment, he was unable to be assisted.

THE CORONIAL INVESTIGATION

4. Mr J's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

5. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

6. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

7. Victoria Police assigned Senior Constable Madlyon Devine (**SC Devine**) to be the Coroner's Investigator. SC Devine conducted inquiries on my behalf, including taking statements from witnesses and submitting a coronial brief of evidence. The coronial brief comprises statements from Mr J's mother, his general practitioner (**GP**) Dr Michael Banning, consultant psychiatrist Dr David Lim, paramedics who rendered

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[1] Referred to as 'Mr J' unless more formality is required.

assistance, the pathologist who examined him and investigating police as well as other relevant documentation. Mr J's medical records from Dr Banning and Eastern Health also formed part of the evidence before the Court.

8. As part of the investigation, the case was referred to the Coroners Prevention Unit (**CPU**).[2] The CPU were asked to review the care provided by Dr Banning as well as Mr J's treatment following his presentation on 2 January 2020 at the Angliss Hospital Emergency Department (**ED**). Dr Martin Koolstra, Director of Angliss Hospital ED, provided two statements to the Court regarding this presentation following receipt of the coronial brief.[3]

9. This finding draws on the totality of the coronial investigation into Mr J's death, including evidence contained in the coronial brief and information provided by the CPU. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[4]

Background

<u>Mental Health History</u>

10. Mr J was diagnosed with first episode psychosis in 2012 after a compulsory three-month inpatient admission in the context of methamphetamine use and psychotic symptoms. Treatment recommendations were to continue antipsychotic medication and abstain from illicit substances.

11. In 2014, Mr J relapsed in the context of non-adherence to his medication and use of methamphetamine, again requiring a compulsory inpatient admission followed by community treatment through a public mental health service. Mr J also engaged in a three-month residential rehabilitation program for substance use.

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[2] The Coroners Prevention Unit (**CPU**) assists the coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

[3] Dated 1 December 2020 and 17 August 2021.

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

12. From 2016, Mr J accessed treatment through GP Dr Banning, attending monthly appointments for administration of the anti-psychotic paliperidone. Mr J was also engaged with a private psychiatrist, Dr David Lim. In early 2017, Mr J reported feeling depressed following a relationship breakdown and commenced an antidepressant (sertraline), which had not been ceased at the time of his death.

13. Mr J's dose of paliperidone was gradually decreased from 150mg in November 2016 to 50mg in July 2018 with no psychotic relapse. Mr J demonstrated good compliance with his antipsychotic medication attending Dr Banning on a monthly basis for administration. Medical records indicate that Mr J denied psychotic symptoms and reported feeling well during most contacts with Dr Banning.

14. In March 2019, Mr J was flagged on Safescript due to accessing benzodiazepines through both Dr Lim and Dr Banning. Dr Banning spoke to Mr J who insisted that he was not addicted. Mr J stated he would not take more than 15mg diazepam per day and did not combine with temazepam. Dr Banning agreed to continue prescribing following this discussion (10 x 5mg diazepam and 10 x 10mg temazepam with no repeats).

15. In September 2019, Mr J elected to cease his antipsychotic. He advised Dr Banning of this during an appointment on 4 October 2019, and stated he had discussed the decision with his mother but not with Dr Lim. At the time Mr J made this decision, he had a stable mental state and had approximately two-years without relapse of psychotic symptoms. Dr Banning discussed risks and documented that Mr J was willing to accept these risks. A safety plan was discussed involving Mr J having regular contact with his mother and contacting her if unwell, and Mr J was to continue on sertraline and benzodiazepines. A four-week review was agreed.

16. On 1 November 2019, Mr J attended an appointment with Dr Banning. He reported feeling well but finding it harder to get to sleep at night, although once asleep he had no issues.

17. On 29 November 2019, Mr J attended an appointment with Dr Banning. He reported feeling well and denied intrusive or unpleasant thoughts. Mr J reported some anxiety and difficulty sleeping. Dr Banning noted slightly pressured speech but

an otherwise usual presentation. Mr J requested a medical certificate to get a one-week extension on a TAFE assignment.

18. On 13 December 2019, Mr J attended an appointment organised by his mother due to concerns about his wellbeing. Mr J's mother called Dr Banning requesting the appointment as Mr J was angry and nasty and not his usual self. Mr J reported feeling angry and upset after a relationship breakdown and described sending an abusive text message to his sister in the context of drinking alcohol. Mr J stated that he was not psychotic and not experiencing any intrusive thoughts. Mr J was noted to present with a normal speech flow and thought content. Dr Banning formed the opinion that Mr J was not experiencing a relapse of psychosis and discussed harm minimisation strategies regarding alcohol consumption. Mr J agreed to a two-week follow-up.

19. Mr J's last contact with Dr Banning occurred on 27 December 2019. On this day, Mr J reported: missing his ex-girlfriend, that she *does not return his messages as often as he wishes* and *is starting to accept he may need to back off a bit.* He also reported seeing his parents over Christmas. Mr J was noted to be his usual self with a normal thought stream and was stable off medication. A four-week follow-up was agreed on and an appointment was scheduled for 30 January 2020 (the day after his death).

Angliss Hospital

20. Mr J's last known contact with health professionals was on 2 and 3 January 2020. Mr J was transported to Angliss Hospital ED via ambulance arriving at 10.30pm on 2 January. The Ambulance Victoria electronic patient care record noted that Mr J took 10 x 5mg diazepam in combination with alcohol and sent a text message to his ex-girlfriend saying he did not care if he lived or died. She subsequently called an ambulance. Mr J denied any plan or intent to suicide but acknowledged that he could deteriorate. Mr J was documented as very unwilling to go to ED and he required extensive reassurance. No disordered speech or thinking was noted, his thought content was described as depressive.

21. Mr J was triaged at 11.15pm where he reported that he was feeling down and suicidal but had no plan and did not think he was a risk to himself. The reason for

admission was noted to be mental health, and the triage notes state: *feeling down, took 10mg Valium, 8 etoh drinks, upset with friend. Sent text saying doesn't care if lives or dies. States is suicidal no plan*. Dr Koolstra confirmed that: *no formal mental health assessment was performed by the doctor or a mental health worker on this presentation*. Mr J was reviewed by Registered Nurse (**RN**) Zhang in the ED and discharged approximately one hour after he was triaged with no follow-up.

22. Mr J was explicitly denying suicidal intent and stated he was not a risk to himself in his discussion with RN Zhang. RN Zhang discussed Mr J's current wellbeing and suicidal intent but there was no reference to his mental health history in the records.[5]

23. After midnight Mr J's friend [redacted] arrived at the ED. [redacted] said that he would stay with Mr J that night and make sure everything was fine. Dr Koolstra stated that a *brief discussion* …[took place] *..with the doctor in charge overnight, Dr Wijeratne, who had not formally seen* [Mr J] *but was reassured that he was with a friend and felt safe to go.*

24. Dr Banning was not aware of Mr J's presentation to the Angliss Hospital.

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

Circumstances in which the death occurred

25. On Wednesday 29 January 2020, Mr J rang his mother and said that *he was feeling anxious about his up coming appointment with his GP* the following day. [redacted] spent some time with her son at his apartment following which he returned to the

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[5] *States was brought in because of a misunderstanding. States has been going to TAFE and met a female friend who he has grown really close to. They would often text all the time and speak on the phone everyday, until about 3 weeks ago became cold and distant to him without giving any obvious reasons. He thinks it might be due to her psychiatrist changing her medications around that time. So he has been a bit stressed and sad recently and texted her today to say that he feels a bit down can he ring and speak to her , when she said no he then said he doesn't care anymore. She then told him to ring life line and notified AV. Pt denies thoughts of suicidal or self harm. he states he doesn't think he is at risk to himself or others. He is upset that he lost a friend. but he never looked her any other way than a good friend. states he had may have taken 7 diazepam 5mg throughout the day 2 in the morning then 3 lunch time and another 2 later in the day. 3 vodka lunch time and 5 x beers tonight before AV arrived to his house. denies recreational drugs. no self harm wounds. making eye contact. walked in normal gait. speech not slurred. Cooperative.*

family home with his mother for some dinner. [redacted] said that he *appeared a little bit anxious.*

26. They shared a meal and Mr J had two beers. After dinner Mr J went upstairs to have a shower and *asked for soap and a face washer like normal.*

27. Approximately 20 minutes later, [redacted] went to investigate an unusual noise and it was at this time that she found Mr J lying on the bathroom floor with blood coming from his chest and neck. She said that he looked at her and said, *I love you Mum.* He did not want to hold a face washer against his neck wounds. A small metal handled folding knife was present at the scene.

28. Emergency services were immediately called (the call was received at 6.43pm) and [redacted] provided assistance to her son including cardiopulmonary resuscitation (**CPR**) under the instruction of the call taker.

29. Ambulance services attended at 6.49pm but unfortunately Mr J was unable to be resuscitated and he was declared deceased at 7.09pm.[6]

30. Police including criminal investigators attended the scene at 7.00pm and commenced an investigation. Photographic evidence was collected by the Knox crime scene unit and formed part of the coronial brief. Mr J's mobile phone was inspected but no relevant information was located.

31. Following their investigation, police found no evidence of any suspicious circumstances and it was apparent that Mr J's injuries were self-inflicted.

32. [redacted] said that at,

no stage today did Mr J indicate his intention to harm/kill himself today. There were no final goodbye or statements that indicated to me that anything was out of the ordinary.

Identity of the deceased

33. On 29 January 2020, [redacted] identified her son Mr J, born [redacted] 1983.

[6] Verification of Death Form.

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

Medical cause of death

35. Clinical Professor and Specialist Forensic Pathologist David Ranson from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on 30 January 2020 and provided a written report of his findings on the same date.

36. Toxicological analysis of post mortem blood specimens detected ethanol (0.01 g/100mL), methylamphetamine (~0.2mg/L), amphetamine (~0.07 mg/L)[7] and diazepam[8] (~ 0.06 mg/L).

37. Toxicological analysis of hair specimens (~2 cm[9]) detected methylamphetamine (~4.6ng/mg), amphetamine (~0.5 ng/mg), diazepam (~ 0.1 ng/mg) and nordiazepam (~0.1 ng/mg)[10].

38. No antidepressant or antipsychotic medications were present.

39. Professor Ranson provided an opinion that the medical cause of death was *Multiple Sharp Force Injuries to Chest and Neck.*

40. I accept Professor Ranson's opinion.

CPU REVIEW

<u>GP care</u>

41. The CPU conducted a review of the available evidence including Mr J's medical records. They considered that it was reasonable for Mr J's GP to support him to cease the antipsychotic in October 2019. Mr J was voluntarily engaging in

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[7] Amphetamines is a collective word to describe central nervous system (CNS) stimulants structurally related to dexamphetamine. Methamphetamine is a type of amphetamine, often known as *speed* or *ice*.

[8] Diazepam is a long acting benzodiazepine with anxiolytic, sedative, hypnotic, muscle relaxant and antiepileptic effects. It is indicated in the short-term management of anxiety, and agitation, acute alcohol withdrawal, muscle spasms, sedation, and status epilepticus. In addition, it is accepted for use in acute behavioural disturbance, night terrors, sleepwalking, panic disorder, sleep disorders, seizures and acute barbiturate or benzodiazepine withdrawal.

[9] The growth rate of hair can vary however, it is generally accepted to be on average 1 cm per month. This allows for an estimation of the time period of drug consumption or exposure as segmental testing provides additional time exposure information.

[10] Metabolite of diazepam.

treatment, had a stable mental state and was capable of making an informed choice to cease antipsychotic medications.[11]

42. Mr J had two episodes of psychosis in 2012 and 2014 requiring compulsory treatment (inpatient and outpatient). Both episodes occurred in the context of illicit substance use, and the second also in the context of non-compliance with antipsychotic medication. A letter from Dr Banning in August 2015 indicates that Mr J was originally advised to remain on paliperidone for four years. Mr J had achieved this recommended period of time. From 2016, Mr J was complaint with medication and had a positive treatment response.

43. The statement of Dr Lim indicated that he considered Mr J's depression and psychosis to be in remission in May 2019. Mr J had remained stable on antipsychotic medication for approximately three years with gradual decreases in dose and no relapse of psychosis. His social situation was stable, and he had a supportive mother.

44. The CPU advised that ideally patients stopping an antipsychotic would do so under the monitoring of a psychiatrist, however the medical records of Dr Banning indicated that he continued monthly contact with Mr J to monitor his mental state and it is unlikely that Mr J would have had any more frequent contact with a psychiatrist. Appropriate discussion and education about risks and safety planning occurred with Dr Banning, and Mr J agreed to continue regular contact with Dr Banning after ceasing paliperidone. There is also evidence that Dr Banning objectively monitored Mr J's mental state and asked him about symptoms of psychosis. Medical records from Dr Banning suggest there was no clear deterioration in Mr J's mental state up to late December 2019 to alert his regular treatment providers to increasing risk. Dr Banning stated there was no evidence of psychosis after ceasing medication, but Mr J did report psychosocial issues: challenges in his TAFE study and interpersonal difficulties with his girlfriend and sister.

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11 *When stopping an antipsychotic, individual circumstances must be carefully considered including illness severity and history, risk of relapse and its consequences, treatment response and prognostic factors, and the patient's social situation,* National Prescribing Service. www.nps.org.au/australian-prescriber/articles/stopping-and-switching-antipsychotic-drugs#withdrawing-antipsychotics

45. The available information suggests that Mr J was not presenting with his known symptoms of psychosis including paranoid and persecutory delusions (fear for his life, belief that people were following him or out to get him), and auditory hallucinations of people outside his door/property. Mr J may have been exhibiting his early warning signs of psychosis (anxiety, preoccupation, over-interpreting information) as he advised his mother that he was feeling anxious the day of his death. As already noted, Mr J's mother described him as appearing *a little bit anxious* and stated that he made *no statements that indicated to me anything was out of the ordinary*. Mr J's mother was attuned to her son's mental state and had previously contacted his GP and psychiatrist when concerned about his wellbeing.

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46. According to Dr Koolstra, the nurse on duty made a clinical judgement not to admit Mr J. The decision was based on Mr J's stated preference to leave ED, his repeated denial of any suicidal intent and credible explanation regarding a misunderstanding with his ex-girlfriend/friend, and his calm and cooperative presentation. Although no formal assessment occurred, there were no obvious signs of psychosis or intoxication. Staff were also reassured that Mr J was leaving in the company of a friend. No discharge summary was sent to Mr J's GP as he was never formally admitted and therefore a discharge summary was not generated.

47. Based on his presentation and statements, there were no grounds on which to utilise the *Mental Health Act 2014*. To have a mental health assessment, Mr J would have had to voluntarily remain in the ED overnight and he was not willing to do so. In allowing Mr J to leave, staff were respecting his right to make decisions about treatment and believed him capable of making such a decision.

48. The CPU considered that the decision to respect Mr J's preference to leave ED without a formal mental health assessment was justifiable in the circumstances and there was no obligation to refer Mr J for a mental health assessment based on his statements or presentation.

49. I accept the advice of the CPU on these matters.

Conclusion

50. There is no information in the GP medical records from 2015 onwards regarding Mr J's illicit substance use. Dr Banning was aware that illicit substance use contributed to Mr J's psychotic episodes in 2012 and 2014, and therefore any illicit substance use would be a significant risk factor for relapse.

51. On 2 January 2020, Mr J denied any recreational substance use during his assessment. The analysis of his hair samples however suggest some methamphetamine use in the months prior to his death. The use of methamphetamine can lead to a sudden deterioration in mental state either while intoxicated or in withdrawal. As there was no antidepressant present in toxicology, Mr J would have been more vulnerable to a deterioration in mental state particularly in the context of illicit substance use.

52. Mr J did not have an extensive history of suicidal ideation and attempts. In 2014 he experienced suicidal ideation in the context of a situational crisis and depression. In 2017 he reported feeling depressed after a relationship breakdown and was commenced on an antidepressant. There were possible suicidal ideation/threats on 2 January 2020, but Mr J seems to have credibly described this as a misunderstanding between him and his friend. The available information suggests that Mr J's suicidal ideation occurred in the context of reactive depression rather than psychosis. It is possible that Mr J was experiencing a relapse of depression prior to his death.

53. It is not known if Mr J intentionally ceased his antidepressant medication without the knowledge of Dr Banning or if he had simply run out of the medication. The last script for sertraline provided to Mr J by Dr Banning was on 4 October 2019. This was for 60 x 100mg tablets with two repeats. Therefore, Mr J would have had a three-month supply of sertraline and, if he were compliant with dosing, would likely have run out prior to his death.

54. Mr J's mother described him as anxious prior to his death but does not mention symptoms of psychosis and states that he did not say or do anything out of the ordinary. In these circumstances it is not known what lead to his actions or prompted Mr J's decision on 29 January 2020.

COMMENTS

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

55. Dr Koolstra indicated that Angliss Hospital has limited access to overnight mental health assessments. He said,

"*the doctor on duty could not prioritise a formal assessment of* [Mr J] *for some time due to more urgent priorities*"

"staff working night shift do not have access to the same services available during the day and have many competing demands. A formal Mental Health Assessment overnight will often have to wait until a quieter moment, when morning staff arrive or when more overt signs of a crisis appear. Staff cannot detain patients when they request to leave unless there are clear reasons to do so and in this case those reasons were not apparent.

There is no onsite overnight cover at the Angliss and anyone needing assessment waits in the ED until morning. There is a liaison worker on call overnight who is based at Box Hill Hospital or Maroondah hospital. This service is accessed by a designated psychiatric triage number that also receives calls from the community. When calling this number you often cannot speak to a clinician as they are busy and end up leaving a message on an answering service. There are also no inpatient mental health beds at the Angliss Hospital."

56. I note that this issue was raised at the Royal Commission into Victoria's Mental Health System with the final report stating:

that people experiencing mental illness or psychological distress wait much longer than other emergency department patients for admission to an inpatient bed (where this is the outcome of their presentation) or to be discharged.[12]

57. As a result **Recommendation 8(3)***:* Responding to mental health crisis was made to *improve emergency departments' ability to respond to mental health crises.*

[12] Chapter 9, p. 531.

58. Mr J was noted to be very reluctant to attend ED however he was cooperative with paramedics and nursing staff. The CPU considered that a busy ED may not have been the ideal place to address Mr J's presenting issues (relationship breakdown and associated distress).

59. I note that this issue was also raised at the Royal Commission into Victoria's Mental Health System with the final report stating:

For those in crisis, police and ambulance callouts and visits to emergency departments will no longer be the only options. A range of new consumer-led, safe spaces will be available for people experiencing different levels of distress or crisis. These will be provided in compassionate settings where people can stay safe and access support.[13]

60. It is possible that Mr J would have been better suited and more willing to engage with a 'safe space' model of mental health care consistent with **Recommendation 9**: Developing 'safe spaces' and crisis respite facilities.

RECOMMENDATIONS

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

(i) I endorse the following Royal Commission recommendation with the aim of preventing like deaths:

Recommendation 9: Developing 'safe spaces' and crisis respite facilities of the Royal Commission into Victoria's Mental Health System:

The Royal Commission recommends that the Victorian Government:

1. invest in diverse and innovative 'safe spaces' and crisis respite facilities for the resolution of mental health and suicidal crises which are consumer led and, where appropriate, delivered in partnership with non-government organisations.

[13] Executive Summary, p. 24

2. *in collaboration with the new agency led by people with lived experience of mental illness or psychological distress (refer to recommendation 29) and non-government organisations that deliver wellbeing supports, establish:*

   a. *one drop-in or crisis respite facility for adults and older Victorians per region (refer to recommendation 3(3)); and*

   b. *four safe space facilities across the state*

3. *establish a crisis stabilisation facility, in consultation with people with lived experience, led by a public health service or public hospital in partnership with a non-government organisation that delivers wellbeing supports.*

(ii) I further recommend that,

The Victorian Government ensure such safe spaces are available 24/7 to allow for out-of-hours and overnight access as this is not explicitly stated in the above recommendation.

(iii) I further endorse the following Royal Commission recommendation with the aim of preventing like deaths:

Recommendation 8(3): Responding to mental health crisis of the Royal Commission into Victoria's Mental Health System:

improve emergency departments' ability to respond to mental health crises by:

a. establishing a classification framework for all emergency departments and urgent care centres, based on their capability to respond to people experiencing mental health crises;

b. using the classification framework to ensure that health services are appropriately resourced to perform their role in a regional network of emergency departments and urgent care centres; and

c. ensuring there is at least one highest-level emergency department suitable for mental health and alcohol and other drug treatment in each region.

FINDINGS AND CONCLUSION

61. Pursuant to section 67(1) of the Act I make the following findings:

    (a) the identity of the Deceased was Mr J, born [redacted] 1983;

    (b) the death occurred on 29 January 2020 at [redacted], Victoria, from *Multiple Sharp Force Injuries to Chest and Neck*, and

    (c) the death occurred in the circumstances described above.

62. I convey my sincere condolences to Mr J's family for their loss and acknowledge the tragic circumstances in which his death occurred. I further acknowledge the ongoing support provided by his family.

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

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

    [redacted]**, Senior Next of Kin**

    Victorian Government

    Senior Constable Madlyon Devine, Victoria Police, Coroner's Investigator

Signature:

Coroner Sarah Gebert

Date: 17 May 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 investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.