IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2016 004536

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 63(1)

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

Deceased:	SJ[1]
Delivered on:	18 January 2023
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing date:	25 to 29 October 2021
Findings of:	Coroner Paresa Antoniadis Spanos
Counsel assisting the coroner:	Leading Senior Constable Duncan McKenzie from the Police Coronial Support Unit
Representation:	Ms Debra Foy appeared on behalf of Orygen Youth Health Ms Fiona Ellis appeared on behalf of the Peter MacCallum Cancer Centre
Key words:	Cancer patient, depression, mental health, low risk, suicide

[1] The published version of this finding has been de-identified in accordance with the family's wishes.

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INTRODUCTION[2]

1. SJ grew up in the Werribee and Hoppers Crossing area, raised by his mother after his parents' relationship broke down while he was still quite young. He attended McKillop Catholic College Werribee during his high school years where he had a large social group of friends and played sports. He then went on to study Advertising and Marketing at Victoria University, Footscray. SJ completed an electrician apprenticeship and went onto further study Advertising and Marketing at Swinburne. He also received an invitation to study at RMIT for the same course, whilst he worked part-time on weekends.

2. SJ began living with his grandmother at age 16 years after his mother moved to the United States. He thereafter remained in close contact with his mother.[3]

3. Several years later, SJ re-established contact with his father, even living with him for a short period. However, they did not go on to maintain a close relationship.[4]

4. SJ thereafter returned to live with his grandmother in Hoppers Crossing and continued to live with her until his death aged 24 years.

CIRCUMSTANCES PROXIMATE TO DEATH

5. SJ self-reported that he had experienced low mood and negative thinking for a period of about six years before his death. Other than a handful of psychology sessions in 2011 and 2013, he had not received ongoing treatment. SJ's mother and grandmother did not observe him to exhibit any mental health related symptoms and generally described him as healthy and happy.[5]

6. From early 2016, SJ's mental health began to deteriorate, and he began to withdraw from friends and social activities.[6] He had previously engaged in poly-substance use but stopped at about this time.[7] In mid-2016, he began experiencing physical symptoms. His family noticed that he began to look thin and tired and had a reduced appetite.[8]

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[2] This section is a summary of background and personal circumstances and uncontentious circumstances that provide a context for those circumstances in which the death occurred.
[3] Coronial Brief (**CB**), page 10.
[4] CB, page 10; Transcript, pages 16-18.
[5] CB, pages 15, 17, 286.
[6] Transcript, pages 26-27.
[7] CB, pages 252, 254.
[8] CB, pages 12, 17; Transcript, pages 26-27.

7. On 26 May 2016 SJ attended a general practitioner (**GP**) at Westgate Medical Centre with a history of runny nose, sore throat, and phlegmy cough. On assessment his temperature was normal, and his chest was clear. The GP diagnosed a viral upper respiratory tract infection.

8. On 15 July 2016, SJ self-presented to the Werribee Mercy Hospital Emergency Department after experiencing suicidal ideation and intrusive negative thoughts. His presentation followed a situational crisis where he reported feeling desperate and had tied a noose at home. He disclosed he had been experiencing low mood, weight loss, increased isolation, and thoughts of suicide for about seven months.[9] A provisional diagnosis of depression with psychotic features was made and SJ was referred to the Youth Access Team (**YAT**) and Orygen Youth Health (**Orygen**) before being discharged that evening.[10] [11]

9. Psychiatric registrar Dr Azri Mohammad reviewed SJ on 21 July 2016 at which time the diagnosis was revised to *"moderate depressive episode".*[12] He was subsequently commenced on fluoxetine[13] with plans to increase the dose in seven days.[14] Over the following weeks SJ was also prescribed diazepam,[15] temazepam,[16] and zopiclone[17] at clinically appropriate dosages.

10. SJ was subsequently accepted into the Orygen Youth Mood Clinic[18] and allocated a case manager, psychologist Amy Gibbs. SJ went on to have several face-to-face appointments with his Orygen treating team.

11. On 20 August 2016, SJ returned Westgate Medical Centre with an ongoing chesty cough, green sputum, and fever. He was prescribed antibiotics (amoxycillin) but did not improve over following days. He returned to his GP on 25 and 30 August at which time he was prescribed a further antibiotic (azithromycin) and referred for a chest x-ray.

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[9] CB, pages 75, 84, 251-254.
[10] CB, pages 377-378.
[11] Orygen Youth Health provides specialist mental health services for young people aged 15 to 24 who reside in the western and northern regions of Melbourne. It is a service within NorthWestern Mental Health and Melbourne Health.
[12] CB, page 288.
[13] Fluoxetine is a selective serotonin reuptake inhibitors (SSRIs) class of antidepressant used to treat depression, obsessive-compulsive disorder, and premenstrual dysphoric disorder. It is the recommended first line antidepressant for adolescents and young adults.
[14] CB, page 288.
[15] 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.
[16] Temazepam is a benzodiazepine, is habit-forming and used in the short-term treatment of insomnia.
[17] Zopiclone is used for the short-term treatment of insomnia.
[18] The Youth Mood Clinic is a specialist clinical program at Orygen Youth Health that addresses the needs of young people with complex mood disorders.

12. The chest x-ray on 31 August 2016 revealed significant consolidation (infection/pneumonia) within the right lung and bilateral pleural effusions and several pulmonary nodules.[19] On 5 September 2016 the x-ray results were discussed with SJ, including the urgency of hospital attendance.

13. On 6 September 2016, SJ presented to Werribee Mercy Hospital where he was diagnosed with a pleural effusion. The following day, 7 September 2016, he was admitted to Royal Melbourne Hospital for further investigation and then transferred to the Peter MacCallum Cancer Centre (**PMCC**). On 10 September 2016, SJ commenced treatment for Stage 4B diffuse large B-Cell non-Hodgkin lymphoma, considered treatable at that time, with a six-month treatment plan made.[20]

14. During his admission to PMCC, the focus of SJ's clinical management and care was on the treatment of his cancer. The referral information from Werribee Mercy included reference to SJ's recent mental health diagnosis and the pharmacist who completed the medication reconciliation made a note of his mental health history.[21]

15. SJ continued to engage with his Orygen case manager via phone during his hospital admission.

16. SJ was also supported by his family, including in particular his grandmother and his cousin, BA, who visited him almost daily throughout his illness, bringing him clothes and other items that he requested.[22] BA described SJ as depressed in the six months prior, and that during that time he had identified free falling from a building as a method to die, but also stated he wanted life.[23] However, SJ also told BA that because he had had so much time to reflect while in hospital, he was peaceful, feeling mind, body and soul were connected, something he had not previously felt, and was positive. She believed SJ had become more hopeful and positive, with plans for writing and travel. BA was not concerned about his mental health during his admission.[24]

17. Similarly, evidence from various members of SJ's medical treating team at PMCC indicates that SJ did not exhibit ongoing symptoms of mental ill health and did not voice any suicidal

[19] The radiologist noted SJ had been instructed to attend hospital.
[20] CB, pages 51-54, 522; Transcript, pages 57-60.
[21] CB, page 604.
[22] CB, page 23; Transcript, pages 34-35.
[23] CB, page 25; Transcript, page 32.
[24] CB, page 24; Transcript, pages 33, 37-38, 43.

thoughts or intentions during his admission. He appeared engaged and co-operative and responded to his health predicament in a typical manner.[25]

18. SJ was initially planned for discharge on 21 September 2016 following the draining of a pleural effusion. However, on 20 September 2016 he was noted to have tachycardia and was reviewed. SJ requested temazepam and is recorded as having slept. However, he was recorded by day shift nursing staff as febrile and having had diarrhoea and vomited overnight.[26]

19. On 21 September 2016, SJ was reviewed by his treating team. He was described as flat, fatigued, not eating, non-engaging, reported pain, and wanted to be left alone. He is noted to have experienced further diarrhoea, vomiting, fever, and tachycardia and a MET Call was made at 2.30pm. SJ was treated with intravenous antibiotics and placed on a Sepsis Pathway, which was standard practice for a febrile illness in a haematology patient. Given these developments, his planned discharge was delayed. SJ was noted to have been disappointed about this but indicated he understood the need for intravenous antibiotics.[27]

20. At about 4.00pm SJ called Ms Gibbs to cancel his appointment for that week because he had to remain in hospital. She planned to contact him on 26 September 2016 when he expected to be discharged.[28]

21. On 22 September 2016 at 4.50am records note SJ experiencing diarrhoea and abdominal pain. He was febrile and blood cultures were taken at 5.15am.[29] In the retrospectively written nursing note by Nurse Sunita Maharjan, SJ is described as alert at 7.30am and engaging in conversation, although he reported poor sleep overnight.[30]

22. At 8.30am the High Acuity Team reviewed SJ as a routine follow-up to the MET call the previous day.[31]

23. At 8.45am Nurse Maharjan returned to SJ's room, completed his vital observations, and offered his routine medications. SJ did not want to take the oral medications because he was

[25] CB, pages 32, 58-59, 66; Transcript, pages 63, 89.
[26] CB, page 57, 543-546.
[27] CB, pages 58, 68-69, 547-548; Transcript, pages 39-40.
[28] There was some confusion in the evidence as to when this call took place. Ms Gibbs' handwritten notes appear at CB, page 338. In her first statement, Ms Gibbs noted this call took place at 4.00pm on 21 September 2016: CB page 76. She subsequently amended this in a further statement to say it took place on the morning of 22 September 2026: CB, page 79. However, in oral evidence Ms Gibbs confirmed that the telephone call during which SJ cancelled his appointment occurred on the afternoon of 21 September 2016: Transcript, pages 197, 210-211.
[29] CB pages 548-549.
[30] CB, pages 28, 551.
[31] CB, pages 28, 549.

still nauseated. The decision was made to give SJ intravenous metoclopramide 10 mgs and oral PRN loperamide (short-term treatment of diarrhoea) at about 9.00am, and to re-offer the other oral medications when his nausea had abated. SJ also told Nurse Maharjan that he had food he would eat once he felt better. They negotiated to change the dressing on the peripherally inserted central catheter (PICC) later in the day. SJ told Nurse Maharjan he was expecting his cousin to visit later that day and he thought he would go home the following day.[32]

24. At 9.10am SJ sent a text BA asking her to bring in pants when she visited later in the day, and said he was staying in hospital.[33]

25. At 9.20am the haematology team reviewed SJ and noted he was settled and engaged, with a reactive affect and good mood. He appeared tired, but this was in keeping with the infection over the preceding 24 hours.[34]

26. At 9.30am Nurse Maharjan went to SJ's room after he had contacted her via the ASCOM (patient/nurse communication device) because the intravenous infusion pump battery was beeping, and she plugged it into the mains. Nurse Maharjan went directly to the bedroom and noticed that SJ was using his phone and telling someone the things he would require to be brought into him. They did not verbally communicate but exchanged smiles as SJ continued to use his phone.[35]

27. In her statement, Nurse Maharjan recalled that SJ appeared tired that morning. He reported he had interrupted sleep over night and was therefore fatigued. However, he generally engaged in conversation with her and was responsive that morning.[36] She did not observe any mental health symptoms.[37]

28. At 9.33am SJ made a call to Orygen Health that lasted for two minutes and 48 seconds. It is unclear whether he spoke to a person at this time or whether he was put on hold and then ended the call.[38]

29. At about 9.54am SJ left his room and went to the level 7 rooftop garden at PMCC where his movements were captured on the hospital's closed-circuit television (**CCTV**) footage. That

[32] CB, pages 28-29, 447; Transcript, pages 112, 116-117, 119-124.
[33] CB, pages 24, 147.
[34] CB pages 29, 32, 58.
[35] CB, page 29, 551; Transcript, pages 114-115, 117-118.
[36] CB, pages 29-30.
[37] Transcript, page 111.
[38] CB, page 172. Transcript, pages 231-232, 242-243.

footage shows SJ walking to the 1.88metre-high glass barrier at the edge of the building and unsuccessfully trying to climb over it before walking over to nearby tables and chairs, grabbing a chair, and walking back to the glass barrier. SJ then placed the chair next to the glass barrier and climbed over onto a ledge that extended beyond the glass barrier. CCTV captured SJ looking over the ledge for about four minutes before he jumped off the roof, landing on the street below.

30. Passers-by came to his assistance and resuscitation attempts where commenced on the street by PMCC employees and other witnesses but were unsuccessful.[39]

31. At about 9.55am Nurse Maharjan noted SJ's bedroom door was open, which was unusual. On entering, she found the room empty, and his intravenous tubing disconnected and still running. Nurse Maharjan alerted other staff and started looking for SJ before she was informed of his death.[40]

32. Investigators did not find a suicide note nor any indication on social media of SJ's intentions to take his own life.

INVESTIGATION AND SOURCES OF EVIDENCE

33. This finding draws on the totality of the material the product of the coronial investigation into SJ's death. That is, the brief of evidence compiled by First Constable Cameron Shoppee, reconfigured for the inquest by Leading Senior Constable Duncan McKenzie of the Police Coronial Support Unit, the statements, reports, and oral evidence of those witnesses who testified at inquest, and any documents tendered through them and the submissions of counsel representing the parties.

34. All of this material, together with the inquest transcript, will remain on the coronial file.[41] In writing this finding, I do not purport to summarise all the material and evidence but will only refer to it in such detail as is warranted by its forensic significance and the interests of narrative clarity.

[39] CB, pages 34, 44.
[40] CB, pages 29, 551.
[41] Access to documents held by the Coroners Court of Victoria is governed by section 115 of the ***Coroners Act 2008*** (the Act). Unless otherwise stipulated, all references to legislation that follow are to provisions of the Act.

PURPOSE OF A CORONIAL INVESTIGATION

35. The purpose of a coronial investigation of a 'reportable death'[42] is to ascertain, if possible, the identity of the deceased person, the cause of death, and the circumstances in which death occurred.[43] SJ's death was reportable as it appeared to be unnatural and/or the result of accident or injury.[44]

36. The term 'cause of death' refers to the *medical* cause of death, incorporating where possible the mode or mechanism of death. For coronial purposes, the term 'circumstances in which 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 all those circumstances which might form part of a narrative culminating in death.[45]

37. The broader purpose of any coronial investigations is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of recommendations by coroners, generally referred to as the 'prevention role'.[46]

38. Coroners are empowered to report to the Attorney-General in relation to a death; to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.[47] These are effectively the vehicles by which the coroner's prevention role can be advanced.[48]

39. It is important to stress that coroners are not empowered to determine the civil or criminal liability arising from the investigation of a reportable death and are specifically prohibited

[42] The term is exhaustively defined in section 4 of the Act. Apart from a jurisdictional nexus with the State of Victoria a reportable death includes deaths that appear to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from an accident or injury; and, deaths that occur during or following a medical procedure where the death is or may be causally related to the medical procedure and a registered medical practitioner would not, immediately before the procedure, have reasonably expected the death (section 4(2)(a) and (b) of the Act). Some deaths fall within the definition irrespective of the section 4(2)(a) characterisation of the 'type of death' and turn solely on the status of the deceased immediately before they died – section 4(2)(c) to (f) inclusive.
[43] Section 67(1).
[44] See section 4 for the definition of 'reportable death', especially section 4(2)(a).
[45] This is the effect of the authorities – see for example *Harmsworth v The State Coroner* [1989] VR 989; *Clancy* v *West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J.)
[46] The 'prevention' role is now explicitly articulated in the Preamble and purposes of the Act, compared with the *Coroners Act 1985* where this role was generally accepted as 'implicit'.
[47] See sections 72(1), 67(3) and 72(2) regarding reports, comments, and recommendations respectively.
[48] See also sections 73(1) and 72(5) 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.

from including in a finding or comment any statement that a person is, or may be, guilty of an offence.[49]

IDENTITY OF THE DECEASED

40. SJ was identified by his father, AL, who signed a formal Statement of Identification to this effect on 7 September 2016. SJ's identity was not in issue and required no further investigation

MEDICAL CAUSE OF DEATH

41. Senior Forensic Pathologist, Dr Matthew Lynch, from the Victorian Institute of Forensic Medicine (**VIFM**), reviewed the circumstances of SJ's death as reported by police to the coroner, post-mortem CT (computed tomography) scanning of the whole body performed at VIFM, and performed an external examination of SJ's body in the mortuary on 23 September 2016.

42. Having done so, Dr Lynch provided a written report of his findings dated 27 October 2016. He noted SJ was a young man diagnosed with non-Hodgkin's lymphoma on 6 September who commenced chemotherapy on 15 September 2016. He subsequently developed neutropaenia and sepsis. He noted SJ jumped from the 7th floor of Peter MacCallum Hospital on 22 September 2016 and died from injuries sustained.

43. Dr Lynch's external examination of the body and subsequent findings were consistent with the reported history. The post-mortem CT scan revealed fractured skull with pneumocranium, fractures of ribs, left humerus and right calcaneus, and bilateral haemopneumothoraces.

44. Routine toxicological analysis of post-mortem samples detected metoclopramide (an anti-emetic drug used for the treatment of nausea and vomiting) and paracetamol (an analgesic drug) at levels consistent with therapeutic use but no alcohol or other commonly encountered drugs or poisons.[50]

45. Dr Lynch concluded by advising that it would be reasonable in the circumstances to attribute SJ's death to *"1(a) Injuries sustained in fall from height",* without the need for an autopsy.

[49] Section 69(1). However, a coroner may include a statement relating to a notification to the Director of Public Prosecutions if they believe an indictable offence may have been committed in connection with the death. See sections 69(2) and 49(1).
[50] The toxicology report includes a list of the drugs/poisons routinely screened for and does not include chemotherapy drugs which can be specifically tested for if necessary: CB, page 7.

46. I accept Dr Lynch's opinion as to the cause of SJ's death.

FOCUS OF THE CORONIAL INVESTIGATION

47. As is often the case in this jurisdiction, the focus of the coronial investigation and inquest into SJ's death was on the circumstances in which the death occurred. More specifically the focus of this inquest was the adequacy of the management and care provided in relation to SJ's pre-existing and known depression, specifically:

    (a) the handover of clinical information between Orygen and PMCC;

    (b) the adequacy of PMCC's response to knowledge of SJ's major depression;

    (c) the adequacy of Orygen's support and follow-up to SJ and PMCC;

    (d) the findings of internal reviews undertaken by Orygen and PMCC; and

    (e) the prescribing of metoclopramide to patients with psychiatric co-morbidities.

ORYGEN YOUTH HEALTH'S SUPPORT AND FOLLOW-UP

48. Following SJ's presentation to Werribee Mercy Hospital Emergency Department on 15 July 2016, he was assessed by YAT on 17 July 2016 and provided further information about his life and history. He was noted to have presented as *"very pleasant, cooperative, rapport easily established".* While he disclosed a clear plan to take his own life four days earlier, his current risk was assessed as low as he was help-seeking and hopeful about the prospects for recovery. The plan was to assess whether SJ was eligible for the PACE or Mood clinics.[51]

49. On 18 July 2016, the YAT contacted SJ via telephone at which time no risks were reported.[52]

50. At the psychiatric review on 21 July 2016, Dr Mohammad formed the impression that SJ had been experiencing moderate symptoms of depression over the preceding seven months. He had no current suicidal and was future-focussed but vulnerable to increasing suicide risk and there was a risk he would engage in drug use. He was assessed as eligible for the Mood Clinic.[53]

[51] CB, pages 254-279, 282.
[52] CB, page 282.
[53] CB, pages 284-288.

51. Over following days, the YAT contacted SJ via telephone several times and he underwent a medical review on 27 July 2016.[54] SJ was subsequently downgraded from the acute team and transferred to the Mood Clinic.

52. Ms Gibbs assessed SJ on 3 August 2016[55] and then again on 19 August 2016 once she was appointed his case manager.[56] There were also several telephone contacts and psychiatric assessments in the intervening period during which time SJ's risk was repeatedly assessed as low.[57]

53. SJ thereafter attended face-to-face appointments with Ms Gibbs on 24 August,[58] 29 August,[59] and 5 September 2016.[60] The evidence shows that SJ had good rapport with Ms Gibbs.[61] During their engagement, he reported some control of his anxiety, improvement in mood and decreased suicide thinking.[62] SJ's last reported suicidal thinking was on 24 August 2016.[63]

54. Between 24 and 28 August 2016 SJ self-ceased fluvoxamine. He told his grandmother he felt better not taking the mental health medication because he had experienced a cold heavy head and his chest was heavy.[64] Given his rapid improvement and apparent engagement with his treating team, he was assessed as low risk, and his treating team accepted his preference not to be on medication.[65]

55. SJ's last face-to-face assessment was with Ms Gibbs on 5 September 2016. At this time, SJ described fluctuating mood across the previous week, and he continued to report high levels of anxiety and difficulty leaving the house. His risk remained settled, and he denied any suicidal ideation, plan, or intent.[66] SJ subsequently cancelled his scheduled appointment for 8 September 2016 because he had been admitted to hospital by that time.[67]

56. SJ contacted Ms Gibbs on 12 September 2016 advising of his admission to PMCC and diagnosis. Ms Gibbs noted that despite the gravity of the news, he described his hospital

[54] CB, pages 292-296
[55] CB, page 280; Transcript, pages 223-224.
[56] CB, page 314.
[57] CB, pages 300-313.
[58] CB, pages 316-317.
[59] CB, pages 318-319.
[60] CB, pages 324-325.
[61] CB, page 25; Transcript, pages 30, 47.
[62] CB, pages 75-76.
[63] CB, page 316.
[64] CB, page 20, 85.
[65] CB, page 85.
[66] CB, pages 76, 324-325.
[67] CB, pages 76, 326.

experience as positive.[68] They next spoke on 14 September 2016 when he advised that the treatment plan was to treat his cancer and she noted he was *"unsure how he was feeling about the diagnosis"*.[69]

57. Their last telephone contact was on the afternoon of 21 September 2016 as noted above. Ms Gibbs was of the opinion that SJ's attitude and demeanour remained unchanged, and she perceived nothing to indicate she should be concerned about his mental state at that time.[70]

58. In a letter to the Office of the Chief Psychiatrist, Dr Sophie Adams, then Medical Director at Orygen, described Ms Gibbs' telephone contacts with SJ while he was admitted to PMCC as lengthy and included risk assessments, reflection, and supportive therapy. SJ reported he was feeling well, did not appear to be distressed, and was well engaged with his case manager. As such, his treating team felt any risks were minimal and he was able to be monitored via phone calls until his discharge from PMCC.[71]

59. I am satisfied the care provided by Orygen was clinically appropriate. SJ's engagement with Ms Gibbs appears to have been therapeutic and they had established a good rapport. His engagement with Dr Mohammad, who met with SJ on four occasions, appears to have been of a similar nature.

60. The initial and follow-up assessments were comprehensive and complete, the treatment options and plans were based on the assessments, and the ongoing type and frequency of engagement with SJ was appropriate.

61. The medical records support SJ as being involved in decision making regarding his treatment, which is the best practice model for recovery based mental health care. In addition, Ms Gibbs met with SJ and his grandmother on 24 August 2016 and safety planning was undertaken. The prescribing of the antidepressant fluoxetine complied with clinical guidelines, and it was prescribed at appropriate frequency and dosage.

62. SJ reported significant improvements in his mood and symptomatology while he took the fluoxetine and engaged in therapy and assessments with Ms Gibbs and Dr Mohammad. SJ self-ceased the fluoxetine and informed Orygen staff only sometime afterwards. At this stage Ms Gibbs discussed with SJ the benefits of continuing the medication, especially in the context of the positive response he had experienced to date. In addition, she arranged for SJ

[68] CB, page 330; Transcript, page 210.
[69] CB, pages 76, 330, 332.
[70] Transcript, page 212.
[71] CB, page 85.

to be reviewed by Dr Mohammad, who then repeated the advice to continue the antidepressant. SJ remained resistant to recommencing the antidepressant and consequently the decision was made with SJ to revisit his taking an antidepressant at his next medical review, which was reportedly scheduled the week of SJ's death.

63. The first line treatment of SJ's depression with psychotherapy was appropriate especially as SJ chose to cease the antidepressant. However, his last formal therapy session was on 5 September 2016. Although this does not diminish the quality of subsequent telephone contact and support given by Ms Gibbs, which was of reasonable duration when it occurred, there is no evidence of recognised or formal therapy after the last face-to-face session. This essentially means SJ was without treatment for a diagnosed depressive disorder of some weeks' duration.

64. However, it is important to acknowledge that SJ and Ms Gibbs had a good rapport and he continued to engage with her voluntarily during his hospital admission. During their telephone contacts, SJ did not voice any distress, and there was no evidence that his mental state had deteriorated or that his risk had increased. He remained future-focussed, engaged, and supported by his family. This was corroborated by BA's observations that SJ remained positive, and also by the observations of his PMCC treating team.

65. I accept counsel's submissions that that there was nothing in the conversations between Ms Gibbs and SJ to hint or suggest any possibility of his actions on the morning of 22 September 2016.

PETER MACCALLUM CANCER CENTRE'S RESPONSE TO SJ'S MENTAL HEALTH DIAGNOSIS

66. While in PMCC SJ was referred to the ONTrac, Victorian Adolescent and Young Adult Cancer Service. According to Katherine Thompson, Program Manager, ONTrac is a multidisciplinary service at PMCC that provides care to young people diagnosed with cancer aged 15 to 25 years. The service comprises adult and paediatric oncologists, social workers, a nurse consultant, psychologist, occupational therapist, exercise physiologist, and school and vocation advisor.[72] There is no requirement that a young person have a history of mental ill health in order to be referred to the service.[73]

[72] CB, page 94; Transcript, pages 173-174.
[73] Transcript, page 62.

67. ONTrac uses the HEEADSSS psychosocial assessment framework adapted for the cancer setting to health care professionals develop rapport with a young person while also gathering information about their lives. While the assessment does include asking a young person about suicide risk, self-harm, and mental health, it does not incorporate a mental state examination. If suicide risk is evident, the young person is immediately referred to the PMCC Psychosocial Oncology Service for specialist psychiatric assessment.[74]

68. Social Worker Mairghread Clarke saw SJ on 12 and 16 September 2016.[75]

69. During his initial ONTrac review on 12 September SJ revealed his longstanding mental health history and his relatively recent presentation to an emergency department in the context of a significant anxiety or panic attack. He reported that as a result of this presentation, he was referred to Orygen and he was currently actively engaged with that service with weekly sessions. He confirmed he had spoken with Ms Gibbs, his case manager, about his diagnosis.[76]

70. Ms Clarke's notes included that SJ denied current distress, low mood, and anxiety and he did not have any immediate support needs. She planned to speak to Ms Gibbs to ascertain the extent of Orygen's involvement with SJ.[77] Ms Clarke subsequently detailed SJ's social and mental health history in his patient records and spoke to his nurses about his mental health.[78]

71. Despite the HEEADSSS assessment tool prompting information to be sought from the patient about suicide and/or self-harm, Ms Clarke did not elicit information from SJ about those topics at their first meeting. She explained that the HEEADSSS assessment tool is a live document and an evolving assessment. Given that she did not observe any indicators that SJ was at imminent risk to himself at their first meeting, she did not enquire about suicidality.[79]

72. At a clinical meeting on 13 September 2016, Ms Clarke presented SJ's history. Actions that arose from the meeting were to continue psychosocial assessment and to liaise with Orygen after receiving SJ's consent to do so.[80]

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[74] CB, pages 94-95; Transcript, pages 306-307; Exhibit C.
[75] CB, pages 53-55, 88-90, 509-511, 519, 526, 626-627.
[76] CB, pages 70-71, 88; Transcript, pages 308-310.
[77] CB, page 511; Transcript, page 310.
[78] CB, page 88; Transcript, pages 310-311.
[79] Transcript, pages 312, 328-329.
[80] CB, page 89; Transcript, pages 313, 331; Exhibit D.

73. At what was to be SJ's final contact with ONTrac on 16 September 2016, Ms Clarke noted SJ appeared and reported feeling fatigued, which he attributed to chemotherapy. He denied distress or concern. SJ was asked to consent to PMCC staff contacting Orygen, specifically his psychologist. However, SJ refused as he wanted to keep his medical treatment and mental health treatment separate.[81]

74. On 21 September 2016, Ms Clarke discussed SJ at the Adolescent & Young Adult Multidisciplinary Meeting at which time she noted the absence of consent to liaise with Orygen. At the meeting's conclusion, she received a direction to revisit the consent discussion with SJ, alongside ongoing development of rapport and psychosocial assessment.[82] Ms Clarke did not see SJ again before his death.

75. I accept the evidence that while SJ understood that he had an aggressive form of cancer, he understood that it was treatable, and generally expressed positivity that he would be cured.[83] There was no evidence that he was experiencing a worsening in his mental health. Nurse Maharjan confirmed that she held no concerns regarding SJ's mental state and that if she had, she would have escalated her concerns.[84] Similarly, Ms Clarke did not see a need to refer him to the PMCC psychiatry service.[85]

76. Dr David Speakman, Chief Medical Officer at the PMCC, gave evidence that changes of psychological impact is always something that watches out for in his patients, irrespective of whether they have a history of anxiety or depression. He went on to explain that while a history of anxiety and depression may put him on higher alert, that alone would not prompt a referral to the psychiatry team. In order to initiate a referral, he would need some indication of mental health deterioration. There was no evidence that this was the case with SJ.[86] As late as the morning of 22 September 2016, SJ was observed by his treating team to be:[87]

> *... alert and appropriately interactive with a reactive affect and good mood. He appeared tired in keeping with his infection over the preceding 24 hours. He was friendly and appreciative toward the medical team.*
>
> *He did not appear to have a low mood or any distress.*

[81] CB, pages 70-71, 89-90, 92, 526, 626; Transcript, pages 318, 331-332.
[82] CB, pages 90-91; Transcript, page 334; Exhibit E.
[83] CB, pages 26, 63, 522; Transcript, pages 48, 58-63.
[84] CB, pages 29-30; Transcript, pages 111, 113.
[85] Transcript, page 321, 334, 347.
[86] Transcript, pages 149-150.
[87] CB, page 58.

77. I accept that during his admission, including the morning of his death, there was no indication to refer SJ to the PMCC psychiatry team.

HANDOVER OF INFORMATION BETWEEN ORYGEN YOUTH HEALTH AND PETER MACCALLUM CANCER CENTRE

78. The Australian Commission on Safety and Quality in Healthcare noted in the *National Safety National Safety and Quality Health Service Standards*, that:[88]

> *Clinical handover is the transfer of professional responsibility and accountability for some or all aspects of care for a patient to another person or professional group. It involves the transfer of patient information between individuals or groups and is an important part of clinical care.*
>
> *... Breakdown in the transfer of information or in 'communication' has been identified as one of the most important contributing factors in serious adverse events and is a major preventable cause of patient harm. Poor handover of information can also lead to waste of resources. The consequences of poor handover include: unnecessary delays in diagnosis, treatment and care; repeated tests, missed or delayed communication of test results; and incorrect treatment or medication errors.*

What was known about SJ's mental health when he was admitted to the Peter MacCallum Cancer Centre?

79. At the time of his transfer to the PMCC, SJ's medical records included a registrar's note of 7 September 2016 made at Royal Melbourne Hospital indicating a history of anxiety and depression without current medication, and a medication reconciliation dated 8 September 2016 where a pharmacist made a note of SJ's depression.[89]

80. At about this time a relatively new system of information sharing between hospitals and agencies that formed part of a 'precinct partnership relationship'[90] was being implemented. PMCC's medical records had been a hybrid of electronic and paper-based records and when PMCC moved from East Melbourne to the Victorian Comprehensive Cancer Centre (which is integrated with the Royal Melbourne Hospital) in June 2016, there was also an attempt to

[88] Australian Commission on Safety and Quality in Healthcare., National Safety National Safety and Quality Health Service Standards, Standard 6, available at: https://www.safetyandquality.gov.au/sites/default/files/migrated/NSQHS-Standards-Fact-Sheet-Standard-6.pdf.
[89] CB, pages 65, 496, 604; Transcript, page 56, 91.
[90] The precinct partnership consists of Royal Melbourne Hospital, Peter MacCallum Cancer Centre, Royal Women's Hospital, and the Royal Children's Hospital: Transcript, page 141.

integrate medical records. This meant that *some* PMCC staff had access to view Royal Melbourne Hospital records, which were apparently difficult to navigate.[91]

81. Orygen records were not available to PMCC staff in 2016. Usual practice at that time would be to obtain a patient's consent to access the records and then make a request to NorthWestern Mental Health.[92]

82. As integration of the records progressed, records relating to immediate healthcare and treatment needs were prioritised (for example, intensive care unit or emergency department records). Indeed, complete records across the precinct partnership only became available in August 2020.[93] I note here that if a patient has been previously treated outside one of the precinct partnership hospitals, the usual consent and request process would need to occur, that is there is no automatic or instant access.

Was SJ's treating team was aware of his mental health history?

83. According to Dr Lieschke, he was aware of SJ's history or anxiety and depression from the outset of his treatment once SJ was transferred to PMCC on 10 September 2016.[94]

84. Dr Robert Wright, haematology registrar, explained that the treating team sought more information on 20 September 2016:[95]

> *My resident medical officer, Dr Amy Halliday and I sought more information regarding his mental health history through the Royal Melbourne Hospital scanned documents tab that exists in the Peter MacCallum Cancer Centre electronic medical record system VERDI. Through this we became aware that he had experienced previous suicidal intent and that he had been managed through Orygen. The most recent notes available to us from August 24th 2016 implied that he was doing well from a mental health point of view with no suicidal intent and that he had been compliant with follow-up. We were unable to access all notes due to technical difficulties.*
>
> *We planned to further clarify his mental health history and current status in more detail to assess the need for referral to our psychiatry team. This was place on our*

[91] Transcript, pages 66, 137-138.
[92] Transcript, page 140.
[93] Transcript, page 141.
[94] Transcript, pages 56, 91.
[95] CB, page 57.

jobs list on the ward handover document. As he had not manifested any signs of depression during his stay this was not seen as clinically urgent.

85. As noted above, Dr Speakman explained that at this stage, the new data system was in its infancy and staff were still familiarising themselves with it. He said, *"... I think that the experience of using it and getting to the right place in a timely manner was difficult."* But they went on to find information regarding SJ's subsequent consultations with Orygen, which revealed there was no active suicidal ideation.[96]

Should Orygen Youth Health have provided a handover to Peter MacCallum Cancer Centre

86. At an Orygen clinical review meeting on 13 September 2016, plans were made for Orygen staff to contact PMCC.[97] Ms Gibbs subsequently contacted PMCC on 26 September 2016 for the purpose of informing staff that SJ was a current Orygen client only to be informed of his death.[98]

87. According to Dr Mark Phelan, SJ's consultant psychiatrist, the delayed contact with PMCC was due to lack of clarity as to whose responsibility it was to make contact with PMCC. In addition, it appears there was a misapprehension that PMCC staff had access to the electronic Orygen records.[99]

88. Dr Phelan also noted that there was no indication that SJ was at acute risk, which would have triggered a more urgent contact or response.[100] Ms Gibbs confirmed this assessment in her oral evidence – she was not concerned about SJ's risk and there were no flags to trigger earlier communication with PMCC.[101]

89. In her letter to the Office of the Chief Psychiatrist, Dr Adams noted the internal review finding that:[102]

The lack of liaison with VCCC [Victorian Comprehensive Cancer Centre] is the key modifiable factor in this case. The Documented evidence in file notes of intent of contacting the medical team at VCCC ... There was no indication of reasonable time

[96] Transcript, pages 183-184.
[97] CB, pages 83, 328.
[98] CB, page 76.
[99] CB, pages 83, 85; Transcript, page 272.
[100] CB, page 83.
[101] Transcript, pages 215-217, 220.
[102] Coronial brief, page 86.

frame for this to occur within. The provision of clinical handover did not occur in a timely fashion.

90. In oral evidence, Professor Andrew Chanen, Medical Director at Orygen, agreed and noted it would have been *preferrable* for the handover to occur earlier. However, his preference for earlier contact was not in the context of concern about risk, rather it was good practice. And in SJ's case, the information may have simply been *"this is someone recovering from depression, who is considered to be of low risk, and that there are no major concerns"*. He ultimately believed that earlier handover would not have changed the outcome.[103]

91. I note that SJ did not provide Ms Clarke at ONTrac consent to contact Orygen for his history. It is likely he would have similarly refused consent for Ms Gibbs to contact PMCC about his history.

92. I am satisfied that Orygen has recognised the lack of follow through on the planned and documented contact with PMCC and have implemented changes (discussed below) to improve safe, responsiveness, and timely clinical communication to other services involved in a client's care.

Should Peter MacCallum Cancer Centre have sought information about SJ's mental health history?

93. While some information was available to PMCC staff about SJ's history at Orygen, this period was in the early days of the precinct partnership's shared records, which were incomplete, not familiar to all users, and/or complex to access. The only way for PMCC to gain a comprehensive understanding of SJ's mental health history would have been to obtain that information from Orygen. However, SJ refused to provide Ms Clarke with consent to contact Orygen as he wanted to keep his medical treatment and mental health treatment separate. The question then is whether PMCC should have acted against SJ's explicit wishes?

94. Ms Clarke explained that the right of confidentiality is immediately voided if a patient is assessed at imminent risk to self or others. However, she and other members of SJ's treating

[103] Transcript, pages 271, 295.

team did not hold any concerns about SJ that would have warranted acting against his wish for confidentiality.[104]

95. Ms Gibbs' evidence was that if she had been contacted by PMCC staff, without SJ's consent she would have only provided general information – he had anxiety and depression.[105] This information was already available to PMCC.

96. I accept that in the absence of risk, there were no grounds for PMCC to breach SJ's confidentiality and act against his refusal to provide consent.

INTERNAL REVIEWS UNDERTAKEN BY ORYGEN YOUTH HEALTH AND PETER MACCALLUM CANCER CENTRE

Orygen Youth Health's internal review and recommendations

97. Orygen completed an internal review following the death of SJ and provided an executive summary. The recommendations of the review included:[106]

    (a) clarification of clinician responsibility and recording of progress of actions is now identified at clinical review meetings;

    (b) the requirement for clinician responsibility and progress of actions was communicated to all Orygen clinicians; and

    (c) the handover form used to handover information to general practitioners has been adapted and expanded to include clinical handover of information to other medical clinicians and services involved in an Orygen client's care.

98. In oral evidence, Professor Chanen confirmed that the first recommendation had been implemented so that the case manager now has the primary operational responsibility to enact decisions of the clinical review team.[107] He also explained that clinical review meetings are also now tightly run so that allocated tasks are checked off.[108]

[104] CB, page 92. Confirmed by Dr Speakman's oral evidence: Transcript, page 181. Ms Clarke also confirmed this in her oral evidence: Transcript, pages 318-321. This view was also held by Katherine Thompson, Program Manager of ONTrac: Transcript, page 346.
[105] Transcript, page 213.
[106] CB, page 86.
[107] Transcript, pages 274-275.
[108] Transcript, page 281.

99. The new handover proforma had also been implemented, which Professor Chanen noted could be used for other services and was not limited to general practitioners.[109]

100. I am satisfied that the actions taken by Orygen should result in greater and more timely efforts to communicate with other services involved in the clinical management and care provided to a current Orygen client.

Peter MacCallum Cancer Centre's internal review and recommendations

101. PMCC also completed an internal review following SJ's death.[110] The outcomes of the review focused on environmental safety and clinical handover. This resulted in the following recommendations:

(a) furniture on the 7th floor/terrace of the PMCC building to be secured so it cannot be moved over distances, and additional signage to be posted requesting furniture not be moved and advising that CCTV is in place;

(b) review of the medical handover process for patients transferring from a precinct partner hospital to ensure all relevant past and presenting hearing history is communicated at the time of handover;

(c) all patients with a history of mental ill health or current mental illness are referred to the psycho-oncology program if appropriate; and

(d) raised awareness of the need for prompt referral to the psycho-oncology department.

102. For any newly admitted or transferred patient, an electronic Admission Transfer Document is completed that prompts clinicians to provide information about behavioural risk, which includes risk of self-harm or suicide. If a person is identified at risk, the system then provides guidance regarding escalation and prompts to complete other relevant information or plans. The risk is also flagged in the opening screen of the patient's electronic medical records.[111] The new screening tool allows treating teams to be proactive rather than reactive.

103. As part of the implementation of these recommendations, PMCC has promoted awareness of mental health across staff in terms of staff being cognisant that new cancer patients may

[109] Transcript, page 276.
[110] CB, pages 73-74. On 1 February 2018, PMCC also provided the Court with an executive summary of the internal review.
[111] Transcript, pages 147-148.

develop suicidal ideation. Junior medical staff also receive education about mental deterioration during cancer treatment.[112]

104. Following SJ's death, café furniture located on the rooftop garden was fixed to the ground and a sign erected to state that portable furniture from within the café was not to be moved outside. PMCC also confirmed with relevant authorities that the building complied with all applicable building codes.[113]

105. I am satisfied that the actions taken by PMCC have reduced the access to means for people to climb the barrier on the rooftop by securing the furniture. The process for the identification of a patient with a current or history of mental illness is improved through the inclusion of key selection criteria to guide nursing staff to refer a patient to the specialist psycho-oncology program, greater awareness of the potential for a patient to experience mental health issues, implementation of an established referral system, and improved access to and support from a specialist mental health program.

PRESCRIBING OF METOCLOPRAMIDE

106. Metoclopramide is an anti-emetic drug that is used for the treatment of nausea and vomiting. It is commonly used in the treatment of vomiting associated with radiotherapy and intolerance to cytoxic drugs.[114]

107. SJ received five pre-chemotherapy intravenous doses of metoclopramide 10 mgs on 15, 16, 17, 18 and 19 September 2016, and PRN doses orally on 18, 19 and 20 September 2016 to reduce nausea and vomiting and other side effects of chemotherapy.[115] SJ then received an intravenous dose of metoclopramide 10mgs at about 9.00 am on 22 September 2016, some 30 minutes prior to his death.[116] [117]

108. SJ's mother, SN, raised concerns regarding the connection between prescription of metoclopramide and his depression.

[112] Transcript, page 188.
[113] CB, pages 69-70; Transcript, pages 134-137; Exhibit B.
[114] CB, page 96.
[115] CB, page 72.
[116] CB pages 28, 30, 447; Transcript, page 112.
[117] In his undated statement at CB page 72, Dr Speakman stated SJ was not administered metoclopramide on 22 September 2016. However, in his further statement dated 21 October 2021, Dr Speakman confirmed SJ was administered 10mg of intravenous metoclopramide on the morning of 22 September 2016: Exhibit A. Also see Transcript, page 132.

Warnings for psychiatric adverse events of metoclopramide

109. The warnings for potential psychiatric adverse events in Australian drug information, including the Full Product Information from the Therapeutics Goods Administration and MIMS are equivalent to warnings included in the United Kingdom, United States of America, and Canadian medicine information databases. At the time of SJ's death, information from the Therapeutics Goods Administration and MIMS provides the following precaution:[118] [119]

> *Metoclopramide induced depression has been reported in patients without a prior history of depression. Metoclopramide should be given to patients with a prior history of depression only if the expected benefits outweigh the potential risks.*

110. The available information supports that acute depression is a rare adverse event of metoclopramide use (fewer than 1 in 1000 cases), however the potential outcomes associated with such an adverse reaction is high, if not critical. Anxiety or agitation may occur, especially after rapid injection.

111. More common adverse reactions are restlessness, drowsiness, fatigue, and lassitude (which occurs in about ten percent of patients). Less frequent adverse reactions are insomnia, headache, dizziness, nausea, or bowel disturbances.

112. To assist my understanding of this drug, I requested advice from VIFM toxicology as to whether metoclopramide is associated with suicidality or increased suicidality. Dr Linda Glowacki, Manager, Toxicology, subsequently provided a report dated 17 September 2019[120] referring to the above precautions.

113. Dr Glowacki referred to a literature review that identified only 12 cases of metoclopramide induced mood and behavioural effects, four of which included suicidal ideation (in combination with depression and/or anxiety) and involved a dosage of between 20 and 80 mg per day.[121]

114. She also referred to an article that suggested that metoclopramide may also have some antipsychotic efficacy, and as an antipsychotic treatment has been identified as one of the factors responsible for the increased suicide in persons with schizophrenia. She was of the

[118] See MIMS Australia Full Prescribing Information, revision date 1 July 2016: Exhibit F bundle.
[119] This precaution remains the same in the revised version dated 1 January 2021 (accessed 13 January 2023).
[120] CB, pages 96-98.
[121] Surawski and D Quibbm *Metoclopramide and Homicidal Ideation: A Case Report and Literature Review,* Psychosomatics, 2011 Volume 52 Number 2: Exhibit F bundle.

view that it follows that any drug with antipsychotic efficacy, and which can cause akathisia (such as metoclopramide), may cause an increased risk of suicide.[122]

115. Due to reports of tardive dyskinesia, reports of extrapyramidal disorders, and cardiac issues, in 2015 the Therapeutic Goods Administration made changes to the product information for metoclopramide so that adults should only receive a maximum dose of 30 mg daily and the maximum treatment duration was limited to five days.[123] The warnings for the onset of akathisia and tardive dyskinesia are included in the Full Product Information and prescribing information in Australia.[124]

Whether metoclopramide was appropriate for SJ

116. Dr Speakman stated he was aware that suicide was listed as a risk of metoclopramide but was unaware of any issues or concerns about the use of this medication as an antiemetic in the setting of chemotherapy for the treatment of cancer. He noted, and confirmed in oral evidence, that the total amount SJ received during his admission was relatively minimal. He believed most of the literature regarding risk was in regard to long term use of the medication.[125] SJ had not demonstrated any side effects of toxicity to the medication, including change in mood or suicidal ideation, despite receiving multiple doses.[126]

117. In response to Dr Glowacki's report and the cited Marks article, Dr Speakman noted the article referred to single case of suicide rather than a study. The patient in that case had a different mental health history, including a familial history of mental ill health, was taking other medications, and had been receiving Maxolon for a period of nine months with the patient first complaining of depression on the third month of treatment.[127]

118. Dr Speakman explained that SJ had only five days of treatment and did not exhibit any features of substance induced mood disorder nor metoclopramide toxicity. He also believed there was no evidence that SJ suffered from acute depression while he was admitted to the PMCC.[128] While SJ may have suffered fatigue, he noted most cancer inpatients would be fatigued in a loud hospital environment.[129]

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[122] D Marks, *Depression Leading to Suicide As An Adverse Effect of Metoclopramide*, The Internet Journal of Gastroenterology, 2006 Volume 5 Number 2: Exhibit F bundle.
[123] *Metoclopramide and neurological adverse events,* Australian Prescribed, Volume 38 Number 1: Exhibit F bundle.
[124] MIMS Australia Full Prescribing Information, revision date 1 July 2016: Exhibit F bundle.
[125] CB, page 72; Transcript, page 150-151.
[126] Transcript, page 151.
[127] Transcript, pages 155-156.
[128] Transcript, pages 156-158.
[129] Transcript, page 162.

119. Dr Graham Lieschke, clinical haematologist at the Royal Melbourne Hospital and the PMCC, provided oral evidence about the way SJ's drug regime was decided upon. He explained that the administration of metoclopramide was part of the standard regime chosen by a multidisciplinary team that was in accordance with best practice. He considered SJ's history of anxiety and depression was not a contraindication for any of the medications he was prescribed. It was, however, one of many considerations to be taken into account.[130] Now aware of the full extent of SJ's mental health history, he would not make any changes to his treatment regime.[131]

120. At inquest Dr Speakman was asked whether there was any reason to change what Dr Lieschke described as best practice in 2016, which was to prescribe metoclopramide as part of the supportive cocktail to the chemotherapy regime approved by the multidisciplinary team for SJ. He responded that there was no reason and noted that Therapeutic Goods Administration and the product information with most forms of metoclopramide currently still say that metoclopramide can still be used for patients who have a history of anxiety and depression where the benefit outweighs the risks.[132] He said:[133]

> *And I think what this illustrates to me is that the risks, particularly in SJ's case, seem to be relatively – or exceedingly rare, or low, and that if they – if the metoclopramide was successfully controlling any nausea and vomiting he was having as a result of treatment, or the complications thereof, then it was an appropriate medication to use.*

121. Dr Speakman was adamant that that the prescription and administration of metoclopramide was best practice and there was no particular to change the standard regime even in light of SJ's mental health history. It was a drug well known to be able to control nausea and vomiting associated with chemotherapy with the least side effects. He noted that of the over 2,000 adverse effects reported to the Therapeutic Goods Administration, none were in regard to suicidal ideation.[134]

122. Ultimately, Dr Speakman did not believe metoclopramide had any relationship with SJ's death.[135]

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[130] Transcript, pages 69-75, 78.
[131] Transcript, page 98.
[132] Transcript, pages 159, 163.
[133] Transcript, page 159.
[134] Transcript, pages 163-165.
[135] Transcript, page 159.

Conclusion regarding metoclopramide

123. Notwithstanding the absence of any evidence causally linking the metoclopramide administration with subsequent suicide, there is enough evidence to suggest its use in a person with a known depression or history of depression be reviewed and that the risks versus the benefits should be subject to greater consideration regardless of the intended use and context of use. Depression is not deemed to be a contraindication for the prescription of metoclopramide. Rather, the evidence supports that a clinician should turn their mind to whether the benefits outweigh the potential risks – a balancing test with which clinicians are familiar.

124. I am satisfied that in SJ's case the benefits outweighed the risks and prescription of metoclopramide was reasonable. I am also satisfied that the total amount of metoclopramide SJ received was minimal. During the time he received it, he did not report or was observed to exhibit an increase in mental health symptoms. I am therefore satisfied that that there is no evidence of a causal link between metoclopramide and SJ's subsequent suicide.

125. I also note Dr Speakman gave oral evidence that PMCC has now amended its standard treatment protocols for patients so that the standard antiemetic is now granisetron or ondansetron. This change came about in approximately 2017 following recommendations of the American Society of Clinical Oncology that granisetron or ondansetron was a more appropriate prophylactic for routine chemotherapy courses. It does not appear that risk of depression and/or suicidality was a trigger for change, rather more practical reasons such as ease of use (single dose versus multiple doses). However, metoclopramide is still recommended for use if the other agents fail, or the patient is not in an inpatient setting.[136]

FINDINGS AND CONCLUSION

126. The applicable standard of proof for coronial findings is the civil standard of proof on the balance of probabilities, with the *Briginshaw* gloss or explications.[137]

127. Moreover, the effect of the authorities is that Coroners should not make adverse comments or findings against individuals or institutions, unless the evidence provides a comfortable

[136] Transcript, page 152-154, 165.
[137] *Briginshaw v Briginshaw (1938) 60 C.L.R. 336 especially at 362-363. "The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences…".*

level of satisfaction that they departed materially from the standards of their profession and in so doing, caused or contributed to the death.

128. It is axiomatic that the material departure from applicable standards be assessed without the benefit of hindsight, on the basis of what was known or should reasonably have been known at the time, and not from the privileged position of hindsight. Patterns or trajectories that may be appreciated at a later time or may even obvious once the tragic outcome has come to pass are to be eschewed in favour of a fair assessment made while standing in the shoes of the individual or institution whose conduct is under scrutiny.

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

(a) The deceased is SJ, born 10 January 1992.

(b) SJ died on 22 September 2016 at or near the intersection of Flemington Road and Grattan Street, Parkville, Victoria.

(c) The cause of SJ's death is injuries sustained in a fall from height.

(d) For completeness and although not part of the formal scope at inquest, I am satisfied that SJ's GP at Westgate Medical Centre investigated SJ's symptoms in a logical and sequential fashion. He prescribed antibiotics and symptomatic treatment initially, covered atypical infections when symptoms persisted, and investigated when SJ did not respond and became febrile again. SJ had pneumonia on chest x-ray and the GP's assessment and management were reasonable. It is likely the chest x-ray assisted rather than delayed the diagnosis of lymphoma.

(e) SJ was forward thinking in the days immediately before his death with plans for future activities and appointments which he took the time to arrange. In the hours immediately before his death two medical teams and night and day shift nurses reviewed him separately and regularly. He had sought help to correct the beeping noise on the intravenous pump and had communicated with his cousin and with Ms Gibbs to arrange future activities. Although the evidence suggests SJ was tired after a night of disrupted sleep and physical illness, he was engaged and responsive. Neither the professionals nor his family had concerns about his mental health at the time.

(f) The available evidence supports a finding that proximate to his death, SJ's mental health appeared stable and there were no indications that he should be referred to the

psychiatry team at PMCC. Similarly, there were no indications to suggest his articulated request for confidentiality should be breached.

(g) While SJ had a number of risk factors such as childhood sexual abuse, substance use, and depression (amongst others), the investigation of his death has not identified any proximal trigger for suicide. SJ had a history of seeking help when distressed and it is unknown why he was unable or unwilling to alert staff on this occasion to a change in his mental state before he removed his intravenous lines and went to the PMCC rooftop. There was no apparent indication that SJ was at imminent risk of self-harm or suicide.

(h) SJ's decision to take his own life is inconsistent with his behaviour and interactions with staff and family on the morning of his death. It is likely that the decision to take his own life was a spur of the moment decision, or a decision made earlier and kept to himself.[138] In either scenario, none of the clinical staff involved in his clinical management or care had the opportunity to intervene and prevent his death.

(i) The available evidence does not support a finding that there was any want of clinical management or care on the part of the staff of Orygen or PMCC that caused or contributed to SJ's death.

130. I convey my sincere condolences to SJ's family for their loss.

131. I also wish to acknowledge all those witnesses who testified at inquest in difficult circumstances both in terms of the subject matter of the inquest and the constraints related to the COVID-19 pandemic. In particular, I wish to acknowledge BA who was an impressive witness and had a close and supportive relationship with her cousin which must have been of great comfort to him. Also, Ms Gibbs and Ms Clarke, both of whom impressed as witnesses who had formed a good rapport with SJ and felt a loss at his passing that was apparent as they testified several years after his death.

[138] I agree with Professor Chanen's explanation of 'impulsive' versus 'spur of the moment': Transcript, page 287.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death including matters relating to public health and safety or the administration of justice:

132. I note Professor Chanen's evidence that most suicides occur in people who are considered low risk. He said, *"SJ sadly, tragically illustrates, this is exactly what we see. They're the people who come from leftfield and it was completely unexpected"*.[139]

133. The Victorian Suicide Register (**VSR**) is a database containing detailed information on suicides that have been reported to and investigated by Victorian Coroners between 1 January 2000 and the present.

134. The VSR indicates the annual frequency of suicides occurring in the state of Victoria has been steadily increasing for the past decade, from 550 deaths in 2011 to a peak of 697 deaths in 2018 and 700 deaths in 2019 (there were 690 deaths in 2020 and 693 deaths in 2021).[140]

135. The primary purpose of gathering suicide data in the VSR is to assist Coroners with prevention-oriented aspects of their suicide death investigations. VSR data is often used to contextualise an individual suicide with respect to other similar suicides; this can generate insights into broader patterns and trends and themes not immediately apparent from the individual death, which in turn can lead to recommendations to reduce the risk that further such suicides will occur in the future.

136. So much is still unknown about suicide and, given that every suicide occurs in unique circumstances to a person with a unique history and life experience, possibly there is much we will never be able to quantify and understand. But through recording information about each individual suicide in the VSR, particularly information about the health and other services with whom the person had contact, and then looking at what has happened across time and across people, we hope the VSR can at least lead us to new understandings of how people who are suicidal might better be supported in our community.

137. I commend Orygen and PMCC for the internal reviews undertaken and for the changes and improvements made to their respective practices which should improve patient safety in the future.

[139] Transcript, page 286.
[140] Coroners Court Monthly Suicide Data report, October 2022 update. Published 21 November 2022.

PUBLICATION OF FINDING

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

DISTRIBUTION OF FINDING

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

SN, senior next of kin
AL, senior next of kin
Melbourne Health (NorthWestern Mental Health) (care of DTCH Lawyers)
Peter MacCallum Cancer Centre (care of MinterEllison Lawyers)
Office of the Chief Psychiatrist
Senior Constable Cameron Shoppee, Victoria Police, Coroner's Investigator

Signature:

Coroner Paresa Antoniadis Spanos
Date: 18 January 2023

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