IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2018 005721

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

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

Inquest into the passing of Mathew James Luttrell

Findings of:	AUDREY JAMIESON, Coroner
Delivered on:	16 May 2023
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank, Victoria 3006
Hearing dates:	2-6 May 2022 (held at Mildura Magistrates' Court) 9-11 May 2022; 25 May 2022 and 10 August 2022 (held at Coroners Court at Melbourne)
Appearances:	Ms Ingrid Giles, Counsel Assisting the Coroner, instructed by Ms Ann Kho, Coroner's Solicitor Ms Claire Harris KC and Mr Nicholas Boyd-Caine of Counsel, for the Family, instructed by Ms Siobhan Doyle of the Victorian Aboriginal Legal Service

	Mr Paul Lawrie (then of Counsel), for the Chief Commissioner of Police, instructed by Ms Rita Scammell of the Victorian Government Solicitors Office Ms Naomi Hodgson of Counsel, for Mildura Base Public Hospital and Ramsay Health, instructed by Mr Angus Rooney of Lander & Rogers
Catchwords	Mildura, Aboriginal; Suicide; Access to mental health services; Royal Commission into Victoria's Mental Health System; Cultural safety and wellbeing

Aboriginal and Torres Strait Islander readers are advised that this content contains the name of a deceased Aboriginal person.
Readers are warned that there may be words and descriptions that may be culturally distressing.

TABLE OF CONTENTS

I, AUDREY JAMIESON, Coroner, having investigated the passing of **MATHEW JAMES LUTTRELL**

AND having held an Inquest in relation to this passing on 2-6 May 2022

at the Mildura Magistrates' Court, 56 Deakin Avenue, Mildura, Victoria 3500

AND FURTHER on 9-11 and 25 May 2022 and 10 August 2022

at the Coroners Court of Victoria, 65 Kavanagh Street, Southbank, Victoria 3006

find that the identity of the deceased was **MATHEW JAMES LUTTRELL**

born on 27 September 1975

passed on 13 November 2018

at 1/430 Etiwanda Avenue, Mildura, Victoria 3500

from:

1 (a) HANGING

In the following summary of circumstances:[1]

On 13 November 2018, Mathew James Luttrell was found hanged in the carport of his son's home in Mildura. On the previous day, he had been discharged from Mildura Base Hospital (as it then was) shortly before 5pm, following an in-patient admission relating to suicidal ideation. He had been transported to Mildura Base Hospital by Victoria Police members at approximately 2pm on 11 November 2018, reportedly after a suicide attempt earlier that day.

[1] This section is a summary of facts that were uncontentious and provide a context for those circumstances that were contentious and will be discussed in some detail below.

BACKGROUND CIRCUMSTANCES

1. Mathew James Luttrell (**Mathew**)[2], a proud Yorta-Yorta man, was 43 years of age at the time of his passing.[3] His early years were spent in the Shepparton-Kyabram locality, where he met his partner, Nicole Dempsey (**Nicole**). Together they had five children, Jack (*now passed*), Aidan, Brielle, Tarkyn and Zackariah Luttrell.

2. Mathew is remembered by his family as a kind, bubbly, intelligent person who valued honesty, was a larrikin and who was passionate about reading books.[4]

3. Mathew's medical history included a diagnosis of Borderline Personality Disorder (**BPD**), Attention Deficit Hyperactivity Disorder (**ADHD**) and chronic polysubstance abuse. Mathew also faced a number of physical health issues (including antitrypsin deficiency and an inguinal hernia) and had an extensive history of self-harm and attempts at suicide.

4. Nicole's statement provided for the Coronial Brief, as well as her evidence at Inquest, eloquently described Mathew's struggle in obtaining assistance in relation to his mental ill health. In her view, Mathew '*didn't really want to get diagnosed as he didn't want to be known as someone having mental health issues*'.[5] Nicole described Mathew as having struggled in Mildura to obtain a clear diagnosis and regular access to mental health treatment.

5. Mathew also had a history of family violence that led to Victoria Police members applying for multiple Family Violence Intervention Orders (**FVIOs**) on behalf of Nicole and their children. Despite the conditions under the FVIOs precluding Mathew from attending Nicole's home or having contact with Nicole and their children, there were several occasions upon which these orders were breached.

6. On 21 January 2015, Mathew was sentenced to 3 months imprisonment at the Echuca Magistrates' Court for his persistent contravention of a FVIO in place at the time. It was also

[2] At the request of Mathew James Luttrell's family, he was referred to as 'Mathew' during the course of the Inquest. For consistency, save where formality requires, I have also only referred to him as 'Mathew' throughout the Finding.
[3] The term 'passing' is generally more accepted and sensitive terminology to use when discussing the death of Aboriginal and Torres Strait Islander people due to the spiritual belief around the life cycle (*see* 'Sad News, Sorry Business: Guidelines for caring for Aboriginal and Torres Strait Islander people through death and dying', Queensland Government, December 2015, available here). On the advice of the Coroners Aboriginal Engagement Unit, the term 'passing' was used throughout Mathew's Inquest and will be used instead of 'death' in this Finding, save where required by the words of relevant statutes.
[4] Joint Family Coronial Impact Statement.
[5] Coronial Brief (**CB**), Statement of Nicole Dempsey, p. 17.

during this period that Nicole decided to move to Mildura with her children to *'make it better for [her] family'* and *'move away from the issues'*.[6]

7. Shortly after his release from custody in 2015, Mathew moved to Mildura to join Nicole and their children, but had no fixed place of abode. At this time, Nicole obtained a house in Kelvin Avenue, Mildura, and Mathew moved into this residence. Later, the family moved to a residence in Cleary Avenue, Mildura.[7]

8. The Department of Families, Fairness and Housing ('**DFFH**' as it is now known – previously being 'DHS' or 'DHHS') became involved with Nicole, Mathew and the family during this period. Mathew's daughter Brielle recalls her father self-harming at this time, and describes Mathew attempting suicide by hanging in late 2016. The attempt was unsuccessful due to the intervention of Mathew's son Aidan.[8]

9. Following this attempted hanging, Mathew was brought in by Victoria Police members to Mildura Base Hospital (**the Hospital**)[9] on 19 December 2016 and was assessed as suffering a situational crisis, polysubstance misuse, family violence, chronic suicidal ideation and deliberate self-harm. Mathew was then discharged back into police custody to be interviewed regarding a FVIO, with a plan to be followed up by the Acute Community Intervention Service (**ACIS**) on 20 December 2016. Mathew did not attend this appointment and the episode of care was closed the following day, following discussion with the ACIS psychiatrist, on the basis that he was likely not suffering a major mental illness.[10]

10. Mathew continued to reside in Mildura during this period and attended at a GP at the Tristar Medical Group on a sporadic basis, including for physical health issues. There are no records in the Coronial Brief of his attendance for any mental health treatment during this period.

11. However, Mathew's workers continued to have concerns about his mental health. On 20 April 2018, a member of staff of the DFFH Child Protection Unit (**Child Protection**)

[6] CB, Statement of Nicole Dempsey, p. 18.
[7] CB, Statement of Brielle Luttrell, p. 259.
[8] *Ibid*, p. 260.
[9] Prior to 15 September 2020, the hospital in Mildura was known as 'Mildura Base Hospital' and was a public health service operated by a private operator, Ramsay Health Care (**Ramsay Health**). On 15 September 2020, the administration and governance of the hospital reverted to the Victorian Government, and the hospital became known as 'Mildura Base Public Hospital' (*see* Additional Materials (**AM**) AM-1). This Finding will refer to both Mildura Base Hospital and Mildura Base Public Hospital as '**the Hospital**' unless the legal distinction between these entities is relevant to an issue being described.
[10] CB, Statement of Dr Katherine James, p. 32.

contacted the Hospital's Mental Health Triage requesting that Mathew be seen for mental health support. Reasons for the referral were documented as relating to Mathew's history of suicidal ideation and the fact that he had made threats of suicide in front of his family. In the absence of acute risks or symptoms of acute mood disorder, Child Protection was advised to encourage Mathew to attend his GP for a mental health care plan (**MHCP**) and a referral to a psychologist or a psychiatrist.[11]

12. On 26 June 2018, Mathew was convicted of drug and property-related offences and was sentenced to a 10-month Community Correction Order (**CCO**) at the Mildura Magistrates Court. He was required to complete supervision, assessment and treatment (including testing) for drug abuse or dependency as directed, mental health assessment and treatment as directed, offending behaviour programs as directed, and 100 hours of unpaid community work.

13. Mathew was also referred at this time by Child Protection to the Mallee District Aboriginal Services (**MDAS**) in Mildura for support services. His treatment and care were coordinated by an Aboriginal mental health case worker at MDAS, Mr Peter Matsumoto (**Mr Matsumoto**), who conveyed Mathew to appointments, provided material support and assisted Mathew to access appropriate mental health treatment.

14. Through MDAS, Mathew was referred to psychiatrist Dr Santhusha Wijekoon (**Dr Wijekoon**), who he attended an appointment with on 27 September 2018, and who recorded a diagnosis of, *inter alia*, BPD. Dr Wijekoon recommended that Mathew start on a course of sodium valproate, pending the outcome of liver function tests. Mathew saw Dr Wijekoon on only one occasion, with Dr Wijekoon planning to review him in 2 months from that appointment.

15. During his time as Mathew's mental health caseworker, Mr Matsumoto recalled Mathew was at times difficult to engage as he was often unable to make contact or locate him.[12] Further, in the months preceding his passing, Mr Matsumoto and other MDAS workers noted that Mathew was experiencing a deterioration in his mental health, a lack of stable accommodation, fresh incidences of family violence, and poor physical health.

[11] CB, Statement of Dr Katherine James, p. 32.
[12] CB, Statement of Peter Matsumoto, p. 622.

16. On 22 October 2018, Mr Matsumoto made contact with the Hospital's Mental Health Triage, expressing concern about Mathew's level of vulnerability, and seeking to determine whether the Hospital doctors could provide medication for Mathew, who had presented to him that day as agitated, anxious and pacing. He was advised that Mathew could attend the Hospital for review, and the need for further assessment by ACIS could be considered. In the alternative, he could consult with a MDAS GP.

17. Mathew ultimately attended an appointment with a MDAS GP on 23 October 2018 with the assistance of Mr Matsumoto, and Mr Matsumoto attempted to put in place a range of other supports Mathew required, including temporary accommodation.

IMMEDIATE CIRCUMSTANCES OF MATHEW'S PASSING

18. According to the statement of Constable Emily Faulkner, on Monday, 5 November 2018, Nicole attended the Mildura Police Station and reported that she had tried to end the relationship with Mathew, but he would not leave the house in Cleary Avenue and was threatening suicide. A Family Violence Safety Notice (**FVSN**) was issued, with a court date of 12 November 2018 set down at Mildura Magistrates Court for the hearing of the police application for a FVIO.[13]

19. A welfare check was immediately conducted on Mathew by members of Victoria Police, who attended Nicole's residence in Cleary Avenue, transported Mathew to the police station for the purpose of serving the FVSN, and who thereafter transported him to his son Aidan's residence, given that the conditions of the FVSN precluded him from being at or within 200 metres of the Cleary Avenue address or having contact with Nicole.

20. Mathew denied threatening suicide or using violence against Nicole and was initially agitated in police presence. Police members allowed Mathew's son to accompany him to the police station, and for Mathew to have a cigarette, and by the time he arrived at his son's residence, Mathew had calmed.[14]

21. On Saturday, 10 November 2018, Mathew returned to the family home at Cleary Avenue in breach of the FVSN. Brielle and her partner were at home while Nicole was away with

[13] Statement of Constable Emily Faulkner, CB, pp. 35-36; Family Violence Safety Notice, CB, p. 809.
[14] CB, Statement of Constable Anthony Box, pp. 37-8; Statement of Senior Constable Tim Wisseman, pp. 41-43.

Tarkyn and Zackariah, staying at her brother's home. According to Brielle, Mathew was apparently distressed at being unable to see Nicole and her younger brothers.

22. On the morning of 11 November 2018, Brielle saw Mathew smashing his head into the wall in distress, and his head split open. She also observed red marks round his neck. Mathew informed Brielle that he had attempted to hang himself in the shed, '*but the rope broke.*' Brielle's partner went to the shed and ripped down the rope which was secured to the ceiling, with a noose on the ground that had split from the rest of the rope, to preclude Mathew from re-attempting to hang himself.

23. Having called her mother Nicole for advice, Brielle then rang '000' to obtain assistance for her father, but he decamped on foot while she was on the phone to the '000' operator. Mathew was crying and said he was heading towards 'Ward 5' (the in-patient unit of the Mental Health Service at the Hospital).[15] The '000' operator indicated that she had called for police to attend to render assistance to Mathew *en route.*

24. Following a job being dispatched via Police Communications, at approximately 2pm on 11 November 2018, Mathew was located by police member Sergeant Jason Harris (**Sergeant Harris**)[16] outside the old Hospital location on Twelfth Street near Deakin Avenue. A second police member, Leading Senior Constable Stephen Fincher, (**LSC Fincher**) attended a few minutes later to assist Sergeant Harris, and Mathew was transported to the Hospital's Emergency Department (**ED**).

25. Mathew was triaged by a nurse and then reviewed by an ACIS clinician, Ms Zoe Burnett (**Ms Burnett**). On review by Ms Burnett, Mathew reported feeling suicidal and said that he intended to end his own life, noting that his partner was applying for a FVIO the following day.[17] Ms Burnett observed abrasions on Mathew's head and a redness on his neck. Based on Mathew's presentation and review of the Client Management Interface (**CMI**), Ms Burnett formed the diagnostic impression that Mathew was facing a situational crisis and

[15] CB, Statement of Brielle Luttrell, p. 261; '000' call between Brielle Luttrell and '000' operator on 11 November 2018 at 13:33. Nicole's brother, Robert Dempsey, also made a call to '000' on 11 November 2018 at 13:32 to report the incident.
[16] For ease and consistency, Police members are referred to in this Finding by the rank achieved at the time of giving evidence at Inquest.
[17] CB, Statement of Zoe Burnett, pp. 124-5.

displayed cluster B personality traits. She was of the view that Mathew's symptoms were not indicative of any acute mood disorder or psychotic illness.[18]

26. Ms Burnett discussed Mathew's presentation with the on-call psychiatrist, Dr Joanne Pollock, and it was agreed that he be admitted as a voluntary patient to the in-patient unit (**IPU**). The treatment plan was for Mathew to remain in the IPU for a 24-hour 'crisis containment' with 5-10mg of diazepam every four to six hours as required (maximum 40mg per 24 hours). Mathew reportedly settled and slept during the night of 11 November 2018.

27. On the morning of 12 November 2018, nurse-in-charge, Rachael Costello (**Nurse Costello**), noted that Mathew was difficult to engage, uncooperative, angry and frustrated. She also described Mathew as expressing themes of hopelessness and helplessness.

28. While Mathew stated that he could guarantee his safety on the ward, he reportedly told Nurse Costello that *'if he was to leave the ward then he would attempt suicide*'. Mathew requested diazepam after his morning review but was denied due to the fact that '*he was not willing to engage with the treating team*'.[19]

29. Mr Matsumoto visited Mathew around lunchtime after being alerted to his admission at the Hospital by a Family member, and assisted Mathew by retrieving some of his personal possessions, but left after Mathew told him to '*fuck off and not come back*'.

30. At around lunchtime, Mathew reportedly became more agitated when he was told he could not consume his lunch in his bedroom but would instead be required to eat it in the courtyard. He was reported to have accidentally dropped his lunch tray as he entered the courtyard, smashing his plate, and commenced cutting his neck with a broken piece of plate.

31. A Code Grey and then Code Black was called, and police officers were called to contain Mathew.

32. Mathew was then examined and placed on an Assessment Order (**AO**) under the *Mental Health Act 2014* (Vic) (**MHA**) at approximately 1pm. Police officers escorted him to a seclusion room. He was physically restrained and administered 10mg of olanzapine by intramuscular (**IM**) injection. His neck wounds, which were noted to be superficial, were dressed.

[18] *Ibid*, p. 125.
[19] CB, Statement of Rachael Costello, pp. 613-7.

33. At approximately 4:30pm, when reviewed by nursing staff, the senior psychiatry registrar and the consultant psychiatrist, Dr Graham Kernutt (**Dr Kernutt**), Mathew was reportedly more settled. Dr Kernutt reported that at this time, Mathew denied thoughts or intent to harm himself or others. Dr Kernutt's clinical impression was that Mathew was not 'acutely suicidal' given his denial of further suicidal ideation and self-harm.

34. Mathew was then offered two treatment options by Dr Kernutt: to remain in the Hospital but stay in the seclusion area, or be discharged from the Hospital with community support through the ACIS and a referral for counselling.[20] Mathew wanted to remain as a voluntary patient on the open ward, but he was not given the option to receive treatment there, as the treating team considered his behaviour too risky to staff and other patients. He did not want to remain in the seclusion area.

35. Dr Kernutt formed the opinion there were no grounds to detain Mathew under the MHA given there was no evidence in his assessment, at that of point of time, of a mental illness within the definition of the MHA.

36. At 4:42pm, Mathew left the Hospital on foot. Following this, he was believed to have walked to his son Aidan's home. The AO was officially revoked at 5pm and Dr Kernutt made a note that police ought to be called if Mathew returned to the Hospital.

37. The following morning, Mathew's son Aidan and his partner, Chloe, left home together for work. Mathew was observed asleep on the living room couch. Upon returning home at approximately 12:30pm, Aidan and Chloe located Mathew hanging from a free-standing chin-up station at the carport. Chloe immediately contacted emergency services and Aidan tipped over the exercise tower in an attempt to assist his father.

38. Paramedics attended the scene and declared Mathew deceased. Victoria Police also attended the scene and commenced an investigation. In a duffle bag located in the living room, police officers located a handwritten 'note' by Mathew in which he noted his 'suicide plan'.

39. Ultimately, no suspicious circumstances were found as a result of the police investigation. A Victoria Police Professional Standards Command Oversight investigation concluded that attending police members acted in accordance with their required responsibilities.[21]

[20] CB, Statement of Dr Graeme Kernutt, dated 7 October 2019, pp. 126-8.
[21] CB, PSC Oversight Investigation report, pp. 853-856. Notably, this report did not include consideration of the police conduct in transporting Mathew to Hospital on 11 November 2018.

THE CORONIAL INVESTIGATION

Jurisdiction

40. Mathew's death[22] was a *'reportable death'* under section 4 of the *Coroners Act 2008* (Vic) (**the Act**), because it occurred in Victoria, was considered unexpected, unnatural or to have resulted, directly or indirectly, from an accident or injury. While Mathew was not a 'person placed in custody or care' within the definition of section 3(1) of the Act, I note that he was subject to an AO under section 30 MHA that was revoked approximately 19 hours prior to his passing.

Purpose of a coronial investigation

41. The specific purpose of a coronial investigation of a reportable death[23] is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[24] The cause of death refers to the medical cause of death, incorporating where possible the mode or mechanism of death. The circumstances in which death occurred refer to the context or background and surrounding circumstances but are confined to those circumstances sufficiently proximate and relevant to the death, and not all those circumstances which might form part of a narrative culminating in death.[25]

42. The broader purpose of any coronial investigation 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.[26]

43. The Coroners Court of Victoria is an inquisitorial jurisdiction.[27] Coroners are not empowered to determine the civil or criminal liability arising from the investigation of a reportable death

[22] The word 'death' is used in this section, rather than 'passing', to reflect the formal language of the Act.
[23] 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).
[24] Section 67(1) of the Act.
[25] This is the effect of the authorities – see for example, *Harmsworth v The State Coroner* [1989] VR 989 (***Harmsworth***); *Clancy* v *West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J).
[26] 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'.
[27] Section 89(4) of the Act.

and are specifically prohibited from including in a finding or comment any statement that a person is, or may be, guilty of an offence.[28]

44. 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.[29] These are effectively the vehicles by which the coroner's prevention role can be advanced.[30]

The holding of an inquest

45. Section 52(2) of the Act provides that it is mandatory for a Coroner to hold an Inquest into a death if the death or cause of death occurred in Victoria and a Coroner suspects the death was as a result of homicide, or the deceased was, immediately before death, a person placed in custody or care, or the identity of the deceased is unknown. While Mathew would have been considered 'in care' for the purposes of section 3(1) of the Act the day prior to his passing by virtue of being subject to an AO, he was not 'in care' *immediately* prior to his passing. Therefore, whether or not to hold an Inquest was a matter of discretion under section 52(1) of the Act.

46. Pursuant to this provision, Coroners have absolute discretion as to whether to hold an Inquest. However, a Coroner must exercise the discretion in a manner consistent with the preamble and purposes of the Act.

47. In deciding whether to conduct an Inquest, a Coroner should consider factors such as (although not limited to), whether there is such uncertainty or conflict of evidence as to justify the use of the judicial forensic process; whether there is a likelihood that an Inquest will uncover important systemic defects or risks not already known about and, the likelihood that an Inquest will assist to maintain public confidence in the administration of justice, health services or public agencies. I will return to this issue further below.

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[28] Section 69(1) of the Act. 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) of the Act.
[29] *See* sections 72(1), 67(3) and 72(2) of the Act regarding reports, comments and recommendations, respectively.
[30] *See also* sections 73(1) and 72(5), which requires publication of coronial findings, comments and recommendations and responses respectively; sections 72(3) and 72(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.

Sources of evidence

48. This finding draws on the totality of the material; the product of the Coronial Investigation into Mathew's passing. That is, the Court's records maintained during the Coronial Investigation, the Coronial Brief of Evidence and further material sought and obtained by the Court, the evidence adduced during the Inquest as well as closing submissions from Counsel Assisting and Counsel representing Mathew's Family, the Chief Commissioner of Police (**CCP**) and the Hospital.

Standard of proof

49. All coronial findings must be made based on proof of relevant facts on the balance of probabilities. The strength of evidence necessary to prove relevant facts varies according to the nature of the facts and the circumstances in which they are sought to be proved.[31]

50. In determining whether a matter is proven to that standard, I should give effect to the principles enunciated in *Briginshaw v Briginshaw*.[32] These principles state that in deciding whether a matter is proven on the balance of probabilities, in considering the weight of the evidence, I should bear in mind:

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

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

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[31] *Qantas Airways Limited v Gama* (2008) 167 FCR 537 at [139] per Branson J (noting that His Honour was referring to the correct approach to the standard of proof in a civil proceeding in the Federal Court with reference to section 140 of the *Evidence Act 1995* (Cth); *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* (1992) 67 ALJR 170 at 170-171 per Mason CJ, Brennan, Deane and Gaudron JJ.

[32] *Briginshaw v Briginshaw (1938)* 60 C.L.R. 336 esp. 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…'*

Conduct of my Investigation

52. Detective Senior Constable Christopher Dellas (**DSC Dellas**), the nominated coroner's investigator, investigated the circumstances surrounding Mathew's passing, at my direction, including the preparation of the first coronial brief. I am grateful to DSC Dellas for his extensive investigations, including those proximate to Inquest, and for his attendance and assistance at the Melbourne portions of the Inquest.

INVESTIGATIONS/HEARINGS PRECEDING THE INQUEST

Identity

53. On 13 November 2018, Mathew James Luttrell, born 27 September 1975, was visually identified by his son, Aidan Luttrell, who signed a formal Statement of Identification to this effect.

54. The identity of Mathew James Luttrell is not in dispute and required no further investigation.

Medical cause of death

Post-mortem examination

55. On 14 November 2018, Senior Forensic Pathologist Dr Gregory Ross Young (**Dr Young**) from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on the body of Mathew James Luttrell. In preparing his report, Dr Ross reviewed the preliminary examination report and a post-mortem computed tomography (**CT**) scan and referred to the Victoria Police Report of Death (**Form 83**). Dr Young provided a written report of his findings dated 15 November 2018.

56. The post-mortem examination revealed evidence of a ligature abrasion around the neck with multiple superficial incised injuries both sides of the neck. There was evidence of abrasions on the frontal scalp and right side of the forehead. CT scanning did not reveal any significant pathology.

Toxicology

57. Toxicology analysis of post-mortem samples revealed the presence of diazepam, nordiazepam, olanzapine and delta-9-tetrahydrocannabinol (cannabis). Ethanol (alcohol) was not detected.

Forensic pathologist opinion

58. Dr Young ascribed the medical cause of death to "1 (a) HANGING".

Coroners Prevention Unit[33]

59. At my request, the Coroners Prevention Unit (**CPU**) provided advice in relation to Mathew's care and treatment during his in-patient stay at the Hospital from 11-12 November 2018, including reviewing the Hospital's Clinical Sedation Guidelines. In this regard, the CPU made particular note of Recommendation 54 of the Royal Commission into Victoria's Mental Health System (**RCVMHS**), which recommended that the Victorian Government, *inter alia*, act immediately to reduce the use of seclusion and restraint in mental health and wellbeing service delivery, with the aim to eliminate these practices within 10 years.[34] The CPU also provided invaluable support in review of medical records in the lead-up to Inquest.

Expert evidence and its role in determining whether to proceed to Inquest

60. I obtained three expert reports prior to Inquest. The first of these related to Mathew's human rights and, for this purpose, the Court engaged Professor Bernadette McSherry (**Professor McSherry**), Emeritus Professor at Melbourne Law School, University of Melbourne. Professor McSherry provided an expert opinion on 10 March 2021. While I accept that making findings as to the law is within my domain as Coroner, I was greatly assisted by Professor McSherry's report and by her analysis and conclusions in relation to Mathew's human rights during his in-patient stay, given her considerable expertise in the field of human rights.

61. Professor McSherry opined that Mathew's human rights had been '*unreasonably and unjustifiably breached on three occasions during his inpatient stay*' at the Hospital in relation to the following aspects:

> *1. The decision to make an Assessment Order under the Mental Health Act 2014 in relation to Mr Luttrell on 12 November 2018;*
>
> *2. The decision to use bodily restraint, seclusion and sedation in relation to Mr Luttrell; and*

[33] The Coroners Prevention Unit is a specialist service for coroners created to strengthen their prevention role and provide them with expert assistance by reviewing a range of reportable and reviewable deaths and collecting and analysing data relating to reportable and reviewable deaths.
[34] *See* CPU 'Review of the Mildura Base Hospital clinical Sedation Guidelines', dated 3 March 2021, CB, pp. 254-8.

3. The decision to discharge Mr Luttrell on 12 November 2018 and make a notation that he ought not to be readmitted to hospital if he re-presented, and that police ought instead to be contacted.[35]

62. Given the adverse nature of this opinion, to which I will refer further below, I provided this report to Mathew's Family and to the legal representatives for the Hospital on 7 May 2021 to provide the latter with an opportunity to make any response to the report, including any concessions, with the view of assisting me to determine if any Inquest would be required.

63. On 30 July 2021, I was provided with a response on behalf of the Hospital along with four additional statements. I was urged on the basis of this additional evidence and the submission that Professor McSherry's expertise was in human rights rather than clinical practice, not to make any of the proposed adverse findings based on Professor McSherry's report.[36] No concessions were made as to any shortcomings in the treatment of Mathew by the Hospital.

Request for Inquest

64. Shortly thereafter, on 3 August 2021, legal representatives for Mathew's family submitted a *Request for Inquest into death*, accompanied by a letter submitting that a number of factual issues required investigation and that there were important public interest implications arising from the circumstances of Mathew's passing, including whether Mathew, as an Aboriginal man, was provided with medically and culturally competent care at the Hospital prior to his passing; and whether there are 'lessons to be learnt' from his passing so that similar incidents could be prevented in relation to other Aboriginal people seeking mental health services and treatment from the Hospital (**Application**).

65. On 4 August 2021, Counsel Assisting conveyed to Interested Parties that I intended to grant the Application. Having considered the family's arguments therein, I determined to exercise my discretion to hold an Inquest into Mathew's passing as: (i) no concessions had been made on behalf of the Hospital that would have allowed the scope of the issues before me to be narrowed; (ii) there remained significant discrepancies in the documentary evidence before me that could only be resolved through the hearing of *viva voce* evidence, and further; (iii) the circumstances of Mathew's passing entailed critical matters of public health and safety that warranted further exploration through a public hearing.

[35] Expert Opinion of Professor Bernadette McSherry, CB, pp. 242-253. I will refer further to the expert evidence later in this Finding.
[36] CF, Outline of Submissions on Behalf of Mildura Base Public Hospital and Ramsay Health, dated 30 July 2021.

Directions Hearings

66. A first Directions Hearing was held on 10 August 2021. No submissions opposing the Application were made. In view of the basis of the Application and the information that my investigation had received to date, I ruled that an Inquest was required to reconcile several areas of disagreement on the available evidence, with a scope to be finalised in due course.[37] Counsel Assisting me, Ms Giles, had distributed a draft scope of Inquest prior to that hearing, with the view that submissions on the scope would be received and that the scope would be further refined following receipt of additional materials.

67. During the Directions Hearing, Mathew's family requested to explore further the cultural competency of the mental health services provided by the Hospital. At this time, I was still in the process of obtaining evidence on the cultural care provided to Mathew, including the details of MDAS's involvement immediately before Mathew's passing. Accordingly, I had invited Interested Parties to make submissions regarding the need to obtain an opinion from a cultural expert on the adequacy of Mathew's clinical care from a cultural standpoint. These submissions were received in written form on 1 September 2021.

68. A second Directions Hearing was held on 25 November 2021. By that stage, I had further statements, including from employees of MDAS, as well as an expert report from psychiatrist Associate Professor Vinay Lakra (**A/Prof Lakra**), dated 15 November 2021.[38] I flagged my intention at that hearing to engage a cultural expert to provide an opinion on the adequacy of Mathew's treatment and care from a cultural perspective, anticipating that the experts engaged by the Court would give evidence individually and by way of a Panel at the conclusion of the *viva voce* evidence of all other witnesses.[39]

Scope of Inquest

69. The scope of Inquest, which was finalised following the second Directions Hearing, was the adequacy from a **clinical, cultural and human rights perspective** of Mathew's diagnoses, treatment and care, based on the following:

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[37] Court File (**CF**), Transcript of Directions Hearing on 10 August 2021, p. 13.
[38] Expert report of Associate Professor Vinay Lakra, dated 15 November 2021, CB, pp. 793-797.
[39] The cultural report was provided on 13 April 2022 prior to the commencement of Inquest, with the Court engaging Ms Vanessa Edwige (**Ms Edwige**), psychologist and Ngarabal woman, to provide her opinion on the cultural aspects of Mathew's care, diagnoses and treatment by the Hospital - *see* Expert report of Ms Edwige, dated 13 April 2022, CB, pp. 1565-1587.

1. The relevance of previous contact made in relation to Mathew with Mildura Base Hospital, including in April and October 2018 through the Mildura Base Hospital Mental Health Service;

2. The extent of information-sharing between Mildura Base Hospital and other treatment providers such as MDAS as to Mathew's clinical history, diagnoses and follow-up options;

3. The role of Corrections Victoria in supervising Mathew on a Community Correction Order (CCO) with a mental health assessment and treatment condition;

4. The role of Victoria Police in transporting Mathew to Mildura Base Hospital on 11 November 2018 and his subsequent admission as a voluntary patient;

5. The purpose of the Aboriginal Health Unit and the extent to which it was engaged to provide culturally-specific supports to Mathew during 11-12 November 2018;

6. The knowledge and training of Mildura Base Hospital staff members in de-escalation techniques for patients with challenging presentations;

7. The extent to which Mathew's challenging presentation impacted upon his treatment options and care provided by Mildura Base Hospital;

8. The clinical decisions made at Mildura Base Hospital on 11-12 November 2018 in relation to Mathew, including each decision under the Mental Health Act 2014 to place him on an Assessment Order, to place him in seclusion, to restrain him and to sedate him;

9. Mathew's discharge from Mildura Base Hospital in close temporal proximity to being placed on an Assessment Order, including the treatment options provided to him prior to discharge and degree of subsequent discharge planning and follow-up; and

10. The extent to which the policies and procedures of Mildura Base Hospital were followed in relation to the decision made to admit, detain under an Assessment Order and discharge Mathew, and the extent to which the policies and procedures of Mildura Base Hospital were followed to ensure that Mathew, an Aboriginal man, was provided with culturally-appropriate support whilst an inpatient.

Interested Parties

70. Prior to the commencement of Inquest, I considered that, in addition to Mathew's Family who was represented by the Victorian Aboriginal Legal Service (**VALS**), five entities had sufficient interest in the Inquest proceedings pursuant to section 56 of the Act:

    a) **Mildura Base Public Hospital** and **Ramsay Health Care** (referred to collectively as **'the Hospital'**), given that Mathew had been admitted as an in-

patient for suicidal ideation two days prior to his passing, and was discharged the evening prior to his passing;

b) **Mallee District Aboriginal Services** (**MDAS**), which had provided mental health and other support to Mathew in the community from mid-2018 onwards;

c) **The Chief Commissioner of Police (CCP)**, given, *inter alia*, that Victoria Police members had transported Mathew to the Hospital on 11 November 2018 following '000' being called, and had determined this could occur on a voluntary basis; and

d) **Corrections Victoria**, noting that Mathew was subject to a CCO at the time of his passing that had a mental health assessment and treatment condition.

71. I authorised MDAS and Corrections Victoria to keep a 'watching brief' over the Inquest proceedings rather than participate at Inquest via bar table, which was attended by legal representatives for the Family, the Hospital (namely Mildura Base Public Hospital/Ramsay Health), and the CCP. In the case of MDAS, this 'watching brief' status was authorised on the basis that MDAS is a resource-limited Aboriginal community-controlled organisation, and any anticipated adverse finding in relation to MDAS could be appropriately managed by way of a written process if required.

72. In the case of Corrections Victoria, a 'watching brief' status was authorised due to the fact that three detailed statements and a wealth of supporting policies and procedures had been provided to me in the lead-up to Inquest which negated the requirement for these witnesses to give *viva voce* evidence. A number of concessions were identified that satisfied me that any relevant prevention opportunities had already been identified and appropriately actioned. I consider the approach of Corrections Victoria to have been valuable, commendable and assisted me greatly in discharging my functions under the Act.

INQUEST

Viva Voce Evidence at the Inquest

73. 20 witnesses were called in total to give *viva voce* evidence at the Inquest:

- **Nicole Dempsey**, Mathew's partner, who gave evidence about Mathew's health history, background, the issues he was facing in the lead-up to passing, and her attendance at the Hospital on 11 November 2018;[40]

[40] Transcript of evidence at Inquest (**T**), T-14-T-49, 2 May 2022, Mildura.

- **Brielle Luttrell**, Mathew's daughter, who gave evidence about issues faced by Mathew in the lead-up to his passing, calling '000' after Mathew's suicide attempt on 11 November 2018, and her attendance at the Hospital later that afternoon;[41]
- **Peter Matsumoto**, Mathew's Aboriginal Mental Health Case worker, MDAS, who gave evidence about his intensive engagement with Mathew to support him in relation to his mental health issues, and his attendance at the Hospital on 12 November 2018;[42]
- **Jacki Turfrey**, CEO of MDAS, who gave evidence about MDAS and its programs, as well as the supports offered to Mathew by MDAS in 2018, based on MDAS records;[43]
- **Zoe Burnett,** mental health clinician / social worker, ACIS, Hospital, who gave evidence of her assessment of Mathew when he presented at the Hospital via the Emergency Department on 11 November 2018;[44]
- **Rachael Costello,** mental health nurse, Hospital, who gave evidence of being nurse-in-charge on 12 November 2018 and of being part of the team treating Mathew, as well as details of a Code Black being called on 12 November 2018 and Mathew's subsequent placement on an AO and seclusion, restraint, and sedation;[45]
- **David Kirby,** Executive Director, Mental Health, Hospital, who gave evidence in relation to the Hospital's policies and procedures, as well as his own involvement in the Code Black on 12 November 2018 and Mathew's discharge that afternoon;[46]
- **Adj. Professor Thomas Callaly,** Clinical Director, Mental Health, Hospital, who gave evidence about his discussions with Mathew's treating team on 12 November 2018 and observations preceding the Code Black;[47]
- **Dr Graeme Kernutt,** Locum Consultant Psychiatrist, Hospital, who gave evidence in relation to his assessment of Mathew on the morning of 12 November 2018, Mathew's subsequent seclusion, restraint, sedation and placement on an AO as well as the options Dr Kernutt provided to Mathew following a mental state examination conducted around 4:30pm that day;[48]

[41] T-49-T-60, 2 May 2022, Mildura.
[42] T-62-T-101, 2 May 2022, Mildura.
[43] T-102-T-125, 3 May 2022, Mildura.
[44] T-126-T-176, 3 May 2022, Mildura.
[45] T-177-T-260, 3 May 2022, Mildura.
[46] T-261-T-388, 4 May 2022, Mildura.
[47] T-389-T-505, 5 May 2022. Mildura.
[48] T-729-T-955, 10 and 11 May 2022, Melbourne.

- **Sharon Johnson,** Director, Aboriginal Health, Hospital, who gave evidence about her new role at the Hospital and delivery of culturally-appropriate services to Aboriginal and Torres Strait Islander patients, as well as the role of the Aboriginal Health Unit (**AHU**);[49]
- **Derik Jones,** (former) Aboriginal Liaison Officer (**ALO**), AHU, Hospital, who gave evidence in relation to the functions of an ALO at the Hospital at the time Mathew was an in-patient, the role of the AHU, and the process for supporting Aboriginal and Torres Strait Islander patients in the Mental Health Unit and across the Hospital;[50]
- **Steven Portelli**, (former) Manager, AHU, Hospital, who gave evidence about his former role as the Manager of the AHU at the time Mathew was an in-patient, the functions of the AHU, and the process for supporting Aboriginal and Torres Strait Islander patients in the Mental Health Unit and across the Hospital;[51]
- **Senior Constable Danielle Lowry,** police member, who gave evidence about attending the Hospital on 12 November 2018 to assist in responding to the Code Black, Mathew's presentation, and a conversation she had with Dr Kernutt thereafter;[52]
- **Leading Senior Constable Shelley Mattschoss,** former police member, who gave evidence about attending the Hospital on 12 November 2018 to assist in responding to the Code Black and Mathew's presentation at this time;[53]
- **Sergeant David Dowell,** former police member, who gave evidence about attending the Hospital on 12 November 2018 to assist in responding to the Code Black and Mathew's presentation at this time;[54]
- **Sergeant Jason Harris**, police member, who gave evidence about answering a job put through by Police Communications on 11 November 2018 and transporting Mathew to the Hospital;[55] and
- **Leading Senior Constable Stephen Fincher**, former police member, who gave evidence about answering a call for back-up put through by Sergeant Harris on 11 November 2018 and transporting Mathew to the Hospital.[56]

[49] T-507-TT-546, 5 May 2022, Mildura.
[50] T-548-T-568, 6 May 2022, Mildura.
[51] T-649-T-687, 9 May 2022, Melbourne.
[52] T-568-T-602, 6 May 2022, Mildura.
[53] T-602-T-618, 6 May 2022, Mildura.
[54] T-635-T-649, 9 May 2022, Melbourne (Webex).
[55] T-688-T-714, 9 May 2022, Melbourne (Webex).
[56] T-715-727, 9 May 2022, Melbourne (Webex).

74. As noted, three expert witnesses were also called to give evidence by way of a Panel:[57]

- Giving evidence on human rights issues was **Professor Bernadette McSherry**, a human rights expert and emeritus law professor;
- Giving evidence from a clinical perspective was **Associate Professor Vinay Lakra**, a psychiatrist and President of the Royal Australian and New Zealand College of Psychiatrists; and
- Giving evidence from a cultural perspective on that Panel was **Ms Vanessa Edwige**, registered psychologist, a Ngarabal woman from northern NSW.

ISSUES INVESTIGATED AT THE INQUEST

75. I considered that a number of issues I am required to make findings in relation to under section 67(1) of the Act required no ventilation at Inquest, including Mathew's identity, the medical cause of his death, and aspects of the circumstances surrounding his passing.

76. In particular, noting that the evidence before me (including what is quite clearly a suicide note detailing a suicide plan),[58] I am satisfied on the balance of probabilities that Mathew's passing was in fact by way of suicide as a result of intentional hanging. I am also satisfied that there are no issues arising in relation to the response of emergency services on 13 November 2018 as to the management of Mathew's scene of passing or the way in which he was treated by first responders on this date.

77. The primary focus of the Inquest, as is evident from the scope outlined above, related to the circumstances in the immediate lead-up to Mathew's passing and matters related to the clinical care and treatment Mathew received at the Hospital. This was in the context of Mathew being admitted to the Hospital on 11 November 2018 following a suicide attempt, being placed on an AO, being medicated with olanzapine, being discharged on 12 November 2018 with a notation that police may need to be called if he returned to the Hospital, and taking his own life on 13 November 2018.

[57] T-966-T-1125, 25 May 2022, Melbourne (Professor McSherry and Ms Edwige appeared via Webex and A/Prof Lakra appeared in person).
[58] AM-8.

EVIDENCE ARISING FROM AND DURING THE INQUEST

i. *The relevance of previous contact made in relation to Mathew with Mildura Base Hospital, including in April and October 2018 through the Mildura Base Hospital Mental Health Service*

78. As I have noted, there was evidence before me of three previous contacts prior to November 2018 with the Hospital that were explicitly related to Mathew and his mental health issues:

a) **19 December 2016**: Mathew was brought in by police to the Hospital's ED following a suicide attempt, and was assessed as suffering a situational crisis, polysubstance misuse, family violence, chronic suicidal ideation and deliberate self-harm. Mathew was then discharged back into police custody to be interviewed regarding a FVIO, with a plan to be followed up by ACIS on 20 December 2016. Mathew did not attend this appointment and the episode of care was closed the following day. Mathew's name was recorded on the CMI on this occasion as 'Matthew Lutterall'.

b) **20 April 2018:** Child Protection contacted the Hospital's Mental Health Triage Service to refer Mathew for mental health support. On the basis that Mathew was not threatening self-harm or presenting with an acute mood disorder, the matter was categorised as Triage Category G and Child Protection was advised to refer Mathew to his GP for a MHCP and to utilise triage as needed.

c) **22 October 2018:** Mr Matsumoto attended the Hospital's Mental Health Triage due to concerns about Mathew's heightened emotional state and level of vulnerability. Mr Matsumoto noted that Mathew had been reviewed by Dr Wijekoon at MDAS with a plan to start Epilim once he completed a workup of liver function tests, and sought to determine whether it was possible for a psychiatrist to provide him with medication. The call was also assessed as Triage Category G and Mr Matsumoto was advised to either bring Mathew in for triage assessment or attend at a MDAS GP. Mr Matsumoto noted that Mathew was reluctant to present to the Hospital's Mental Health Service due to fears of being admitted to 'Ward 5'.

79. In relation to the 2018 contacts recorded on the CMI, which directly formed part of the scope of Inquest, I accept the evidence of A/Prof Lakra that these were adequate and appropriate, insofar as '*it appears there was consideration of a number of factors including patient preference and risk assessment in arriving at a conclusion regarding a further plan of*

action'.[59] It is important in this regard to note that the 2018 contacts did not involve any attendance of or assessment of Mathew, but constituted two contacts made on his behalf by concerned workers.

80. In particular, the contact initiated by Mr Matsumoto on 22 October 2018 occurred in the context of Mr Matsumoto's intensive efforts to support Mathew in the community in the latter half of 2018 and to escalate his treatment and care to the Hospital where it was felt that support by MDAS in the community was not possible due to a heightening in Mathew's presentation.[60] Mr Matsumoto gave evidence at Inquest that '*the state we saw him in, we thought it would be best to get him to the hospital and have him assess properly there'*.[61]

81. This course appears to have been thwarted in part by Mathew's reluctance to present at the Hospital due to fears of being admitted to Ward 5, which Mr Matsumoto gave evidence was not uncommon amongst the clients he supported: '*it's just a part of the stigma around the mental health, part of the hospital, that if you're presented there you were automatically locked up in the mental health ward. So that was a big issue we had trying to reassure clients that they could go there, they could get treatment without being admitted as a patient to the ward*'.[62] While this points to a broader issue that I will turn to below, I do not consider there to be any missed opportunities in relation to these triage contacts regarding Mathew.

82. As to the relevance of these previous contacts to Mathew's presentation to the Hospital on 11 November 2018, I heard evidence at Inquest from Ms Burnett, ACIS clinician, that she factored the 2018 contacts into her in-person assessment of Mathew on this date, though they are not explicitly referred to.[63] Ms Burnett gave evidence that, by contrast, the notes of Clinician Jan Layton from 19 December 2016 were *not* accessed or factored into Ms Burnett's assessment on 11 November 2018, due to a misspelling of Mathew's name in the 2016 entry which meant that this entry was unavailable to Ms Burnett when she searched the CMI prior to her assessment of Mathew.

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[59] CB, Report of A/Prof Lakra, p. 794.
[60] The evidence of Ms Edwige, which I wholly accept, is that Mr Matsumoto '*made significant attempts to address Mr Luttrell's social and emotional wellbeing through ongoing support and case management. It is noted that Mr Luttrell was difficult to engage and frequently did not accept or want his support. Despite these difficulties it is evident that significant attempts were made to support Mr. Luttrell with his attendance at meetings and compliance with [DFFH]. It was apparent that there were a number of psychosocial stressors impacting on Mr. Luttrell and from reading the evidence, Mr. Matsumoto made significant attempts to address the*se' – CB, p. 1578.
[61] T-74-T-75.
[62] T-73.
[63] T-144.

83. I note that Ms Burnett indicated during her evidence that she was aware of previous suicide attempts on Mathew's part and that access to the 2016 entry may not have changed her immediate assessment of Mathew's risk. She stated: '*It would have, I guess, informed a history of his risk, a history of his behaviours, which ultimately does become a part of your risk assessment. But, at that time, I'm basing a decision on what, what is happening in that moment'*.[64]

84. Therefore, while it is unfortunate that this 2016 entry was not factored into Ms Burnett's risk assessment given the rich history detailed therein, including what Counsel for the Family deemed the 'mirroring' of the suicide attempt for which Mathew was presenting on 11 November 2018, this did not appear to materially affect Ms Burnett's assessment of Mathew or impact upon the treatment plan devised thereafter. It may simply serve as a reminder for clinicians to use 'wildcards' when searching names in the CMI to ensure all relevant entries are accessible, which Ms Burnett noted was a possibility to yield broader search results.

ii. *The extent of information-sharing between Mildura Base Hospital and other treatment providers such as MDAS as to Mathew's clinical history, diagnoses and follow-up options*

85. There was evidence in my brief about a 'Mental Health Demonstration Project' (**Demonstration Project**) between MDAS and the Hospital that related to treatment and care of shared mental health clients, though it was unclear until I heard further evidence at Inquest as to what this constituted and what the governance arrangements were. Indeed, Ms Sharon Johnson (**Ms Johnson**), Director of Aboriginal Health at the Hospital, gave evidence that the AHU at the Hospital was not involved with the Demonstration Project, which appeared unusual, given the role of the AHU.[65] A Memorandum of Understanding (**MoU**) between MDAS and the Hospital, produced during Inquest, did not refer at all to the project.

86. Ms Turfrey, CEO of MDAS, gave evidence that the Demonstration Project was a pilot project started by the state government for MDAS to work in collaboration with the Hospital. She stated that the current arrangements in place through the Demonstration Project are '*to work together to support mutual clients, navigate between two systems of health - one, obviously, being run by the Hospital in the acute care system and MDAS, which is a*

[64] T-162. *See also* CB, Submissions of Counsel for the Hospital, T-1224-T-1226.
[65] T-529-T-530.

community support system, but particularly for referrals to specialists as MDAS does not have those specialists available in its service'.[66]

87. To clarify the current status of the agreement between the entities, I sought and received a statement on the last day of Inquest from Mr David Kirby (**Mr Kirby**), Executive Director, Mental Health at the Hospital, regarding the Aboriginal Mental Health Services Consortium, which was formed to undertake the Demonstration Project to test a new mental health treatment model for Aboriginal and Torres Strait Islander people, with a focus on those who have come into contact with the criminal justice system, in light of the high numbers of Aboriginal and Torres Strait Islander people in the region on CCOs – of whom Mathew was one. One of the listed outcomes of the Demonstration Project was stated to be '*increased access by Aboriginal and Torres Strait Islander people to the Mildura Base Hospital Mental Health Services due to improved cultural safety'*.[67]

88. However, the evidence of Mr Kirby at Inquest was that a Service Level Agreement drafted in 2017 aimed at formalising the project remains unsigned between MDAS and the Hospital, which Mr Kirby opined to be due to the fact that at the time the agreement was contemplated, the Hospital did not yet have the resources to provide the 0.5 FTE psychiatric registrar for the project. However, Mr Kirby indicated that this position was filled on or around February 2020, and there is no evidence before me as to why a formal agreement between MDAS and the Hospital remains outstanding.[68]

89. It was submitted to me in closing by Counsel for the Hospital that the delay in executing an agreement between MDAS and the Hospital was not a '*failure of information-sharing'*, and that the failure to execute an agreement regarding the Demonstration Project was distinct to what would have been contained in an information-sharing agreement.[69]

90. I do not consider the evidence supports this. Firstly, I note that one of the documents provided by Mr Kirby describing the Demonstration Project, dated 2 March 2017, states that:

[66] T-107-8.
[67] AM-16 – *see in particular* AM-16-8.
[68] I note Mr Kirby's statement indicates that there are ongoing discussions underway as to finalising a new agreement [AM-16-2]; Ms Jacqui Turfrey, the MDAS CEO, also gave evidence that the intention of MDAS was to finalise the agreement, [T-122] despite perceived deficiencies in the Demonstration Project's capacity to cater for what she deemed to be the 'mid-point' of the system [T-123].
[69] T-1230-1.

> *'As part of the shared care arrangements, the MDAS mental health teams will work collaboratively with the hospital mental health teams – Acute Community Intervention Service (ACIS) and Service Access Team (SAT) – to increase access between clients and hospital services. This collaborative approach with ACIS and SAT will include the development of crisis management plans for clients so if a client presents to MBH after hours the hospital will have access to the plan.* ***This arrangement will include consent forms to enable streamlined information sharing of clients'***.[70]

91. I find that the agreement anticipated to overlie the Demonstration Project: (a) relates to information-sharing; and (b) was by its very nature the sort of initiative that may have assisted someone like Mathew, who was an existing client of MDAS and whose mental health issues were well-known to MDAS and reflected in the MDAS records (notwithstanding what I note to be the retrospective insertion of Dr Wijekoon's handwritten assessment of Mathew from 27 September 2018) but who presented to the Hospital out-of-hours. The evidence of Mr Kirby was that, as at the time of Mathew's passing and still at the time he gave evidence in May 2022, access to information such as MDAS records by the Hospital after hours '*is not possible'*.[71]

92. The finalisation of an agreement between the Hospital and MDAS, including the development of appropriate information-sharing arrangements, therefore appears to be critical to the success of the project and of an organisation such as MDAS to provide support to its clients when they require referral to the services of the Hospital, noting the evidence of Ms Turfrey that lack of information-sharing from the Hospital '*is absolutely not ideal, because we don't know what state of mind or what treatment or what needs they might need for a follow-up support once they come back into our service'*.[72]

93. Indeed, the evidence I heard at Inquest was that, while Mathew indicated upon his initial assessment with Ms Burnett that he was engaged with a mental health worker from MDAS as part of the Demonstration Project and had seen psychiatrist Dr Santhusha Wijekoon through arrangements made by MDAS, the Hospital did not contact MDAS following Mathew's admission to the IPU to alert them of the same, or to seek collateral information.

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[70] AM-16-15 (emphasis added).
[71] T-306-7.
[72] T-109. At T-108, Ms Turfrey also noted: '*MDAS provides the hospital with a full background briefing on the client - medical record information, obviously, with the client's consent, but also any other factors impacting the client, to enable the best level of assessment to be made at the hospital to support the client. However, that information sharing does not come back from the hospital. And, in fact, we are not even informed, typically, on a client's discharge when they've been admitted to hospital'.*

94. The Hospital further did not contact MDAS on 12 November 2018 when it discharged Mathew from its care, though a phone call was made the following day by a Hospital staff member to MDAS, at a time when Mathew had already passed, to alert them as to Mathew's reported threat against Mr Matsumoto.

95. In these circumstances, I find that the lack of agreement and concomitant information-sharing arrangement supporting the Demonstration Project meant that there was no established conduit via which to share Mathew's health information between MDAS and the Hospital.

96. While collateral information ought to have been obtained by Mathew's treating team as a requirement of the Hospital's own policies, which I will address further below, Mathew's circumstances as: (i) an Aboriginal man; (ii) subject to a CCO; (iii) already linked to MDAS; (iv) presenting to the Hospital out-of-hours, appears to have typified the very patient identified by the Demonstration Project as requiring a shared approach to client care and enhanced information-sharing arrangements. I therefore consider the lack of agreement between MDAS and the Hospital to be a lost opportunity to support two-way information-sharing for mutual clients/patients, and which would assist in a person-centred approach to treatment and care of those persons.

97. A pertinent Recommendation will follow.

*iii. The role of Corrections Victoria in supervising Mathew on a Community Correction Order (**CCO**) with a mental health assessment and treatment condition*

98. Corrections Victoria (**Corrections**) was invited to participate in these proceedings as an Interested Party on the basis that the material in my brief pointed to the fact that Mathew was on a CCO with a mental health assessment and treatment condition at the time of his passing, and which was imposed on 26 June 2018 at Mildura Magistrates Court. I considered this to be a relevant background factor to the circumstances of his passing and to systems-based opportunities to engage him in relation to his mental health issues.[73]

99. The evidence before me from Corrections Victoria, through provision of three detailed statements annexing a number of relevant policies and procedures, is that Mathew had

[73] As noted above, Corrections was not required to participate at Inquest and Interested Parties did not address this scope item in their submissions, which focused on the scope items put forward for the Inquest.

extended periods of disengagement from his CCO and from his Community Correctional Services (**CCS**) supervisor.

100. Specifically, Mathew attended appointments with his CCS supervisor as required on 6, 13 and 19 July 2018 and 9 August 2018, and attended without an appointment on 10 September 2018. Mathew then disengaged from CCS until 1 November 2018, on which date he voluntarily reattended at Mildura CCS, and his supervisor discussed his non-compliance and disengagement. Mathew subsequently failed to attend his assessment Offender Behaviour Programs (**OBP**) on 9 November 2018 and reported via telephone to his CCS supervisor that he was homeless and the subject of an FVIO in which he was the respondent. This was the last contact Mathew had with Corrections before it was informed of his passing on 20 November 2018.[74]

101. Despite a number of procedures being faithfully adhered to in relation to Mathew's induction onto the CCO and a number of appropriate referrals being made on Mathew's behalf (including Dardi Munwurro's Men's Healing and Behaviour Change Program and a recorded awareness of DFFH's referral to MDAS), relevant policies and procedures were not adhered to in all material respects, particularly in following Mathew up during periods of disengagement.

102. Further, Mathew's engagement with certain services does not appear to have been established or documented in his CCS file. I note that there is no record of contact between the CCS supervisor and MDAS itself in confirming and following up Mathew's level of treatment/engagement by and with MDAS from the first CCS appointment in July 2018 until the end of October 2018 (noting that engagement with the MDAS Mental Health Demonstration Project was deemed by CCS to constitute the way in which Mathew's mental health assessment and treatment condition was to be fulfilled), which does not accord with the mandatory requirement for regular and ongoing consultation with treatment providers under CCS Practice Guideline 10.4.1.[75]

103. Despite these issues, Mathew's CCS supervisor clearly made culturally-appropriate referrals and ensured that, during Mathew's period of engagement with him, the case management process was culturally-responsive for Mathew as an Aboriginal man.

[74] CB, Statement of CCS Supervisor, pp.1452-1457.
[75] CB, Corrections Practice Guidelines, pp. 1138 and 1146.

104. I note that, in responding to my request for information about Mathew's CCO, Corrections has itself identified ways in which it could have improved its engagement with Mathew on his CCO, including:

a) Involving a senior Community Corrections officer in Mathew's case, given that Mathew returned a positive suicide and self-harm (**SASH**) screening upon assessment and induction, and completing ongoing suicide screening thereafter, including discussion of Mathew's case with a senior officer given Mathew's change in circumstances on 9 November 2018;

b) Ensuring that all required referrals were completed as per standard practice and for CCO participants to be notified of appointments to facilitate timely engagement and treatment;[76]

c) Ensuring appropriate documentation of contacts/attempted contacts and appointments with Mathew;

d) Giving consideration to using a case conference process to assist in assessment, planning, intervention and review, given the multiple service providers involved with Mathew; and

e) Escalating Mathew's non-compliance to a senior officer for discussion and consideration of referral to a Risk and Review Meeting or Compliance Review Hearing to support his compliance and re-engagement after a period of disengagement.[77]

105. Corrections also noted a number of improvements it has made since Mathew's passing, including:

a) Mathew's CCS supervisor has undergone extensive training since Mathew's passing to build his knowledge and capacity in monitoring, identifying and responding to escalation in risk, and has completed relevant courses to assist him in managing his workload;

b) Reform of the 'Better Connected Care' program has occurred to assist in delivery of person-centred services for CCO participants with multiple support needs;

c) The Professional Practice stream has been introduced as part of the CCS Expansion and Reform project, in order to provide regional support to improve case management and reduce re-offending, along with an Enhanced Supervision Framework and Advanced Skills Workshops to assist CCS staff to achieve best practice;

[76] *Ibid*, p. 962.
[77] CB, Statement of Ms Jenny Robert, Director, Community Operations and Parole, Justice Services Division, Corrections and Justice Services, pp. 962-3.

d) Practice Guidelines have been reviewed to strengthen guidance for staff supervising CCO participants, including addressing risk factors of participants; and

e) There has been ongoing support, consideration and progress in actioning a previous coronial recommendation to obtain professional advice about the adequacy, effectiveness and application of the 'Suicide and Self-Harm Risk Screening Suite'.[78]

106. In circumstances in which: (i) Corrections has identified the ways in which its engagement of Mathew could have been improved; (ii) Corrections has noted a number of systems improvements implemented since Mathew's passing; and (iii) the case management process was culturally-responsive for Mathew as an Aboriginal man, I am not persuaded that any adverse comment is warranted against either Corrections or Mathew's CCS supervisor despite the non-adherence to certain Corrections policies. Indeed, I commend the approach of Corrections to my inquiry in pro-actively identifying the ways in which its engagement of Mathew could have been improved and outlining both the specific and systems improvements implemented since November 2018.

iv. The role of Victoria Police in transporting Mathew to Mildura Base Hospital on 11 November 2018 and his subsequent admission as a voluntary patient

107. I heard evidence at Inquest that, following a job being put out over Police Communications, two police officers transported Mathew to the Hospital on a voluntary basis, having located him outside the Old Mildura Hospital. The job was put out at 1:41pm on 11 November 2018 following the two '000' calls made by Mathew's family members in relation to his attempted hanging, as detailed above. Police communications noted '*I've got a bloke who's tried to hang himself up in Hector Street, and […] the rope broke, and he was walking down the road, and ambos and such were trying to catch up with him, but not yet done so*'.[79]

108. Sergeant Jason Harris, the patrol supervisor that day, responded to the job first. Upon locating Mathew on the street at approximately 2:01pm, he called for back-up, and then-Leading Senior Constable Fincher (**LSC Fincher**) attended to provide assistance. Sergeant Harris noted in his statement that Mathew appeared distressed and indicated to Sergeant Harris that he was heading to the Hospital to seek mental health assistance.[80]

[78] *Ibid.*, pp. 963-70.
[79] AM4-1.
[80] CB, Statement of Sergeant Jason Harris, pp 44-45. This accords with the evidence of LSC Fincher, who stated that Mathew '*was a bit agitated, bit distressed*' [T-718].

109. Sergeant Harris noted that, despite Mathew's distress, he posed no risk and could be transported safely to the Hospital in the backseat of the police vehicle, a Toyota Kluger. Sergeant Harris also opined that, in his view, this transport could occur on a voluntary basis, given that Mathew was help-seeking and there was no requirement to 'apprehend' Mathew within the meaning of section 351(1)(b) MHA.[81] I accept Sergeant Harris's assessment, noting that the evidence supports that Mathew was attempting to make his own way to the Hospital and thus could accompany the officers voluntarily without the need to be apprehended.

110. Sergeant Harris gave evidence at Inquest that LSC Fincher attended to assist him as he heard the certain transmissions being put out over the radio.[82] However, it was conceded that he may not have heard the job being initially put out. Sergeant Harris stated at Inquest: '*I don't recall the conversation that I had with [LSC Fincher] when he attended. I'm not sure how much of the radio that he did or didn't hear'*.[83] When the police vehicle arrived at the Hospital, Sergeant Harris was required to provide on-air directions in relation to another job, and it was LSC Fincher who escorted Mathew alone, first to the Mental Health Unit and then to the ED of the Hospital, and waited for the triage nurse to attend to Mathew.

111. I heard evidence that LSC Fincher had himself been undertaking another task at the time the initial job was put through from Police Communications, was unaware of Mathew's recent suicide attempt, had not had an opportunity to obtain a *précis* on the circumstances of his being in the police vehicle from Sergeant Harris, and simply thought Mathew was help-seeking in relation to suicidal ideation. LSC Fincher agreed that if he was aware Mathew had attempted suicide by hanging or by any other means, he would have conveyed this to the triage nurse on duty at the Hospital when he accompanied Mathew there. However, as he was unaware of the recent suicide attempt, this piece of information was not conveyed.

112. Fortunately, as put to me by Counsel for the CCP, Mathew was a good historian and reported his recent suicide attempt, FVIO and homelessness to clinicians at the Hospital, and he was

[81] Had this requirement been triggered, there would have been an obligation on attending police members to undertake certain steps when escorting Mathew to Hospital, including completion of detailed handover information via an L-42 form.
[82] T-698.
[83] T-699.

deemed to require assessment.[84] Ms Burnett included in the CMI notes that Mathew presented at the ED following a suicide attempt and that she could clearly see red marks on his neck. However, there was also evidence before me that the veracity of Mathew's suicide attempt appeared to be doubted by other Hospital clinicians, which in turn appeared to impact subsequent perception of his level of risk. Mr Matsumoto, for example, noted that '*at no point did I have any concerns regarding Mathew harming himself, as there were no signs that confirmed his suicide attempt and this was verified by hospital staff (Rachael)*'.[85]

113. It would be speculative to find that, had the full account of Mathew's suicide attempt as reported via '000' been recounted by police to Hospital staff when Mathew attended at ED, that the Hospital staff's perception of risk to him may have been assessed differently, particularly given that his suicide attempt was not directly witnessed by family members and thus even the '000' calls were reporting to police what Mathew had self-reported to family members. To this end, I note that Ms Burnett indicated that further details from police as to Mathew's stressors may not necessarily have factored into the assessment of Mathew's risk but may have been useful for treatment planning and discharge.

114. However, both Sergeant Harris and LSC Fincher agreed, and I find, that provision of as much information to the Hospital by way of handover is optimal, even in the case of voluntary patients, '*because they need all that information to make the correct decision based on all the information around about the person's demeanour, about their actions, thoughts, what have you, yes – it's all imperative'*.[86]

115. Notwithstanding, despite the fact that the full set of information known to police was not provided to the Hospital, I find that the conduct of police members in transporting Mathew to the Hospital was appropriate in the circumstances and was consistent with existing Victoria Police policies and procedures.

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[84] Ms Burnett gave evidence that the process for admitting a patient brought in voluntarily by police, rather than under s351, is different – '*Our protocol if somebody is brought in by police s351 involuntary transportation, then we must assess them. If they are brought in voluntarily, it is determined by the triage worker dependant on that person's expressed risk and situation whether or not we provide an assessment'* – T-141.

[85] CB, Statement of Peter Matsumoto, p. 633. Mr Matsumoto noted at Inquest – '*If there was signs that he had, uh, made an attempt, then that would have changed how we would have supported him completely. And I would have pushed for him to have been in Ward 5 for longer than he actually was'* – T-83.

[86] T-724 per LSC Fincher. Ms Burnett also gave evidence that '*it is good to have corroborative evidence of – of that situation. If we have a police officer there that says, 'I witnessed this,' then of course, then we have extra evidence. In terms of what he's told me about his attempt, I'm going to take that as face value because I can see his distressed state, I can see the marks around his neck, so I know that something has occurred'* - T-142.

116. A pertinent Comment will follow.

v. *The purpose of the Aboriginal Health Unit and the extent to which it was engaged to provide culturally-specific supports to Mathew during 11-12 November 2018*

117. I heard evidence that Mathew identified as Aboriginal upon admission to the Hospital,[87] and it was the Hospital's standard process that this information would be captured via the TrackCare system, which would in turn assist ALOs in identifying patients each morning to visit and offer support. However, there is no evidence that the AHU was called upon at any point to provide support to Mathew during his in-patient stay, despite this being part of its function (to visit and offer support to all Aboriginal patients at the Hospital, including in Ward 5, during business hours Monday to Friday).

118. Further, it was the usual practice of a member of the AHU to attend the morning handover meeting in the Mental Health Unit between 8:30am and 9:30am. There is no evidence that that meeting was attended by an AHU member on 12 November 2018.

119. I heard evidence from the two members of the AHU who were employed at the time of Mathew's in-patient admission, the first being Mr Derik Jones (**Mr Jones**), former ALO, who indicated that he would have remembered Mathew had he met him at Hospital, given a family connection, even if he had refused AHU assistance.[88] I also heard evidence from Mr Steven Portelli (**Mr Portelli**), former manager of the AHU, that he did not recall meeting Mathew. Mr Portelli also gave evidence that on Mondays, the AHU might be overwhelmed by patients coming in over the weekend and spoke of the difficulties of being one staff member down at the time of Mathew's in-patient admission,[89] given that one ALO position was vacant at the time.

120. I consider it to be unsatisfactory that the Hospital could offer no explanation as to whether Mathew was ever visited by a member of the AHU on 12 November 2018, and if not, why this was not the case. I offer no criticism of Mr Portelli or Mr Jones, who were operating short-staffed and who in any event gave evidence that they would not necessarily get through the whole list of Aboriginal-identifying patients on a particular day. However, it is evident that the Hospital's systems in place at the time of Mathew's in-patient stay were not

[87] CB, Patient Registration Form, p, 509.
[88] T-553.
[89] T-663.

sufficiently robust in terms of effective record-keeping, and this has resulted in a lacuna in the evidence before me.

121. I do note the evidence of Ms Sharon Johnson (**Ms Johnson**), who was appointed to a new position of Director of Aboriginal Health at the Hospital in August 2021, subsequent to Mathew's passing, that record-keeping requirements have been improved so that there is now one location to show activities ALOs are undertaking within their role and in providing care and support, which I consider to be positive.[90]

122. A number of witnesses in Mathew's treating team gave evidence at Inquest that the input of an ALO at various points of Mathew's patient journey would have supported Mathew's engagement and assisted them in their role, including Ms Burnett, Nurse Costello, Mr Kirby, and Dr Kernutt.[91] While AHU staff may have been alerted to Mathew's presence via the TrackCare system, no clinician alerted the AHU to Mathew's presence at any stage.

123. This contravened a number of policies to offer the services of an ALO at various specified points in Mathew's patient journey, including at the point of triage,[92] when conducting a mental state examination (**MSE**) and risk assessment,[93] at the point of seclusion and restraint,[94] at the point of sedation,[95] and for the purposes of compulsory notification of persons under the MHA.[96]

124. I heard evidence at Inquest that, on 12 November 2018, Mathew was reportedly irritable and refusing to engage with his treating team, including during the morning psychiatric review and MSE which was being led by Dr Kernutt. There was no explanation put to me as to why the ALO was not called to be present this point, which was during business hours. Dr Kernutt gave evidence this was the 'intended plan' and conceded that there was no basis for deferring engagement of the services of the ALO when Mathew had refused to engage at the MSE.[97]

125. In some circumstances, when questioned at Inquest, staff members appeared unaware of the requirement to offer services of the ALO when certain actions were initiated, such as

[90] CB, Statement of Ms Sharon Johnson, p. 1487.
[91] Respectively, T-151; T-208; T-370; T-842. Adj. Professor Callaly also gave evidence that it was appropriate for the services of the ALO to be offered in accordance with Hospital policy [T-449].
[92] AM6-513.
[93] CB, p. 197.
[94] CB, pp. 186 and 216.
[95] CB, p. 226.
[96] AM6-614.
[97] T-842.

seclusion.[98] In other cases, as I heard from Mr Kirby, there was evidence of a perception that involving AHU staff members at key points such as Code Greys or Code Blacks, where restrictive practices are frequently deployed, may compromise the AHU staff member's relationship with the patient. Mr Jones and Mr Portelli agreed that in some circumstances it may not be appropriate to request an ALO to attend a 'Code'.

126. This is in clear tension with the policies requiring the services of an ALO to be offered at such points, and Mr Kirby, as the Executive Director of Mental Health, was unable to confirm why this purported discrepancy exists or whether or not there had been input from AHU or Aboriginal staff members on this aspect of the Hospital's policies.[99] In any event, this issue simply did not arise on the facts before me because there is no evidence that the services of an ALO were concretely considered or offered to Mathew at any point during his in-patient stay.

127. Mr Matsumoto of MDAS, Mathew's Aboriginal mental health support worker, *did* provide supports to Mathew at the Hospital after being alerted to his presence via a family member (not by the Hospital itself, despite the fact that staff were aware of Mathew's engagement with MDAS), but there is no evidence before me of any provision of cultural support from the Hospital itself.

128. I concur with the submission put forward by Counsel for the Family that the fact that MDAS provided support to Mathew on 12 November 2018 did not absolve the Hospital of its obligation to offer culturally-specific supports to Mathew. The failure to do so not only contradicted Hospital policy but impacted the clinical options available to staff and to Mathew, particularly noting the use of restrictive practices[100] and in the further options said to have been offered to Mathew following his period of seclusion.

129. I do not consider this to be overstating the impact of the availability of culturally-appropriate supports. I heard evidence from cultural expert Ms Edwige (and was greatly assisted by it) as to her opinion regarding Mathew's assessment on the morning of 12 November 2018 and his apparent lack of engagement. When asked by Counsel Assisting whether an Aboriginal

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[98] T-221.
[99] T-287.
[100] A/Prof Lakra gave evidence in relation to '*less restrictive measures' that he prefers the words 'least restrictive environment', or 'less restrictive settings', because ' it allows you to run your imagination a little bit, if I can use that - that phrase […] depending upon your experience and expertise and - and the - what kind of diversity available around for you*' – T-1094.

or Torres Strait Islander patient could be assessed by a treating team as '*not engaging'* where the service provider is not culturally safe to that patient, Ms Edwige affirmed this proposition, and stated:

> *[…] if you can just kind of refer it back to the situation of Mathew, obviously he was under the bedclothes feeling very unsafe and trying to conduct an assessment in that whilst he was, you know, feeling so dysregulated and so unsafe by not wanting to engage, I think that that was probably an indication that, you know, that it was time to allow him to, you know - a rapport to be established with him opposed to that clinical presentation and that assessment process and I think that behaviour certainly indicated that he at that moment was feeling very, very unsafe in that situation.*
>
> *He was the only - from what I could understand, the only Aboriginal person there and there were a lot of medical staff around him, which would have further caused a level of unsafety that - for him to completely disengage and shut down.*[101]

130. I find that the failure of clinicians to engage an AHU staff member during Mathew's in-patient stay, including upon the first signs that he was not engaging on the morning of 12 November 2018 right through to his discharge without offering any culturally-appropriate supports, constituted a series of lost opportunities to talk with Mathew in a culturally safe way and that may have supported his engagement and given the opportunity to short-circuit his escalation at lunchtime on 12 November 2018.

131. I further find that up to six policies in place at the time of Mathew's in-patient stay were breached by a failure to offer the services of the ALO at key points.[102] I concur with Ms Edwige and the submissions of Counsel for the Family that these policies are intended to centre the cultural rights of the specific Aboriginal or Torres Strait Islander individual, to enable person-focused care, and that in the absence of any engagement with the Aboriginal-

[101] T-1046.

[102] I heard submissions from Counsel for the Hospital that the Hospital's policies were mere guidelines and that it was not appropriate to deem any lack of adherence a 'breach'. I am not persuaded by this submission. Firstly, I note that the distinction between a policy and guideline was put to Adj. Professor Callaly, the Clinical Director of Mental Health Services, who indicated that he drew no distinction between the two [T-494]. Further, taking the Clinical Sedation Guidelines as an example, I note that the document is referred to as both a 'guideline' but also a 'policy' specifying a 'minimum standard designed to deliver optimal care to patient', with a note that employees must comply with the policy.

specific aspects of the polices or of the ALO, none of that underlying care can be said to have been provided to Mathew.

132. Finally, I note the evidence of Ms Johnson that the making of a referral to the AHU by a member of a treating team, even today, might be dependent on the staff members involved in a patient's care, including how busy they are, rather than a process required to be adhered to by all staff.[103] Therefore, it may be the case that, while the AHU has been strengthened through the role of Ms Johnson and the suite of enhancements she has overseen in relation to Aboriginal health at the hospital, which I heard evidence of at Inquest, there may be lost opportunities that may yet impact the treatment of Aboriginal patients despite the existence of a strengthened AHU.

133. Accordingly, a series of pertinent Recommendations will follow, which I recommend be considered and/or led by the Director of Aboriginal Health of the Hospital.

134. In so doing, I wish to make it clear that these do not signal any adverse finding against the staff members of the AHU who were employed at the time of Mathew's in-patient stay. To the contrary, the evidence of Mr Portelli and Mr Jones was very useful, and they were both credible and helpful witnesses. I was also reassured that the new role of Director of Aboriginal Health has been created by the Hospital and greatly valued the evidence of Ms Johnson in outlining the systems improvements made since Mathew's passing, including securing approval the day prior to giving evidence for two Aboriginal health workers in the Hospital's ED working seven days a week, as well as for an ALO to cover the weekend shift, which is positive.[104]

135. Finally, I note the evidence of Ms Johnson at Inquest was that, under her leadership, a community-specific approach is being taken to cultural awareness training, noting the specific cultural context in which the Hospital is operating in Mildura, with a higher than average Aboriginal population, including patients from a number of communities across the border in NSW. I consider this to be positive, and also highly relevant to my recommended review of the Hospital's policies and procedures, noting the evidence of Ms Edwige that these could be tailored to be more responsive to the local community:

[103] T-520.
[104] T-527.

The policies and procedures of Mildura Base Hospital in my opinion do not acknowledge the Aboriginal and Torres Strait Islander community in Mildura. They do not reflect their intentions of acknowledging the importance of Aboriginal and Torres Strait Islander understandings of social and emotional wellbeing. They do not acknowledge the importance of culture and cultural healing practices. They do not acknowledge practitioners' commitment to cultural competence and culturally safety. Their policies and procedures in my opinion need to identify how they will work with the community to enhance self-determination, enhance cultural connections and promote cultural healing, address intergenerational trauma and loss and grief through a culturally respectful and responsive lens.[105]

vi. *The knowledge and training of Mildura Base Hospital staff members in de-escalation techniques for patients with challenging presentations*

Police attendance at lunchtime on 12 November 2018

136. At Inquest, I heard evidence that Mathew's behaviour escalated around lunchtime on 12 November 2018 after he was told he could not consume his lunch in his bedroom, but was rather required to take it to the courtyard (which was a compromise offered by Nurse Costello, so that he did not have to eat in the busy dining room). However, upon entering the courtyard, the door swung onto Mathew, causing him to drop his tray and break his plate, which Nurse Costello described as '*pure accident*'. Mathew commenced banging his head and self-harming with a piece of broken plate. Adj. Professor Callaly heard him yell '*I want to kill myself'*.[106]

137. Upon Mathew escalating in the courtyard, a direct call for assistance was placed by the Hospital to Mildura Police Station. A job was put out by Police Communications at 1:08pm, to the effect that '*there is a male in Ward 5 having a psych episode and they can't contain him'*.[107] Two police officers, Senior Constable Lowry (**SC Lowry**) and then-Leading Senior Constable Mattschoss (**LSC Mattschoss**), who were still at the Hospital

[105] CB, p. 1575.
[106] T-443.
[107] AM5-1.

ED after attending another job, attended upon Mathew within a matter of minutes. They called for back-up upon arrival.

138. They observed that Mathew was alone in the courtyard, who in turn was being observed by patients and staff from the dining room, who appeared '*unsure of what to do'*.[108] Mathew was bleeding, distressed, demanding a cigarette, and picking up cigarette 'bumpers' from the ground. He was not approached or spoken to by any member of staff.[109]

139. SC Lowry requested Mathew to come and speak with her through the glass, stating, '*Mathew, I need to come outside and talk to you but I need you to make me feel safe, I need you to go sit over there on that bench'*, to which Mathew replied '*I'm not going to hurt you, I just need a smoke, can you get me a lighter*'.

140. At this point, three key discrepancies arise in the evidence regarding the events that followed, which I will address below.

141. SC Lowry produced a lighter and instructed Mathew to sit down on a bench. Her evidence is that she and LSC Mattschoss were then able to safely enter the courtyard, give Mathew the lighter, and he '*immediately appeared to become less agitated'*.[110] LSC Mattschoss described Mathew as '*calmer*' but '*sad*'.

142. The two police officers conversed with Mathew to determine why he was upset, and the evidence of SC Lowry is that Mathew stated '*They want me to leave, but I'm not ready. I need help, I need medication or something, I can't stop these voices in my head. If they send me away I'm going to go hang myself*', certain parts of which was heard by LSC Mattschoss, and which she has contemporaneous notes of.[111]

143. SC Lowry and LSC Mattschoss gave evidence that they built rapport with Mathew by speaking about his children, and LSC Mattshcoss gave evidence that both she and SC Lowry reassured him that they would get him some help, though Mathew repeatedly stated that it would be better for everyone if he was not there.

[108] CB, Statement of SC Danielle Lowry, p. 51.
[109] SC Lowry stated: '*As we walked in I noticed there was – there seemed to be a lot of people. Whether they were staff, patients, or I'm not sure who, but no one was interacting with Mathew'* [T-607].
[110] CB, Statement of SC Lowry, p. 51.
[111] AM-9 and AM-10.

144. Answering the call for back-up with his partner, Sergeant David Dowell then entered the courtyard and commenced conversing with Mathew. Sergeant Dowell also observed Mathew to be upset but '*certainly wasn't aggressive or – or uncooperative to me at any stage'*.[112] This contrasts to the observation of Dr Kernutt who gave evidence that Mathew was still angry even when police arrived. When this inconsistency in Mathew's demeanour was put to Dr Kernutt, he stated '*I may have been incorrect but that's what I believed at the time*.[113]

145. Noting their lack of equivocality in relation to Mathew's demeanour in the courtyard, I prefer the evidence of the police officers to that of Dr Kernutt that Mathew was very upset but had calmed significantly once a cigarette lighter was provided to him by police.

146. The next point of divergence in the evidence is that shortly afterward, a male clinician entered the courtyard, whom SC Lowry understood to be Dr Kernutt (but agreed could have been Mr Kirby). SC Lowry testified that the male clinician appeared to ignore Mathew and spoke directly to police, informing police that they were going to move Mathew to an isolation room '*where they could sedate him so he was no longer a threat to staff and he would calm down*'. SC Lowry gave evidence that police were then left to explain the plan to Mathew.

147. The evidence of Dr Kernutt is that both he and Mr Kirby entered the courtyard once police arrived. Dr Kernutt stated that he would usually speak directly to a patient and didn't believe he had spoken directly to police officers, but could not recall the details of the conversation, and agreed when it was put to him by Counsel for the CCP that a direct conversation with Sergeant Dowell may have occurred.

148. Accordingly, I also prefer the evidence of the police members that a male clinician (whether Dr Kernutt or another clinician such as Mr Kirby) entered the courtyard and explained the plan to seclude and sedate Mathew directly to police, rather than to Mathew, noting the strong recollection of the three police members and their evidence given about the lack of rapport or engagement between the male clinician and Mathew.

149. Thereafter, Sergeant Dowell explained to Mathew that he would be taken to an isolation room and sedated to help him calm down, to which Mathew agreed. He continued to state

[112] T-642.
[113] T-855.

that he needed help. He asked for cigarettes from his girlfriend and police offered to attend her address to pick some up for him.

150. Police then escorted Mathew to the sedation room, which he attended willingly.

151. This leads to the next point of divergence in the evidence. The evidence of SC Lowry is that she had a conversation with the male she believed to be Dr Kernutt, who she told in relation to Mathew, '*He is not ok, he just told us if he gets sent home he is going to hang himself'*, to which Dr Kernutt reportedly replied '*he is not going to be here much longer*'. When SC Lowry sought clarification, Dr Kernutt is said to have replied '*we don't have room for him here*'.

152. Dr Kernutt does not recall these specific words being uttered, though stated emphatically he would not have said '*we don't have room for him here*'. Indeed, while I heard evidence that the High Dependency Unit (**HDU**) was undergoing renovation at the time of Mathew's in-patient stay, and thus was unsuitable for use, Counsel for the Hospital urged upon me that not all beds in the Low Dependency Unit (**LDU**) were occupied at that point and that there would indeed have been room for Mathew.

153. I note that SC Lowry was adamant that this conversation occurred and these words were spoken; and Dr Kernutt conceded that his words may have been unclear or misunderstood but also gave detailed evidence that he would never discharge a patient based on bed pressure.[114] In these circumstances, I accept that the conversation occurred as per SC Lowry's recollection but for the utterance '*we don't have room for him here*', which I accept may have been the subject of misunderstanding or miscommunication.

154. Ultimately, police are to be highly commended for the way in which they approached Mathew in the courtyard. While I accept that the presence of police can have a calming effect, and that they have tactical options that clinical staff do not have, the evidence was that they were able to calm Mathew just using conversation, and by meeting a simple request of his; for a lighter to have a cigarette (and in the case of Sergeant Dowell, an offer to pick up further cigarettes). They talked about his children and they assured him they would help him.

[114] T-796.

155. In the words of SC Lowry, '*most people we deal with, it's about building rapport with them and finding something that you can connect with that person*'.[115]

The approach of the clinical staff

156. The evidence of Nurse Costello in particular was that she felt frightened and did not necessarily feel equipped to deal with Mathew's heightened presentation, stating that while she was the most experienced nurse on shift, she was very junior at the time of the incident, being on one of her first nurse-in-charge shifts. Nurse Costello also noted that she had completed PART training but that de-escalation training was scarcer at the time of Mathew's in-patient stay (and had since improved in the present day).[116]

157. Mr Kirby gave evidence of the timing of the initial roll-out of Safewards in 2018, noting that not everyone had had the opportunity to complete it during the initial roll-out phase (including Nurse Costello) and gave evidence as to its subsequent re-introduction.[117] Mr Kirby also gave evidence of the introduction of a new Bendigo Health aggression management training program replacing PART, and noted there was no requirement for non-staff members (e.g. locums, such as Dr Kernutt) to participate in aggression management training.[118] Dr Kernutt gave evidence that while he thought he may have completed de-escalation training before, he could not recall the details of this.[119]

158. The evidence before me is that no staff member felt equipped to de-escalate Mathew in the courtyard at lunchtime on 12 November 2018 and all staff members who gave evidence felt very frightened by Mathew and his presentation, to the point where calling the police was perceived as the only option. A/Prof Lakra noted that calling police to be '*an uncommon thing'* and noted that '*management of clinical aggression is one of the core competencies of all staff working at inpatient units*'.[120]

159. I find in these circumstances that knowledge and training of Hospital staff members in de-escalation techniques was limited at the time of the incident involving Mathew. According

[115] T-591.
[116] T-218-9. In terms of training, Nurse Costello had completed PART training ('Predict And Respond To Aggressive Behaviours') but was of the view that Safewards had not been rolled out at the Hospital in 2018 and had not then completed Safewards training, though has completed it since via Zoom – T-207.
[117] CB, Statement of David Kirby, p. 1481.
[118] T-366.
[119] T-943-4.
[120] T-1005; T-1107.

to the evidence of David Kirby, training programs have since been bolstered, as have Hospital staffing levels, including in relation to security personnel.[121]

160. The fact that staff perceived they were poorly-equipped to deal with Mathew's presentation at lunchtime on 12 November led to a Code Grey, then Black, entailing police being called.

161. I do not consider that Hospital staff members ought to have placed themselves in physical danger by immediately entering the courtyard in the context of what they deemed to be an armed threat, given Mathew had a piece of broken plate, or that calling police was improper in circumstances where Hospital staff felt unable to control the situation. I heard evidence from several witnesses, including A/Prof Lakra, that police can have a calming effect on agitated patients.

162. A/Prof Lakra also noted that whether staff can confidently manage aggression or whether they will elect to call police to assist '*really depends upon how threatened they feel. And it also depends upon their skill level'*.[122]

163. However, it is notable that when police arrived they also refrained from entering the courtyard immediately and were able to communicate with Mathew through the glass with raised voices, request him to sit, and provide him with a means by which to have a cigarette. As noted, this did not require the deployment of so-called tactical options but rather just the use of respectful communication.[123]

164. Agitation and aggression in psychiatric in-patient wards are not uncommon and the ability to manage that aggression is very important, through appropriate training, policies and a trauma-informed approach. Therefore, while I find that staff's knowledge and training in de-escalation techniques was limited at the time of Mathew's in-patient stay, I note A/Prof Lakra's evidence that the way in which staff respond to patients' escalating behaviour is determined by the '*perception at that moment on part of the staff at that time*',[124] that staff at the time perceived that a police response was needed, and that aggression management training has now been rolled out more broadly across the Hospital.

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[121] T-292.
[122] T-1106.
[123] T-582. Their strategy harks back to the evidence of Ms Johnson, Ms Edwige and A/Prof Lakra – and, significantly, Mr Portelli and Mr Jones - on de-escalating patients by yarning with them and seeing what's going on for them in a conversational style.
[124] T-1006.

vii. *The extent to which Mathew's challenging presentation impacted upon his treatment options and care provided by Mildura Base Hospital*

165. I concur with the submissions of Counsel Assisting and Counsel for the Family that Mathew's challenging presentation impacted on his treatment and care options at the Hospital, in several notable ways:

    (i) I heard evidence that Mathew's lack of engagement with the treating team at the consultant review on the morning of 12 November 2018 led to a comprehensive MSE being deferred rather than Mathew being engaged through, for example, an ALO, and also led to a refusal to provide PRN Diazepam immediately prior to Mathew's escalation at lunchtime;[125]

    (ii) Hospital staff felt ill-equipped to deal with Mathew's escalating behaviour in the courtyard at lunchtime and considered that calling a Code Grey, then a Code Black which amounts to a request for police to attend, was the most appropriate option in circumstances where they did not feel his risks could otherwise be appropriately contained, which then followed through to his seclusion, restraint and sedation; and

    (iii) The perceived risks to staff and patient safety that persisted as at the time of the psychiatric review at 4:30pm on 12 November 2018 led to Mathew being given the option to remain in the seclusion area or being discharged rather than having the option to be treated on the open ward.

166. I find that Mathew's challenging presentation, based on a lack of engagement on the morning of 12 November 2018, as well as due to being heightened at lunchtime, and due to a perceived threat of violence (bolstered in part due to factors such as the intervention order protecting his partner, his homelessness and his forensic history) impacted on the Hospital staff assessment of risk and his concomitant treatment and care.[126]

167. Consideration of these factors also led to the Hospital excluding Mathew's family involvement in treatment planning and discharge based on assumptions as to Mathew's

[125] I note the submission of Counsel for the Hospital that Mathew was provided with 10mg Diazepam at 10:30am, though the evidence of Dr Kernutt that, in the context of a nurse refusing PRN medication, this should explained by the nurse to the treating team, which did not occur. A/Prof Lakra noted '*so refusal of PRN medication in certain circumstances might be quite appropriate because you want to engage with that person rather than just rely on medications. But on other occasions if the person is experiencing withdrawal symptoms providing PRN medications would be very, very useful to help them relieve of the symptoms they are experiencing*'– T-1001.

[126] See CB, Statement of David Kirby, p. 164; T-297; T-362-3; T-415.

circumstances. Mr Kirby, for example, gave evidence that '*usually we would organise a family meeting and contact with the family to get that collateral information. And, because of the IVO we weren't exactly - and I've got to be honest that we weren't sure of the details of the IVO. But the assumption was made that that would involve not having Mr Luttrell's partner with him within the psychiatric unit*'.[127]

168. Mr Kirby testified further that, despite the fact that Mathew's adult son Aidan was listed as the emergency contact on the file, a decision was made by the treating team not to contact him.[128]

169. This decision and perception of the situation also appears to have led to clinicians' failure to notify Family members of Mathew's discharge or of being placed on an assessment order, restrained and secluded, as required under the MHA (sections 32(2)(a) and 107(a) MHA respectively), though Dr Kernutt gave evidence – extraordinarily, in my view – that he was not aware of this requirement to notify the nominated person of restrictive interventions carried out under the MHA at the time of Mathew's in-patient stay.[129]

170. I accept that part of Mathew's challenging presentation was a threat made towards Mr Matsumoto (described respectively as a threat to slit his throat/cut off his head) and an act of self-harm that led to a Code being called. These two occurrences ought properly to have been factored into any risk assessment (and were). However, I am persuaded by the evidence and the submissions of Counsel for the Family that, through his act of self-harm in the courtyard, Mathew's greatest risk was to <u>himself</u>, and that Mr Matsumoto, knowing Mathew well, was not concerned that the threat that was reportedly made in relation to him would be carried out.

171. Furthermore, there is no evidence that Mathew made any threats of violence to other patients or the treating team. I was particularly unimpressed with the evidence of Mr Kirby in this regard, who indicated in his statement of 17 July 2020 that the decision to enact restrictive interventions was made because Mathew, *inter alia*, was '*throwing objects, threatening nursing staff.*[130]

[127] T-298.
[128] T-327-8.
[129] T-869.
[130] CB. Statement of David Kirby, p. 163.

172. At Inquest, Mr Kirby conceded that he could not recall what threats were made to staff. He also indicated that Mathew was throwing items such as pot plants and ashtrays in the courtyard, though later indicated he could not recall what was being thrown.[131] No other witness gave evidence of threats made to nursing staff or as to items being thrown in the courtyard. Adj. Professor Callaly also resiled from the position that Mathew was '*threatening anyone who came near him*' when questioned by Counsel Assisting,[132] and Dr Kernutt also agreed he had not observed any threats towards staff.[133] I do not accept, on the balance of probabilities, that such threats were made or items thrown.

173. Having regard to the evidence *in toto*, the risk posed by Mathew to others was overemphasised by staff and impacted on the way in which he was dealt with under the MHA from 12 November 2018 onwards. It is significant that certain of Mathew's perceived risks and the way he was managed at the Hospital were based on assumptions about his circumstances that staff failed to seek further information in relation to, and that this impacted his treatment options, particularly when he was found to no longer meet the criteria of the MHA.

174. Furthermore, the weight of the evidence indicates that the means by which to seek such clarity by way of collateral information were not out of reach from the Hospital, even on the Sunday night when Mathew presented there.

175. I heard evidence from Nicole and Brielle that, on the evening of 11 November 2018, being unaware of Mathew's whereabouts, they telephoned the Hospital on the advice of a Family member and were advised that Mathew was an in-patient there. Nicole, Brielle and Aidan's partner Chloe attended the Hospital with some clothing for Mathew and a note they had located that included a suicide plan. Upon attending at the Hospital, Nicole showed the nurse on duty the suicide note (confirmed to be that contained in my brief at AM-8) and pleaded with her; '*Please don't let him out, he's going to kill himself*'. However, the Nurse told Nicole she could not see Mathew due to the presence of the FVIO and the Nurse did

[131] T-335-336.
[132] T-400: 'Ms Giles: *And the evidence before Her Honour is that Mr Luttrell has been described as verbally abusive by Ms Costello, but there's no evidence of threats being made to any staff at the hospital apart from threats to himself, is that your understanding?* Adj. Professor Callaly: *I heard no threats to staff during my time there*.'.
[133] T-853-4.

not use the opportunity to ask questions about Mathew or the stressors he had been facing.[134]

176. The progress notes contain an entry from the nurse at 8pm that records this interaction, noting that Mathew's partner (Nicole) and daughter presented to front door with clothes and toiletries, and noting an IVO would be placed on Mathew tomorrow. The notes record Nicole saying that Mathew has been '*highly suicidal for 3 years'* and she would like to '*sign him in'*. The Nurse advised she could not discuss the patient at length but he was asleep and safe, and that the family were happy with this.[135]

177. Nicole gave evidence that the family were not, in fact, 'happy with this', and that the nurse was rude and dismissive. While the Hospital noted that the nurse answering the buzzer always tried to treat everyone with respect, it accepted that, as noted by Ms Edwige in her expert report, the family left the Hospital that evening feeling diminished, demeaned and disempowered. The Hospital recognises from a systemic point of view, that family members should not leave feeling this way, and recognises this as an area for systemic improvement.[136]

178. This is another lost opportunity on the Hospital's part to seek collateral information from Family around Mathew's challenging presentation and the stressors he was facing, and to engage Family in treatment planning. This is concerning, noting that it not only contravenes Hospital policy but may also have impacted the Hospital's assessment of Mathew's risk. Ms Burnett agreed that where a patient has partial or limited insight, there may be greater concerns about relying on their self-report of history or presentation as it '*may raise their risk'*.[137] This was something Nicole expressed concerns in relation to, and was *why* she attended the Hospital to provide them with information about Mathew's history and circumstances, because '*as if Mat's really going to tell them, you know*?'.[138]

179. Prior to addressing the next scope item, I do wish to revert briefly to the evidence of Mathew's presentation and assessment on 11 November 2018 by Ms Burnett, the ACIS

[134] CB, Statement of Nicole Dempsey, p. 22.
[135] CB, Medical notes, p. 524.
[136] CF, Correspondence from the Hospital to the Coroners Court, 28 April 2022, referring to report of Ms Edwige, CB, p. 1572. I was not provided with any details at Inquest of the way in which this has been concretely addressed by the Hospital or what systemic improvements have been made.
[137] T-169.
[138] T-47.

clinician. Ms Burnett indicated that, upon assessment, '*he was quite distressed. When I first walked into the room he had a blanket over head and he was sitting in the corner of the room*'.[139] Yet Ms Burnett still, commendably, managed to develop sufficient rapport with Mathew to engage him in an assessment that lasted for approximately an hour and to develop a treatment plan in consultation with the on-call psychiatrist. Therefore, I find that Mathew's initial difficulty engaging with Ms Burnett did not appear to impact his assessment at the ED.

viii. *The clinical decisions made at Mildura Base Hospital on 11-12 November 2018 in relation to Mathew, including each decision under the Mental Health Act 2014 to place him on an Assessment Order, to place him in seclusion, to restrain him and to sedate him*

180. I will turn now to the evidence I heard on the clinical decisions made at the Hospital on 11-12 November 2018 in relation to Mathew. In so doing, I note the warning of A/Prof Lakra on the pitfalls of hindsight bias and the need to appreciate the demands of the decision-making of clinicians operating in a complex environment of a mental health ward with high levels of occupational violence, noting the human factors that prevail at any particular point in time, including the level of skill and training of staff.[140] I acknowledge that clinical staff operating in mental health wards are necessarily operating in a challenging environment and that decision-making occurs in a dynamic setting.

181. As urged by Counsel Assisting in closing, I will assess the decisions made under the MHA by clinicians at the Hospital in relation to Mathew through this lens, noting that the environment in which they were operating was one that they found very unusual, frightening and challenging, and that in the case of Nurse Costello, who has, to her credit, given evidence that she has reflected on these events at length and was deeply affected by them, was relatively junior at the time.

a) Assessment

182. I heard evidence that Mathew was assessed at the ED by ACIS clinician Ms Burnett, as detailed above. I note that Mathew was brought in by police on a voluntary basis, and his

[139] T-135.
[140] T-1016-7.

subsequent voluntary in-patient admission appears to have been appropriate. The assessment conducted by Ms Burnett was thorough and sufficiently detailed, and a good basis for subsequent clinical decision-making, and Ms Burnett managed to establish good rapport with Mathew despite him presenting as distressed. This assessment was recorded in the CMI and a summary placed on a temporary file available to the treating team.[141]

183. However, no clinician subsequently involved in Mathew's care or decision-making gave definitive evidence that they read Ms Burnett's assessment in full, which I consider to be most concerning and inconsistent with good or indeed usual clinical practice. The Clinical Director of Mental Health, Adj. Professor Callaly, gave evidence that it would be the usual practice of the consultant psychiatrist to read the CMI notes prior to conducting the review of the patient.[142] The fact that the CMI notes do not appear to have been adverted to at a later point is a lost opportunity in a context where Mathew was refusing to engage, and where a subsequent MSE and assessment scheduled for the morning of 12 November 2018 was deemed not possible. The rich history gathered by Ms Burnett and recorded in the CMI was therefore not harnessed in later clinical decisions in relation to Mathew.

184. I find that the assessment and plan developed by Ms Burnett with on-call psychiatrist Dr Pollock following that assessment was appropriate. However, Mathew's treating team did not fully avail themselves of the plan developed upon assessment. In addition to there being no evidence as to Ms Burnett's detailed assessment being read by Mathew's treating team, I also find it concerning that the recommended substance withdrawal scale was not implemented and the noted physical health issues Mathew was facing were not followed up before Mathew was discharged the following afternoon.

b) Decisions to place Mathew on an AO, and to seclude, restrain and sedate him

185. I heard evidence that:

- At or around 1pm, Mathew was assessed and placed on an AO pursuant to section 30 MHA, which was documented by Nurse Costello to have commenced at 1:15pm;[143]

[141] T-192-3.
[142] T-412.
[143] CB, p. 576. I note for completeness that the times noted in the AO and authorisation for restrictive interventions do not wholly align with that of contemporaneous Police Communications, which would indicate that Mathew was

- At or around 1pm, Nurse Costello authorised Mathew's seclusion 'to prevent imminent and serious harm to another person' under section 111 of the MHA;[144]
- From 1:13-1:15pm, Nurse Costello authorised urgent physical restraint 'to prevent imminent and serious harm' to himself and others;[145]
- At 1:14pm, Mathew was given an injection of 10mg of olanzapine parenterally in his right buttock, authorised by Dr E Wookey;[146]

186. It was the evidence of Professor McSherry, and I was urged by Counsel Assisting to accept this evidence, that the AO was invoked as a vehicle to seclude, sedate and restrain Mathew. Counsel Assisting submitted that the decisions under the MHA to place Mathew on an AO and to seclude, restrain and sedate him were part of the same clinical strategy or course of conduct by Hospital clinicians, informed by their view that no less restrictive means or options were available to assess or contain Mathew where a Code Black had been called, as required by sections 29(d) and 105 MHA.

187. I accept this submission. I consider this 'course of conduct' characterisation to be consistent with the evidence given by clinicians about the sequence of events following the calling of the Code, which appeared to lead inexorably to the conclusion that Mathew was required to be taken into seclusion.

188. Nurse Costello noted that in her view, '*I think a Code Black is pretty clearly go to seclusion*'.[147] Mr Kirby opined on the same terms: *'Um, because of the incident that had occurred, and that we had assessed that there was significant risk to the staff, and also the patient, and also the unpredictability of Mr Luttrell's behaviour - so this is a very complicated situation with a voluntary patient behaving in this manner - that that was - that would have been our risk assessment at that time. Therefore the least restrictive option that we thought was available to us was seclusion'.*[148]

not taken into seclusion until well after 1pm. However, in light of the dynamic situation that was unfolding and of witnesses' evidence that the timings in the AO and other authorisations are approximate, I do not consider this to be an issue requiring further exploration.

[144] CB, p. 583.

[145] CB, pp. 579-81.

[146] CB, pp. 537 and 581.

[147] T-238.

[148] T-340. *See also* Dr Kernutt: '*I think my brief period in the courtyard added to that sense in my mind that something definitely needed to be done and he needed to be removed from that environment, from that situation'* [T-776].

189. The fact that Mathew was a voluntary patient at that stage was clearly an issue in the eyes of Hospital clinicians. While I was urged by Counsel for the Hospital to find this to be erroneous as a matter of law, and that an AO is not necessary an order to seclude a patient, I note the evidence of A/Prof Lakra that, in relation to voluntary patients, '*if you were to use a restrictive intervention, very quickly you also need to make a decision whether the person needs to meet criteria under the Mental Health Act, to be put on assessment order and then that process needs to be initiated.*[149]

190. This is what happened in Mathew's case, and it was clearly on the minds of treating clinicians that Mathew's status as a voluntary patient was an impediment to him being secluded, restrained and sedated. Nurse Costello, who authorised the restrictive interventions and the AO, gave evidence that '*once the decision was [made] to put him into seclusion, I knew that he was under an assessment order, because we can't have a voluntary patient in seclusion*'.[150]

191. Adj. Professor Callaly gave evidence that in his view, '*it was reasonable to make an assessment order to ensure that Mr Luttrell was taken to a safe place, which afforded protection during his assessment, and which ensured he would not leave until the assessment had occurred*'.[151]

192. I find that the evidence demonstrates that the decision to place Mathew on an AO, seclude, restrain and sedate him occurred as part of a single decision-making process to which the requirement for 'less restrictive measures' to be deployed was not individually considered in relation to each action.

193. I find the making of the AO reasonable in the circumstances, given Mathew's heightened presentation and recent self-harm, coupled with the treating team's knowledge of a previous diagnosis of BPD, and that decision appears consistent with the requirements of the four subsections in section 29 MHA.

194. However, in my view, the decision to deploy restrictive interventions was not made consistently with the MHA. Section 105 requires that '*restrictive interventions may only be used on a person receiving mental health services in a designated mental health service*

[149] T-1013.
[150] T-211.
[151] T-395.

after all reasonable and less restrictive options have been tried or considered and have been found to be unsuitable'. The evidence before me was that Mathew had calmed considerably (albeit that he remained upset) in the presence of police.

195. While the requirements of section 29 MHA may have been made out even in those circumstances, the evidence does not point to any less restrictive options being considered by the treating team with respect to sections 111, 114 and 115 MHA. Once the decision had been made that Mathew could not be assessed voluntarily, the full suite of restrictive interventions was deployed in quick succession: seclusion, restraint, and parenteral sedation.

196. I find it was not reasonable or justifiable to authorise restrictive interventions under sections 111, 114 and 115 MHA in circumstances where Mathew had calmed, was accepting of medication, and had made no threats to Hospital staff, and in the absence of evidence as to '*all reasonable and less restrictive options being tried or considered and found unsuitable'*.

197. The weight of the evidence does not indicate that all reasonable and less restrictive options had been tried or considered and found unsuitable as required by section 105 MHA. Mathew, having calmed, was not asked if he would take medication orally, which would have vitiated the need for restraint to administer it parenterally. It is not established on the evidence that clinicians considered whether Mathew could have been taken to another interview room in the LDU to be assessed rather than being placed in seclusion. As noted above, in Nurse Costello's evidence, who authorised the restrictive interventions, '*I think a Code Black is pretty clearly go to seclusion*'.

198. Based on these factual findings I am able to adopt the position advanced by Professor McSherry, to find that in secluding, restraining and parenterally sedating Mathew, the conditions of the MHA were not met and Mathew's rights to liberty, physical integrity and legal capacity were limited, and such limitations were not reasonably and demonstrably justifiable given that he agreed to be given medication to sedate him and had calmed.[152]

199. In A/Prof Lakra's evidence about what might comprise 'less restrictive means', he indicated that '*it allows you to run your imagination a little bit'*[153] – considering use of

[152] CB, Expert Opinion of Professor McSherry, p. 249.
[153] T-1094.

cascading measures of less restrictive character such as an HDU being less restrictive than a seclusion room, or LDU with staff being less restrictive than use of the HDU.

200. Indeed, certain of the options for 'less restrictive means' in Mathew's case resided clearly in the very policies of the Hospital, such as the obligation to offer medication orally prior to parenteral administration – an option that in fact is required under the Clinical Sedation Guidelines – but which does not appear to have considered or pursued in Mathew's case.[154]

201. I also find that the MHA requirements were not complied with insofar as the authorisation of restrictive interventions. Under the MHA, these can only be authorised by the senior registered nurse on duty if the authorised psychiatrist or delegate is unavailable. I heard evidence Nurse Costello was required by the treating team to authorise the seclusion and restraint of Mathew despite Dr Kernutt's availability, and Dr Kernutt conceded that it was he who had made the decisions to carry out these interventions, and ought more properly to have made the relevant authorisations.[155] I do not consider this an appropriate burden to place on a junior staff member who has been deeply impacted by the events of this day, noting her evidence that '*it was very much the treating team made a decision and I followed their orders'*.[156]

c) Mental state examination of Mathew at 4:30pm and revocation of AO

202. I accept that whether or not Mathew continued to meet the criteria under the MHA at 4:30pm when seclusion ceased, having been placed an AO at 1pm and administered olanzapine at 1:13pm, was a matter of clinical judgment on the part of Dr Kernutt. Adj. Professor Callaly and A/Prof Lakra gave evidence, respectively, that they would not place themselves in Dr Kernutt's shoes, and, in the case of A/Prof Lakra: '*It's a clinical decision at that time within the framework of the Act and I always try to not to judge that decision in hindsight because I think it puts us in a slightly difficult position'*.[157]

203. I accept that it is difficult to question Dr Kernutt's assessment at 4:30pm that Mathew no longer met the requirements under the MHA for compulsory treatment and thus the AO

[154] I heard evidence from A/Prof Lakra that parenteral administration of olanzapine would have a much quicker effect than oral administration [T-1102]; notwithstanding, I note that the offer of orally-administered medication was not made to Mathew.
[155] T-868-869.
[156] T-255.
[157] T-493; T-1092.

was required to be revoked, based as it was on his clinical judgment, considerable experience and contemporaneous assessment of Mathew's mental state.

204. However, I am deeply troubled by the considerations that fed into that assessment. I heard evidence that: (i) Dr Kernutt had not read the full and comprehensive assessment conducted by Ms Burnett the previous afternoon;[158] (ii) Dr Kernutt deferred a comprehensive MSE of Mathew on the morning of 12 November 2018 due to his lack of engagement, and thus the 4:30pm MSE was the first he had conducted; (iii) the notes of Nurse Costello reflect that Mathew indicated at lunchtime that he was '*guaranteeing his safety on the ward however states if he was to leave ward he would reattempt suicide'*;[159] (iii) Mathew had been assessed by Nurse Costello at 2:45pm some two hours before he was discharged, as being a '*high'* risk of suicidality and self-harm;[160] (iv) the purpose of the AO was to conduct a comprehensive MSE; (v) the MSE Dr Kernutt conducted lasted, according to the clinical notes, a maximum of 9 minutes (during which time a physical assessment was also completed of Mathew and his discharge options explained); (vi) that assessment was conducted in the seclusion room, described by Aboriginal staff members as '*akin to a gaol cell'*, surrounded by numerous people (up to eight, according to Nurse Knight),[161] and during which Mathew's engagement reportedly remained limited; (vii) no collateral information had been sought or obtained from Family, MDAS or treating psychiatrist Dr Wijekoon; and (viii) no ALO involvement had been considered, sought or obtained. I find that Dr Kernutt's assessment was based on limited information, limited rapport with Mathew, and conducted within an inexplicably limited time period.

205. Hospital policy and accepted clinical practice would have required Dr Kernutt to, at a minimum, contact Family and obtain collateral information to inform his assessment of Mathew. There is no compelling evidence before me as to why this did not occur, and why the services of an ALO were not engaged by the treating team, or why the assessment was conducted in such a heavily truncated timeframe. In accordance with the MHA, Dr Kernutt had a full 24 hours from the time the AO was invoked in which to conduct a comprehensive

[158] '*I don't recall reading that, um, assessment from the point of view of when that may have occurred. Ah, it's most likely that I did not read that assessment in full'* - T-743.
[159] CB, Medical notes, p. 527.
[160] CB, p. 546.
[161] AM-14-2.

mental state assessment to determine the presence or absence of mental illness; only a sixth of that time had elapsed at the time Dr Kernutt revoked the AO.

206. A further issue of concern to me is the consideration given by the treating team to Mathew's diagnosis by Dr Wijekoon. While Mathew was initially assessed as suffering from a situational crisis upon his presentation to the Hospital (albeit one with Cluster B personality traits), the purpose of the AO was to ascertain the presence or absence of mental illness within the meaning of the Act. Dr Kernutt had information before him that Mathew had a diagnosis from Dr Wijekoon of BPD but did not appear to accept the diagnosis, instead stating Dr Wijekoon '*obviously had an opinion based on her initial assessment of Mr Luttrell, and we would take that into account, but ultimately our responsibility is to get all of the information and make our own decision'*.[162]

207. However, the collateral information relating to Dr Wijekoon's diagnosis was simply never obtained. It was Mr Kirby's evidence that '*the incident on the day really prevented - and the - the manner of Mr Luttrell's discharge prevented us from obtaining additional collateral information'*.[163] This is not supportable. Mathew was in seclusion for over three hours. There was ample time, in my view, for collateral information to be obtained, noting the evidence of Dr Kernutt that discussions were ongoing about Mathew '*all afternoon'*.[164]

208. Despite this, there appeared to be no attempts to contact his Family or treating psychiatrist. The failure to do so was a missed opportunity that strayed from usual clinical practice and led to the 4:30pm MSE being conducted without the aid of key information and in the absence of any culturally-specific or Family supports.

209. I also note the arguments of Counsel for the Family that the assessment and treatment of Mathew by the Hospital was compromised by a denial that personality disorders such as BPD could constitute a mental illness within the meaning of the MHA. Nurse Costello, Mr Kirby and Dr Kernutt all gave evidence that BPD cannot constitute a mental illness within the meaning of the MHA. Adj Professor Callaly at one point provided a slightly more nuanced view, accepting that BPD could present in a way that fulfilled the MHA criteria,

[162] T-756. While I accept the need for treating psychiatrists to form their own view of a patient's diagnosis and treatment (noting also in this regard A/Prof Lakra's comments at CB-794 regarding sodium valproate as treatment in context of the diagnostic consideration), I do not consider this to vitiate the requirement to obtain collateral information.
[163] T-279.
[164] T-903.

particularly when a situational crisis was also present, a position with which A/Prof Lakra concurred.[165]

210. As a Coroner, I do not purport to make findings as to whether or not BPD is a mental illness. However, the position that a personality disorder is not a mental illness, which Mr Kirby acknowledged to be that of an 'old-school' clinician, does not appear to be supported by contemporary clinical practice. I note that evidence was produced during Inquest of the Royal Australian and New Zealand College of Psychiatrists (**RANZCP**), the body responsible for training, educating and representing psychiatrists in Australia and Aotearoa New Zealand of a guide on BPD which explicitly described BPD as 'a mental illness'.[166] In those circumstances, it appears arbitrary position to take that BPD cannot constitute a mental illness for the purposes of the MHA.

211. Literature suggests that people with BPD have high rates of contact with inpatient and community mental health services. BPD affects between 1-6% of the general population, yet those with BPD comprise 23% of outpatients and 43% of inpatients in Australia.[167] It is therefore essential that mental health clinicians, particularly those in public mental health services, feel equipped to manage patients with BPD, especially when presenting in crisis. I am concerned that Hospital clinicians did not appear to accept the position of the RANZCP as being consistent with their own clinical view, and consider it may perpetuate a view that contributes to the stigmatisation of conditions such as BPD which impact the effective treatment of those conditions.[168]

d) Recommencement of seclusion for 2 minutes at 4:39pm

[165] T-1036.
[166] AM-12-1.
[167] Lawn S, McMahon J. Experiences of care by Australians with a diagnosis of borderline personality disorder. Journal of Psychiatric Mental Health Nursing. 2015 Sep;22(7):510-21. doi: 10.1111/jpm.12226
[168] T-1197, as per submission made by Counsel for the Family. I note further that the 'old-school' view of personality disorders has been eschewed across a number of disciplines. The law, in some contexts, has traditionally treated consideration of personality disorders differently to other mental health conditions. In a sentencing context, for example, the case of *DPP v O'Neill* (2015) 47 VR 395 had previously excluded personality disorders from consideration by the courts in assessing whether impairment of mental functioning can be considered as a mitigating factor in a person's sentencing in accordance with the principles from *R v Verdins* (2007) 16 VR 269. However, on 25 August 2020, the Victorian Court of Appeal held in *Brown v The Queen* [2020] VSCA 212 that a person diagnosed with a personality disorder should be treated in a similar manner to any other person who seeks to rely on an impairment of mental functioning as a mitigating factor in their sentencing.

212. During Inquest, it became apparent that there was a lacuna in the evidence before me regarding the recommencement of Mathew's seclusion at 4:39pm for a two-minute period. This was recorded in the clinical notes available,[169] but there was no other evidence or authorisation for a further period of seclusion on Mathew's medical file.

213. Accordingly, I sought a statement from Nurse Ashleigh Knight, who had entered the clinical notes regarding this further period of seclusion. Ms Knight was the nurse-in-charge on the afternoon shift on 12 November 2018, which extended from 1:30pm to 10pm.[170] In the circumstances, I did not require Nurse Knight to give *viva voce* evidence at Inquest.

214. Nurse Knight's statement confirms that Mathew was secluded between 4:39pm and 4:41pm in order for the nurse to collect his belongings. No corresponding authorisation occurred for this restrictive intervention. It follows that Mathew was unlawfully secluded immediately prior to discharge, which constituted a clear breach of the MHA and his human rights to liberty, physical integrity and legal capacity. While Nurse Knight noted in her statement that Mathew '*did not seem to mind that the seclusion room door was shut'*, it is unclear what this observation was based on, noting further that Nurse Knight states that she did not explain to Mathew the purpose of the further period of seclusion.

215. I received evidence during Inquest that the Chief Psychiatrist has issued a guideline noting that confinement of a person that meets the MHA definition is seclusion, even if the person agrees to, or requests, such confinement.[171]

216. I do not consider this incidence of unlawful seclusion to be less troubling because of its short duration. I note that Mathew left the Hospital at 4:42pm, immediately after being released from seclusion at 4:41pm. The evidence of Mr Kirby was that Mathew had then escalated from calm to angry:[172]

> *During the course of the assessment with Dr Kernutt, Mr Luttrell was calm, and denying any thoughts of hurting himself or other people. Once the decision had been made - or the options that were presented to Mr Luttrell regarding, the staying in the seclusion area, or potentially discharge, Mr Luttrell had wanted to re-enter the open unit. We said that wasn't an option*

[169] CB, p. 533.
[170] AM-14.
[171] AM13-3.
[172] T-333.

at that stage, so he then made the decision to leave the building. He was obviously unhappy with that. And as he was leaving the building, that's when he started to become angry'.

217. I note that Mathew's unlawful seclusion immediately preceded this further escalation and, given his previous desire to leave seclusion, may have precipitated or contributed to this heightened state. Indeed, the evidence before me was that, following his release from a second period of seclusion at 4:42pm, Mathew uttered the words '*I'll see you in an hour'*.

218. Hospital clinicians appear to have interpreted this as a threat, though Mr Kirby conceded at Inquest that it may in fact have been an expression of a need for further help.[173]

219. I consider that this period of seclusion breached the MHA and Mathew's human rights, including his right to liberty and physical integrity.

ix. *Mathew's discharge from Mildura Base Hospital in close temporal proximity to being placed on an Assessment Order, including the treatment options provided to him prior to discharge and degree of subsequent discharge planning and follow-up*

220. The nature of the treatment options put to Mathew following his MSE at 4:30pm were a point of some contention during Inquest. There was evidence before me that Mathew was offered two options – remain in the seclusion room or area (**Option 1**), or be discharged with supports in the community (**Option 2**). His expressed desire was to return to treatment on the open ward, which the treating team did not offer to him, as he was considered to be a risk to staff and other patients.

221. In relation to Option 1, I find that, if Mathew was indeed offered the option to be in the seclusion **area** rather than the seclusion **room**, which is not recorded in Dr Kernutt's detailed progress notes and thus which is not established in the contemporaneous evidence, this option in any event would have amounted to seclusion under the definition of s3(1)

[173] Per Mr Kirby, T-333-4. The person who heard this utterance appears to have been Nurse Knight, who described Mathew as being '*happy and somewhat smug'* when he made this utterance (AM14-4), and afterwards yelling things but not in an angry tone. This is at odds with the evidence of Dr Kernutt and Mr Kirby on Mathew's heightened presentation as he left the Hospital, which I prefer.

MHA given that there is no evidence that Mathew was told he would have been free to leave.[174]

222. This would be the case, in my view, whether or not a staff member was intended to be present with Mathew. I note the evidence I heard at Inquest that logistics involving staff supervision had not otherwise been decided upon by the treating team as of 4:30pm, which, in my view, is not consistent with this nursing option being put to Mathew. Had Mathew accepted the option at that point, it would have been required to be deployed immediately given that he no longer met the criteria to be detained under the MHA – the fact that the plan was still in motion at the time it was reportedly presented to Mathew demonstrates in my view that no real consideration was given to keeping Mathew in seclusion with a staff member present.

223. A pertinent Recommendation will follow.

224. Of further concern with the use of the seclusion room or area as a treatment option for a voluntary patient is that it is not a trauma-informed solution. I have evidence before me that Mathew had asked to leave seclusion at 3:45pm and did not wish for his seclusion to be prolonged.[175]

225. Yet the evidence of Mr Kirby was that the very purpose of Mathew remaining in seclusion was to keep him alone. When it was put to him by Counsel for the Family that if one was in a seclusion room even with the door open, one would still be very isolated from the rest of the unit, Mr Kirby responded '*Yes. And I've - that was part of the intention*.'[176] I find this deeply concerning in light of the information known by the Hospital about Mathew being alone, particularly as an Aboriginal man, noting that Adj. Prof Callaly agreed at

[174] The evidence of Dr Kernutt on this point was as follows: '*Ah, I'm not even sure whether it was locked or unlocked. Um, ah, it would certainly be important, obviously, to - to - that would be part of the discussion, um, what will be - well, can I say, legally appropriate. How - what is the correct - what would be the correct way to have someone like Mathew kept in that part of the hospital? Would that door be open or closed? I think it would depend on his cooperation. If - if there was a nurse there, one on one, for 24 hours, then if he was, ah, agreeable and cooperative there would be no reason for that door to be locked. I think it would be - it was in the area of having to - that would have to be sorted out when that plan was put - I don't know. I might have been told, 'Look, it's not - it's not possible, your plan about keeping - having Mathew stay in this part of the ward if that door is closed for other reasons'. I may have been told that. I don't know. It didn't - I didn't get to that point of actually going through the steps with the director of nursing'* [T-815].

[175] CB, Medical notes, p. 585 – '3:45pm. Standing near door. Asking to be let out'. *See also* AM14-3 – per Nurse Knight – '*Mathew came across as someone who had participated in a mental state examination before, and I think he was cautious to not say anything that would extend his period of seclusion*'.

[176] Per Mr Kirby, T-342.

Inquest that '*a seclusion room is not a safe place for anyone, really. Particularly for someone like Mr Luttrell, of course, with his [cultural] background*'.[177]

226. In relation to Option 2, Mathew was not offered culturally-specific follow-up options in the community and one of the progress notes suggests Mathew was encouraged to call MDAS for support, when in fact police had been called by the Hospital due to the alleged threat against a MDAS worker. Thus, MDAS support was clearly not viewed by the Hospital as an appropriate option for Mathew and cannot be retrospectively relied upon as evidence that culturally-appropriate discharge support was available to Mathew. I note that Ms Johnson, Mr Jones and Mr Portelli all gave evidence that providing appropriate discharge supports to Aboriginal and Torres Strait Islander patients – including their families - is critical.[178]

227. The evidence before me is that, following Mathew's departure, Dr Kernutt had made the following note in Mathew's clinical notes:

> *He should not be readmitted to hospital due to the unacceptable risks posed to patients and staff… police may need to be called if he returns to Mildura Hospital.'*[179]

228. I concur with the opinion of Professor McSherry and find that the two options provided to Mathew, along with the note that Mathew was not be readmitted to the Hospital if he presented there, constitutes a breach of his human rights, including to the highest attainable standard of healthcare, for the following reasons. As I have noted earlier, Hospital clinicians appear to have emphasised Mathew's purported risk to others over all other considerations. The evidence of Dr Kernutt was that, as of 4:30pm, Mathew guaranteed he would not harm himself or others.

229. His treating team appeared to accept there was no risk Mathew would harm himself, despite being assessed a 'high' risk of suicide just two hours earlier; indeed, Mathew's AO was revoked and discharge options presented to him.

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[177] T-414-5.

[178] *See for example* the evidence of Ms Johnson, T-529 – '*It's so important, and it's important because the person that's being discharged – it's not just about them either, the Aboriginal liaison officer being involved in the discharge planning is also – like, we see it important or the family to understand what's going on, because they can also help if – it depends on the health needs of that person being discharged'.*

[179] CB, p. 532.

230. However, the treating team did not appear to accept that Mathew would not harm <u>others</u>, and he was denied treatment on the open ward as a result. The treatment options presented to him were ill-considered and strayed far from trauma-informed practice.[180]

231. Option 1 does not appear consistent with the permissible uses of seclusion under the MHA and would have been deeply traumatic to someone with lived experience of prison, noting the evidence that the seclusion room was akin to a gaol cell and could never be culturally safe for Aboriginal people. In particular, it ignored the fact that Mathew had indicated to clinical staff that '*he can't be alone because when he is alone he forgets about his protective factors'*, which were his children.[181]

232. Option 2 appears to fall well short of Mathew's complex needs, noting that Mathew was being knowingly discharged to homelessness without any prescriptions, without any Family contact, without any ALO assistance, with identified physical health issues, and a history of declining ACIS follow-up[182] – directly into the events comprising the 'situational crisis' he had been initially assessed as facing.

233. Finally, I have considered Dr Kernutt's explanation of the note that Mathew was not to be readmitted, namely that he was satisfied that if Mathew returned to the ED, he would be assessed and treated as appropriate. In circumstances where Dr Kernutt had noted a directive for police to be called if Mathew returned to 'the Hospital' (rather than directly to Ward 5), it is unclear as to whether he would indeed have been assessed and treated via ED in circumstances where there was a directive to the contrary from a senior clinician.

x. <u>*The extent to which the policies and procedures of Mildura Base Hospital were followed in relation to the decision made to admit, detain under an Assessment Order and discharge Mathew, and the extent to which the policies and procedures of Mildura Base Hospital were followed to ensure that Mathew, an Aboriginal man, was provided with culturally-appropriate support whilst an inpatient*</u>

[180] It is clear that the Hospital recognises the risks associated with discharge; see AM6-113, which contains the Clinicians Reference Guide: '*Discharge/transfer of care is associated with increased risks. The period immediately prior to hospitalisation or directly after discharge appears to be associated with a particularly high degree of suicide risk*'.
[181] CB, p. 517.
[182] CB, p. 599.

234. I heard evidence of what I consider to be breaches of a number of Hospital policies and procedures. As previously noted, I do not consider these documents to represent optional guidelines, as submitted by Counsel for the Hospital; indeed, the opposite is specified in each document as 'minimum standards' all staff are expected to adhere to.[183]

235. Mr Kirby gave evidence that the role of policies is to constitute an interpretation of guidelines and best practice standards from the Chief Psychiatrist's Office, best practice clinical standards and their application to the local environment, as well as a way to operationalise the principles behind the Mental Health Act and National Standards for Mental Health. Critically, Mr Kirby also gave evidence that human rights were considered or operationalised through the Hospital's policies, and agreed that they provided a means of assistance for clinical staff working in a challenging environment.[184]

236. Their significance is therefore not to be understated.

237. The evidence before me was that the breaches of policy include:

a) Failure to offer the services of an ALO at point of MSE; seclusion; restraint; sedation;

b) Failure to offer oral medication on 12 November 2018 in lieu of parenteral administration, as required by the Clinical Sedation Guidelines as a first option;[185]

c) Failure to collect collateral information from Dr Wijekoon, MDAS or Family (a requirement contained in MSE and Clinical Risk Assessment Guidelines); and

d) Separately, there was also a failure to adhere to MHA requirements for an authorised psychiatrist or delegate to authorise restrictive interventions where available, and to inform the nominated person upon the invoking of an assessment order and/or authorisation of restrictive interventions, and an apparent lack of knowledge as to both of these latter requirements.[186]

A pertinent Recommendation will follow.

EXPERT EVIDENCE

[183] CB, p. 173; CB, p. 184; CB, p. 191; CB, p. 202; CB, p. 215, CB, p. 224.
[184] T-270-1; T-288.
[185] I also note A/Prof Lakra appears to raise whether administration of olanzapine rather than a benzodiazepine also constituted a 'lack of adherence' to the Clinical Sedation Guidelines.
[186] T-788; T-869.

238. I have adverted to certain of the evidence put forward by the Court's experts in this matter, namely Professor McSherry, A/Prof Lakra and Ms Edwige. Prior to making my formal comments, recommendations and findings, I wish to express my gratitude to these witnesses (as to all witnesses who gave their time to assist my Inquest) and to note that the opinion evidence of these witnesses was of great assistance to my consideration of the issues within the scope. I have considered their evidence as a whole in reaching my conclusions, and the relevance of their evidence is not restricted to the explicit references made within this Finding.

AMBIT OF THE FINDINGS AVAILABLE UNDER SECTION 67(1)(C) OF THE ACT

239. I will take the opportunity prior to making formal Findings to address the permissible ambit of the findings I can make as to 'circumstances' under section 67(1)(c) of the Act.

240. This was raised as an issue by Counsel for the Hospital in closing submissions, who submitted that, as a threshold matter for making findings, it would be '*beyond the Court's jurisdiction'* to make findings, as opposed to noting such matters in the background facts, which related to Mr Luttrell's diagnosis, treatment and care at the Hospital.[187] This was said to be due to the fact that, in the submission of the Hospital, there was no contributory element or causative link between the conduct of Hospital clinicians and Mathew's decision to take his own life.

241. I heard submissions from Counsel Assisting on this issue at the closing hearing of this Inquest, wherein it was submitted that the Hon. Justice Coate held in the Inquest into the Death of Tyler Cassidy that the meaning of '"*circumstances in which the death occurred*" is a matter for the Coroner to interpret in each case, guided by the scheme of the Coroners Act as a whole, with particular assistance from the preamble and purposes provisions'.[188]

242. In this connection, it was put to me that the preamble of the 2008 Act explicitly recognises that a purpose of the coroner's investigation is to make findings and to reduce the number of preventable deaths and fires and promote public health, safety and the administration of justice. Section 1(c) of the Act states that a purpose of the Act is to contribute to reducing

[187] CF, Outline of Closing Submissions on behalf of the Hospital, dated 1 June 2022.
[188] Finding into death with inquest of Tyler Cassidy, 23 November 2011, (COR 2008 5542), referring to the judgment of The Hon. Justice Beach in *Thales Australia Limited v The Coroners Court of Victoria & Anor* [2011] VSC 133 (***Thales***).

the number of preventable deaths and fires through coroners making findings and recommendations. Under section 67(3) of the Act, I may comment on any matter connected with the death, including matters related to public health and safety or the administration of justice. Similarly, under section 72(2) of the Act, I may make recommendations on any matter connected with a death I have investigated, again including matters related to public health and safety or the administration of justice.

243. Counsel Assisting noted that I had sought submissions on the preliminary scope of Inquest with input from Interested Parties as early as August 2021, and that since that time, it had been demonstrably clear that my intention was that Mathew's admission to the Hospital following a reported suicide attempt, and his apparent suicide within hours of discharge of his in-patient stay, would form the backbone of the Inquest and would be the basis of any concomitant findings of this Court. It was put to me that the Court's jurisdiction to make findings as to Mathew's diagnosis, treatment and care at the Hospital, including under section 67(1)(c) of the Act, is by no means absent for purported want of a causal nexus to Mathew's passing, noting that:

- The circumstances in question revolve around an apparent suicide occurring approximately 19 hours after discharge from the Hospital where the deceased had been previously admitted due to a suicide attempt, ongoing suicidal ideation and an act of self-harm at the Hospital to which there were multiple eyewitnesses. This is not a situation akin to *Harmsworth* in which the Court has conducted a wide-ranging enquiry with a view to exploring any suggestion of a causal link, however tenuous, between some act, omission or circumstance, but rather an examination of the clinical care provided in the hours before the deceased suicided, and that is well within my jurisdictional limits.

- Secondly, the Act has significantly changed since the 1989 case of *Harmsworth* was decided, and which related to review of decisions made in the course of an Inquest being conducted under the 1985 Coroners Act. There was no explicit requirement under the 1985 Act to make a finding as to circumstances in which a death occurred, as there is under the 2008 Act, and under section 67(1)(c) of the current Act, I am required to make Findings, if possible, into the circumstances of deaths I am investigating.

- Thirdly, the *Charter of Human Rights and Responsibilities Act 2006* (**the Charter**) has also been enacted since *Harmsworth* was decided, which gives rise to obligations for

Coroners to, *inter alia*, conduct an effective death investigation (as a corollary to the right to life per section 9) and to make findings as to any breaches of Charter rights as they appear on the evidence and, respectively, make comments or recommendations on human rights issues that may be connected with deaths they are investigating.[189] It was Counsel Assisting's submission that, given the scope of this Inquest and evidence before the Court, I would be unable to discharge my statutory obligations, viewed through the lens of the Charter, without making findings as to Mathew's in-patient stay.

- Finally, it was submitted that my power to comment and make recommendations is engaged in respect of 'any matter connected with the death'. Justice Muir in *Doomadgee v Clements* [2006] 2 Qd R 352 held that there was no warrant for reading 'connected with' as meaning only 'directly connected with', a proposition with which Justice Beach concurred in *Thales*. In the present circumstances, I consider the policies and procedures of the Hospital are matters that are connected with Mathew's passing within the meaning of section 67(3) and section 72(2) of the Act and may constitute a valid basis for comments or recommendations.[190]

244. I accept the submissions of Counsel Assisting and Senior Counsel for the Family on the ambit of the findings open to me under section 67(1)(c) of the Act.

COMMENTS

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

1. Mathew's human rights were demonstrably and unjustifiably breached a number of times during his in-patient stay at the Hospital. Given he presented to the Hospital following a reported suicide attempt, self-harmed at the Hospital and took his own life within hours of leaving the Hospital – after explicitly saying he would do so – in my view, his in-

[189] As to the applicable law regarding the Charter and the Coroners Court, I concur with the analysis of my colleague Coroner Simon McGregor, contained in the Finding into the passing of Veronica Nelson, delivered on 30 January 2023, at Appendix A thereto.

[190] *See in full* T-1134-T-1139. *See also* Submissions made on behalf of the Family, T-1185-6 & T-1191: '*It is absolutely clear in our respectful submission that the nexus of the events at the hospital to Mathew's death is – that they were highly relevant to the circumstances of his death. That does not mean we are putting the proposition that it was causal, or that but for what happened there it would never have happened, but that is not necessary, Your Honour*'.

patient stay clearly forms part of the circumstances of his passing and I am at liberty to make comments thereupon.

2. Notwithstanding the seriousness of the breaches of Mathew's human rights that I have outlined in this Finding, and despite the failure to adhere to a number of policies and accepted standards of clinical practice by the Hospital during Mathew's short in-patient stay, I cannot definitively say his passing could have been prevented in perpetuity. The lessons that may be learned from the Inquest into Mathew's passing have been identified with the benefit of hindsight. I must acknowledge that the evidence before me is that Mathew faced chronic suicidal ideation and had a long history of suicide attempts from a very young age. It cannot now be known if the long-term outcome would have been different if the care of the Hospital had been more responsive to Mathew as an Aboriginal man during his in-patient stay, had he been meaningfully engaged and had his human rights not been breached, but in the short term, and at least as of 13 November 2018, I consider that Mathew's passing was preventable.

3. I have carefully considered the evidence before me that Mathew went from a man who avoided seeking help for his suicidality due to his fear of being admitted to Ward 5, as recently as 22 October 2018, to someone who walked most of the way to the Hospital on a Sunday in November 2018 to try to get the help he needed, despite that fear. Indeed, Mathew, a person who was known to police, voluntarily got into a police car to travel the last few minutes to the Hospital. His Family attended the Hospital that same day – a rare opportunity to obtain collateral information about a patient outside business hours – and their evidence is that they were turned away by the nurse on duty.

4. In light of the foregoing, and by way of comment, with the exception of the assessment of Mathew conducted by Zoe Burnett, Mathew's time at the Hospital and his discharge was characterised by the inability of most clinicians to establish a respectful and trauma-informed therapeutic relationship with him. Mathew had presented in a crisis state and was highly suicidal; the responsibility to engage him lay with the clinicians whose care he was in.

5. I make comment that there are inherent contradictions in the evidence of the Hospital clinicians; Mathew was believed by clinicians at 4:30pm on 12 November 2018 when he

said he would not harm himself and thus could be released from the Hospital's care; but he was not believed when he said he would not harm others and was denied the opportunity to return to the open ward because of the fear that he would. Similarly, Mathew's stay in Hospital was said to be of such a brief nature that it was difficult to have got to know him and treat him; but his stay was so short in part due to the failure to establish a therapeutic relationship by the clinicians involved in his care. Instead of being permitted to be treated on the open ward alongside other voluntary patients, at 4:30pm on 12 November 2018, he was offered the option to stay in the seclusion room; a room described by multiple witnesses as akin to a gaol cell, described as culturally unsafe for any Aboriginal person, described as '*just that reminder'*.[191]

6. Underpinning this is the omission of Hospital clinicians involved in Mathew's treatment to involve Mathew's Family, deciding that the presence of an intervention order precluded this option, even at a time when Mathew's Family had shown up to support him and to seek help on his behalf.

7. Therefore, while it cannot be said that the Hospital caused Mathew's passing in perpetuity, given the tragic outcome that followed his discharge, any potential for improvement should be identified, considered and pursued. The Hospital made very limited concessions in the course of this Inquest; this led to numerous witnesses having to be called and issues ventilated by way of the Inquest hearings. The two concessions appear to be that families should not leave the hospital feeling disempowered and that this is an area for systemic improvement, and secondly, that had they been available, offering the services of an ALO would have been an appropriate step to attempt to engaging Mathew and to making him feel safe and culturally supported.

8. There were certain Hospital witnesses who demonstrated insight into what they could have done better and where improvements can be made, with the benefit of hindsight, and as noted by counsel for the Hospital, adverse findings ought not to be made against individual clinicians in the absence of an exactness of proof. A/Prof Lakra in particular encouraged improvement of systems rather than scrutinising the decisions of clinicians in the calm of the courtroom.

[191] T-555 per Derik Jones.

9. One such 'systems improvement' identified by the Expert Panel through Professor McSherry was the enhancement of the human rights culture of the Hospital and the need for this to be supported through adequate resources and staffing.[192]

10. In circumstances where I consider Mathew's human rights to have been breached at several points during his interactions with the Hospital by the clinicians involved in his care, I make comment that the human rights culture of the Hospital indeed requires attention, close consideration and improvement, and I will proceed to make a series of recommendations explicitly aimed at this.

11. Prior to doing so, I also refer to my earlier findings in relation to the voluntary transport of members of the public to mental health facilities by police. I make a comment inviting the **Chief Commissioner of Police** to consider including guidance in the Victoria Police Manual in cases where police members transport members of the public to a hospital or mental health facility on a *voluntary* basis, rather than under section 351 of the *Mental Health Act 2014*, to provide all available handover information to the hospital or mental health facility assuming care of the person, with the person's consent as necessary, to replicate the handover information required to be provided under the current L42 form. This will assist to ensure that the value added by police transport and access to such information can be appropriately harnessed. It will also ensure clinicians have as much information as possible to assess, diagnose and/or treat people presenting to health services voluntarily for mental health reasons.

12. I also note that, tragically, Mathew's passing forms part of a pattern in the Mildura Region of disproportionate suicidality and self-harm amongst the First Nations communities residing there, often in the context of substance misuse, diagnoses and suspected mental ill health, experience of abuse as both victim and perpetrator, and in some cases, consequent involvement with the criminal justice system, and recent or threatened separation from and/or conflict with a partner. Analysis of the Victorian Suicide Register reveals that, compared to other regional Victorian local government

[192] T-986.

areas, Mildura had the highest average annual suicide rate per 100,000 residents across the period 2010-2019, with a rate of 35.5 suicides per 100,000 Mildura residents.[193]

13. I consider the following recommendations to constitute a critical step in addressing the specific systemic issues that arose in relation to Mathew's passing in the context of the broader incidence of suicide and self-harm of Aboriginal people living in and around Mildura.

14. Finally, by way of comment, I consider that **MDAS** should identify appropriate staff who would benefit from training in the management of Borderline Personality Disorder, and seek training appropriate to the role of their staff.

[193] Per Deputy State Coroner Hawkins in the Finding into the Passing of Boe Memery, issued on 30 August 2022, and Finding into the Passing of Jaymii Mott (Green), issued on 31 August 2022.

RECOMMENDATIONS

Pursuant to section 72(2) of the *Coroners Act 2008* (Vic), and with the aim of promoting public health and safety and preventing like deaths in the context of mental health service delivery, I make the following recommendations connected with the passing:

1. Jointly, **to the Hospital and MDAS**: As a matter connected with Mathew's passing, I make a recommendation to MDAS and the Hospital to finalise an MoU or other form of agreement that relates to information-sharing, to enable timely and direct communication between MDAS and Hospital treating teams where common patients or clients present in crisis, that allows for the sharing of patient information to assist in timely treatment planning and diagnoses.

2. **To the Hospital, to be led by the Director of Aboriginal Health or as appropriate**, I make recommendations aimed at addressing the cultural safety of the Hospital and the way in which the AHU is engaged to support patients, as follows:

   a) That the cultural awareness training described in the evidence of Ms Johnson[194] is appropriately resourced and rolled out to staff working at the Hospital in the Mental Health Unit, as a matter of priority, with a plan in place for refresher training for all staff on a recurrent basis. This training should be a requirement not only for staff members but for locums and all persons working in the Mental Health Unit.

   b) That the Director of Aboriginal Health and the staff of the AHU be given the opportunity to be consulted on all policies of the Hospital with the view of improving their cultural safety. Where these policies state that services of an Aboriginal Liaison Officer be offered to Aboriginal patients, consideration should be given to introducing a system in which wards are required to inform the AHU of the presence of an Aboriginal patient and arrange for an AHU staff member to attend to the patient and introduce themselves and make that offer of support directly;[195]

[194] CB, p. 1486-7, T-520-1.
[195] It is noted that, during Inquest, Ms Edwige, Ms Johnson, Mr Portelli, and Mr Jones all supported this course T-1049-50, T-539; T-676; T-563.

c) That the AHU is resourced to ensure that all AHU staff have culturally appropriate clinical supervision arrangements where sought by and agreed to by AHU staff;[196] and

d) That all clinicians at the Hospital Mental Health Services be: (i) advised of the role of the AHU upon induction; and (ii) required to document in a patient file the steps made to contact the AHU in relation to Aboriginal patients, including any reason why such contact has not been made.

3. Further to the **Hospital**, I recommend the following:

a) That consideration be given to revising Hospital Mental Health Service policies and procedures to clarify: (i) who in the mental health treatment team is responsible for collecting collateral information, and at what stage; and (ii) that the authorised psychiatrist or delegate must always complete authorisations for restrictive interventions where that person is available;

b) That the Hospital work with Spectrum:

i. To identify appropriate training for clinicians in diagnosis and treatment of Borderline Personality Disorder, which addresses both long term treatment and crisis presentations;

ii. Such training should be mandatory for all community and inpatient mental health clinicians;

iii. Such training should occur for all new staff as a part of their induction, and for ongoing staff should be regular and repeated.

c) That the Hospital engage the Victorian Equal Opportunity and Human Rights Commission to provide education to its staff to assist them to meet their Charter obligations; and

d) That the Hospital engage the Victorian Equal Opportunity and Human Rights Commission under section 41(c) Charter to review its policies and practices with a view of strengthening their systems and processes to comply with the Charter.

[196] As per the comments of Ms Edwige - T-1052.

4. **To the Secretary to the Department of Health**, **via its Mental Health and Wellbeing Division or as otherwise appropriate,** I recommend:
   a) That the Department of Health ensures the rollout of the World Health Organisation QualityRights e-training across all designated mental health services as a matter of priority;[197] and
   b) That the recommendations of the Royal Commission continue to be implemented in full, through the Mental Health and Wellbeing Division of Department of Health or as appropriate, with an update to be provided to the Court in relation to the implementation of recommendations 23, 26, 33, 35, 37, 40, 42, 44, 53, 54, and 55.[198]

5. **To the Secretary to the Department of Health, via the Chief Psychiatrist or as otherwise appropriate**: I recommend that consideration be given to clarifying the definition of 'seclusion' in the context of the new Mental Health and Wellbeing Act (including by way of issuing an updated OCA guideline) in order to crystallise whether seclusion relates to: (i) the confinement of a patient alone to an area in which they cannot leave; (ii) the confinement of one or more patients to an area in which they cannot leave; and (iii) whether the definition of seclusion is met if a staff member is present.[199]

CONCLUSIONS AND FINDINGS

Findings

I have made a number of pertinent findings as to the circumstances of Mathew's passing throughout this Finding, based on the weight of the evidence, that I shall not repeat here.

Having applied the applicable standard to the available evidence, I make the following Findings pursuant to section 67(1) of the *Coroners Act 2008*:

1. I find that Mathew James Luttrell, born 27 September 1975, passed on 13 November 2018 at Etiwanda Avenue, Mildura, Victoria 3500, in the circumstances outlined above.

[197] As per evidence of Prof. McSherry T-986; T-1101.
[198] Referred to at Inquest and by Prof McSherry; T-1072-4.
[199] I note that the evidence of the Court's experts differed in this regard T-1080: Professor McSherry cf. A/Prof Lakra, and consider there is a need for absolute clarity to ensure mental health services are treating patients consistently with the legislation.

2. I find that the failure of Mildura Base Hospital to seek cultural support for or collateral information in relation to Mathew James Luttrell from Family or treatment providers impacted upon the understanding of his clinical presentation and stressors he was facing. As a consequence, decisions in relation to his medical care, treatment and management during his short in-patient stay from 11-12 November 2018 were made on the basis of incomplete and inaccurate information.

3. Similarly, I find that Mildura Base Hospital failed to ensure that Mathew James Luttrell was provided culturally-specific care and treatment during his in-patient stay from 11-12 November 2018, and also failed to provide culturally-specific follow-up options or support for his discharge on 12 November 2018.

4. While the making of an Assessment Order in relation to Mathew James Luttrell on 12 November 2018 at approximately 1.00pm was reasonable in the circumstances, I find that the decision to deploy restrictive interventions was not consistent with the relevant requirements of the *Mental Health Act 2014* (Vic) and constituted a breach of Mathew's human rights to liberty and physical integrity.

5. I find that the seclusion of Mathew James Luttrell between 4.39pm and 4.41pm on 12 November 2018 to be unlawful and constituted a clear breach of the *Mental Health Act 2014* (Vic) as well as of Mathew's human rights, including his right to liberty and physical integrity. I direct the Hospital to report this unauthorised period of seclusion to the Chief Psychiatrist, in compliance with the *Mental Health Act 2014* (Vic).

6. I find that the notation of 12 November 2018 that Mathew James Luttrell '*should not be readmitted to hospital due to the unacceptable risks posed to patients and staff… police may need to be called if he returns to Mildura Hospital'*, along with the options presented to Mathew at discharge, constituted a breach of his human rights, including to the highest attainable standard of healthcare.

7. I accept and adopt the medical cause of death ascribed by Dr Gregory Ross Young, and I find that Mathew James Luttrell, an Aboriginal man with an extensive history of mental ill health, passed as a result of hanging, in circumstances where he intended to take his own life.

8. I have considered carefully whether the outcome would have been different for Mathew James Luttrell if Mildura Base Hospital had been more responsive to him as an

Aboriginal man, been meaningfully engaged with him and not breached his human rights during his in-patient stay.

9. I have determined that Mathew's suicide was indeed preventable as at 13 November 2018, given his clinical presentation and mode of discharge the afternoon prior, though cannot say it was preventable in perpetuity given his longstanding mental ill health and chronic suicidality.
10. Further, I find that there were the many opportunities missed to intervene in the course of events immediately preceding his passing and that there was a failure to provide Mathew James Luttrell with care and treatment in a way that responded to his complex health needs and afforded him with cultural safety, dignity and respect.

I convey my sincere condolences to Mathew's family for their loss following his passing.

PUBLICATION OF FINDING

Pursuant to section 73(1) of the Act, unless otherwise ordered by a Coroner, the Findings, Comments and Recommendations made following an inquest must be published on the Internet in accordance with the rules, and I make no such order.

DISTRIBUTION OF FINDING

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

Mathew's Family, via the Victorian Aboriginal Legal Service

Chief Commissioner of Police

Corrections Victoria

Mallee District Aboriginal Services

Mildura Base Public Hospital

Ramsay Health Care

Secretary to the Department of Health

Office of the Chief Psychiatrist

Professor Bernadette McSherry

Associate Professor Vinay Lakra

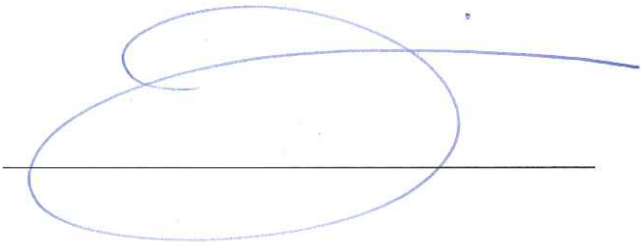
Ms Vanessa Edwige

Detective Senior Constable Dellas, Coroner's Investigator

Australian Health Practitioner Regulation Agency

Victorian Equal Opportunity and Human Rights Commission

Signature:



Date: 16 May 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.