Rule 63(1)

IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2018 2140

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 63(1)

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

Inquest into the death of: JAMIE ANDREW KOWALEWSKY

Findings of:	AUDREY JAMIESON, CORONER
Delivered On:	13 December 2022
Delivered At:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank 3006
Hearing Dates:	3 August 2022
Appearances:	Mr Michael Thorne – Maurice Blackburn – acting for Ms Caryn Kowalewsky Mr Karen Lui – K & L Gates – acting for Melbourne Health – NorthWestern Mental Health
Counsel Assisting the Coroner:	Sergeant Tracy Weir, Police Coronial Support Unit

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I, AUDREY JAMIESON, Coroner having investigated the death of JAMIE ANDREW KOWALEWSKY

AND having held an Inquest in relation to this death on 3 August 2022

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

find that the identity of the deceased was JAMIE ANDREW KOWALEWSKY

born on 3 October 1990

died on 7 May 2018

at Northern Health – Northern Hospital, 185 Cooper Street, Epping Victoria 3076

from:

1 (a) GLOBAL CEREBRAL ISCHAEMIC INJURY IN THE SETTING OF HANGING

In the following summary of circumstances:

Jamie Andrew KOWALEWSKY was located hanged by mental health clinicians in his room in the in-patient psychiatric unit at NorthWestern Mental Health where he had been admitted as a voluntary patient. He was 27 years of age at the time of his death.

BACKGROUND CIRCUMSTANCES

1. Jamie Andrew KOWALEWSKY[1] was born in Greensborough on 3 October 1990 to parents Caryn Kowalewsky (**Ms Kowalewsky**) and Andrew Kowalewsky. Jamie had one sister named Meg Kowalewsky (**Meg**).

2. Jamie grew up in Craigieburn and attended primary and secondary school, completing year 9. From the age of 19 until his death, Jamie lived between his mother's home in Roxburgh Park and the home of his late grandfather, George Kowalewsky in Coolaroo, Victoria. In most recent times, Jamie resided alone at 3 Marcus Crescent, Coolaroo.

[1] With the consent of Jamie Kowalewsky's family he was referred to as "Jamie" during the course of the Inquest. For consistency, save where formality requires, I have also referred to him as Jamie throughout the Finding.

Mental Health Issues

3. At eight years of age, Jamie told his mother that he had been sexually assaulted by a classmate while at school. This incident was reported to police and went on to have a negative impact on Jamie's emotional and mental state for the rest of his life.

4. At 14 years of age, Jamie's parents separated, placing additional emotional stress on Jamie. He commenced residing exclusively with his mother and his relationship with his father became more distant. Around this time Jamie divulged to his mother that he had suicidal thoughts for the first time in his life and had taken recreational drugs.

5. At 20 years of age, Jamie attempted to take his own life (by gassing himself in his vehicle) on a background of problematic relations with his then girlfriend, and a subsequently strained relationship with his sister, Meg. Jamie also had a forensic history, where he had been charged with making a false report to police and was ordered to pay $14,000.

6. Jamie otherwise worked multiple jobs including at a water tech company, a steel manufacturer, and a pest control officer. Throughout this time, Jamie's mental health further deteriorated as he continued to use drugs. In addition, Jamie's paternal grandfather passed away in 2015, further impacting Jamie's mental health.

7. By 2018, Jamie's drug use had continued to the detriment of his mental health, culminating with him being prescribed anti-depressant medication. Jamie maintained a sporadic approach to work while his mother and maternal grandfather (Edward McMillan) did their best to assist and support him, although Jamie began to push his family away.

8. In approximately January 2018, Jamie stopped working and told his mother he was in receipt of Centrelink payments; however, he would often ask her for money. Ms Kowalewsky offered to pay for Jamie's general bills and groceries as she did not want to hand over money to her son for fear, he would use it to purchase illicit substances.

Hospital Admission

9. On 23 April 2018, Jamie asked if he could stay at his mother's house as his electricity had been cut off. He disclosed that he had not been receiving Centrelink payments as

Ms Kowalewsky had suspected. She felt that Jamie's mental health was spiralling out of control, but she did not want him to stay at her house due to the strained relationship between Jamie and his sister Meg, so she offered to stay with him at his house. He refused this offer from his mother, but as she was so concerned for his welfare, she convinced him to let her take him to the hospital the following day. He was originally reluctant to go, but eventually agreed.

10. On 24 April 2018, Ms Kowalewsky took Jamie by agreement to the Northern Hospital to undergo an assessment for his mental health. While at the hospital Jamie disclosed that he had been contemplating taking his own life. He acknowledged thoughts of trying to kill as many people as he could by driving into them to have police attend and shoot him. Jamie disclosed that he had a long history of crystalline methylamphetamine (ICE) addiction and cannabis use. Jamie agreed to admission as a voluntary patient in the low dependency unit of the Northern Psychiatry Unit and was managed by nursing staff under the medium risk observations.

11. On 25 April 2018, a Public Holiday, Jamie was assessed by the on-call psychiatrist, Dr Tharini Ketharanathan (**Dr Ketharanathan**) with a nurse present. He reported depressive symptoms since January 2018, feeling low, unmotivated spending all his time in bed and had significant weight loss. It was assessed that his depression was related to his drug use. Jamie had confirmed his suicidal and homicidal thoughts, however assured that he had no intent to undertake any such act while in the Unit. Ms Kowalewsky attempted to visit Jamie on this day but was told by nursing staff that he was "too angry" for a visitor. However, later in the day Jamie called his mother and asked for clothes and cigarettes.

12. On 26 April 2018, a review of Jamie's condition was conducted by consultant psychiatrist Dr Kausik Goswami (**Dr Goswami**) and intern Dr Rebecca Greenop (**Dr Greenop**) with a nurse present. During this review Jamie stated he was embarrassed by his earlier comments about his homicidal thoughts, and he did not want to die or end up in jail for the rest of his life. Jamie spoke about his heavy use of ICE and cannabis indicating he used illicit drugs daily, and the drugs might be the problem. Jamie spoke about grieving for his grandfather whom he had a strong attachment to and had not dealt with that grief. He had an ex-girlfriend who had a child that he cared about and

stated that this child was his only interest. The overall impression of Dr Goswami was major depression in context of substance use disorder on a background of antisocial and possibly borderline personality traits. There was no evidence of psychosis, and he was noted as being brighter than the previous day.

13. Dr Goswami held a family meeting with Jamie and Ms Kowalewsky, where his diagnosis was discussed. Ms Kowalewsky indicated she understood the concerns and Dr Goswami discussed the need for inpatient admission at NorthWestern Mental Health for approximately one week targeted at mental state stabilisation and risk mitigation. Leave of absence was also discussed in the presence of Ms Kowalewsky at this meeting. Dr Goswami's recollection of this discussion was that it was unanimously agreed by Jamie and his mother that due to Jamie's high risk of drug use and ease of access while on leave he would benefit from leave accompanied by his mother. This was planned for 2 hours over the weekend but only if Jamie was assessed as safe for leave in terms of risks to self/others and risk of substance use. Jamie remained on medium risk whilst on the Unit.

14. On Friday 27 April 2018, a medical review was conducted by intern Dr Greenop at which time Jamie expressed a desire to take leave from the hospital with his mother. During the review Jamie stated he was unsure if he would feel safe while on leave when it came to his mental health and drug use. As a result, a decision was made to not authorise leave for Jamie due to concerns his drug use would resume. Jamie was made aware of this decision; however, this was not communicated to Ms Kowalewsky until the following day.

15. On Saturday 28 April 2018, Ms Kowalewsky visited Jamie around midday, although he was asleep when she arrived. Ms Kowalewsky stepped out for a while and Jamie eventually called her saying he would like to see her. Upon returning to the ward, Ms Kowalewsky was informed that Jamie's weekend leave had been cancelled, causing him to be really upset.

16. Ms Kowalewsky remained with Jamie until around 6.30pm. At approximately 11.30pm, they contacted each other via a Facebook video call, where Ms Kowalewsky thought Jamie to be in good spirits.

SURROUNDING CIRCUMSTANCES

17. On the morning of 29 April 2018, Jamie was given his morning medication in his room. He appeared settled in mood/behaviour, denying suicidal or homicidal thoughts. At approximately 10.00am Jamie requested and was administered Lorazepam medication for anxiety. He was later observed by staff to be "animated and energetic". Around 11.15am, Jamie became uneasy and complained of cravings before requesting Olanzapine medication around 11.30am.

18. Nurse Aby Mathew (**Nurse Mathew**) was working in Jamie's Unit and made observations of Jamie at approximately 12.00pm. He denied suicidal ideation or thoughts of self-harm to Nurse Mathew. At the time, he was watching videos in his room which he said was to distract himself from thoughts of drug use. He insisted on his safety whilst on the Unit.

19. At approximately 12.30pm, Ms Kowalewsky called Jamie. He was upset and crying. He would not explain why he was upset, stating he did not wish to discuss it. He hung up on his mother at 12.32pm. Ms Kowalewsky immediately contacted the hospital to inform the nurse-in-charge that Jamie was upset, and she asked them to check on his welfare. Nurse Praddeep Chandravathy (**Nurse Chandravathy**) spoke with Ms Kowalewsky on the telephone then went and spoke with Jamie. Nurse Chandravathy recalls Jamie stating he was fine and denied any concerns. He did however request that his mother be asked not to visit that day. At 12.39pm, Nurse Chandravathy telephoned Ms Kowalewsky to relay the message from Jamie that he did not wish her to attend that day.

20. Ms Kowalewsky recalls this telephone call with Nurse Chandravathy at 12.39pm and says that the nurse described Jamie as teary. In the course of the investigation, Nurse Chandravathy made two statements, neither describe Jamie as being teary at that time.

21. Shortly after the 12.39pm telephone call between Nurse Chandravathy and Ms Kowalewsky the nurse went back to Jamie's room. He thought Jamie appeared anxious and asked him to come out of his room. At that time, Jamie denied any risk to himself.

Nurse Chandravathy recalls seeing Jamie standing at the nurse's station and in the communal area but noted limited interaction with his peers.

22. At around 1.00pm, Nurse Mathew went to check on Jamie. Nurse Mathew found Jamie lying on the floor of his bedroom with a sheet wedged between the toilet door frame and toilet door. The bed sheet was tied around Jamie's neck. A Code Blue was activated, cardio-pulmonary resuscitation (CPR) was commenced, and a return of circulation was achieved. He was admitted to the Intensive Care Unit for ventilatory support and assessment. Over several days he was observed to have suffered severe hypoxic brain injury on clinical assessment, imaging and EEG. After 8 days in the ICU it was the medical opinion that Jamie would not make any meaningful recovery from his injury. Following discussion with his family it was agreed to withdraw cardiorespiratory supports. The family also expressed a desire for Jamie to become an organ donor after he died but unfortunately although approved by the Coroner, donation did not occur.

23. On 7 May 2018, life support was discontinued, and Jamie was pronounced deceased at approximately 11.38pm.

JURISDICTION

24. Jamie's death was a reportable death under section 4 of the *Coroners Act 2008* ('the Act'), because it occurred in Victoria, and was considered unexpected, unnatural or to have resulted, directly or indirectly, from an accident or injury. In addition, Jamie's death was reportable under section 4(d) because immediately before his death he was a patient within the meaning of the *Mental Health Act 2014*.

PURPOSE OF THE CORONIAL INVESTIGATION

25. The Coroners Court of Victoria is an inquisitorial jurisdiction.[2] The purpose of a coronial investigation is to independently investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[3] The cause of death refers to the medical cause of death,

[2] Section 89(4) *Coroners Act 2008*.

[3] Section 67(1) *Coroners Act 2008*.

incorporating where possible the mode or mechanism of death. For coronial purposes, the circumstances in which death occurred refers to the context or background and surrounding circumstances but is confined to those circumstances sufficiently proximate and causally relevant to the death and not merely all circumstances which might form part of a narrative culminating in death. [4]

26. The broader purpose of coronial investigations is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of recommendations by Coroners, generally referred to as the 'prevention' role.[5] Coroners are also empowered to report to the Attorney-General on a death; to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.[6] These are effectively the vehicles by which the prevention role may be advanced.[7]

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

28. 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. The death of Jamie Kowalewsky did not strictly fall within the purview of s52(2) as he was a voluntary patient immediately before his death and thus not within the definition of "a person placed in care". Nevertheless, and worthy of note, he was in a designated mental

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

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

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

[7] See also sections 73(1) and 72(5) of the Act which requires publication of Coronial Findings, comments and recommendations and responses respectively; section 72(3) and (4) which oblige the recipient of a Coronial recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation.

health facility, and he had his leave refused/revoked arguably making his circumstances analogous to a patient on a compulsory order and thus "in care".

29. Nevertheless, section 52(1) of the Act further provides that a coroner may hold an inquest into any death that the coroner is investigating. 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. 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.

30. Having regard to all of the above, it was appropriate for an Inquest to be held.

31. This finding draws on the totality of the material; the product of the Coronial Investigation into the death of Jamie. That is, the court records maintained during the Coronial Investigation, the Coronial Brief and further material sought and obtained by the Court, including submissions received from the Interested Parties and from Counsel Assisting, Sergeant Tracy Weir.

32. In writing this finding, I do not purport to summarise all of the evidence but refer to it only in such detail as appears warranted by its forensic significance and the interests of narrative clarity. The absence of reference to any particular aspect of the evidence does not infer that it has not been considered.

STANDARD OF PROOF

33. All coronial findings must be made based on proof of relevant facts on the balance of probabilities. In determining whether a matter is proven to that standard, I should give effect to the principles enunciated in Briginshaw v Briginshaw. [8] 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:

[8] (1938) 60 CLR 336.

- 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.

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

INVESTIGATIONS PRECEDING THE INQUEST

Identity

35. On 7 May 2018, Caryn Maree Joy Kowalewsky visually identified her son Jamie Andrew Kowalewsky at the Northern Hospital and completed a Statement of Identification.

36. The identity of Jamie Andrew Kowalewsky was not in dispute and required no further investigation.

Medical Cause of Death

37. On 9 May 2018 Dr Heinrich Bouwer, Forensic Pathologist and the Victorian Institute of Forensic Medicine (VIFM) performed an external examination of the body of Jamie Andrew Kowalewsky and had available to him the Police Report of Death to the Coroner (form 83), the E-Medical Deposition Form and medical records from Northern Health and a post mortem computed tomography (CT) scan.

Toxicology

38. No antemortem specimens were available from the hospital to enable an analysis of drugs in Jamie's blood at the time of death. Post mortem toxicological analysis identified drugs administered in hospital.[9]

Forensic pathology opinion

39. On completing his report on 29 June 2018 Dr Bouwer commented that in the absence of a full post mortem examination, on the basis of the information available to him and at the time of his external examination, and in the known circumstances, a reasonable cause of death would appear to be global cerebral ischaemic injury in the setting of hanging.

Coroners Prevention Unit[10]

40. The Coroners Prevention Unit (**CPU**) prepared an issues paper to assist any Coroner investigating a ligature-involved suicide in an in-patient mental health unit. The CPU initially completed a review and provided a summary of deaths involving ligatures among Victorian mental health inpatients between 2000 – 2017[11] then updated their review on 2 July 2020 and most recently on 28 January 2021 to incorporate the period between 1 January 2000 and 31 December 2020. CPU classified the following types of suicides as ligature-involved suicides for the purposes of preparing the issues paper:
    - **Hanging**. This requires a ligature point in the environment to which the person can attach the ligature, and which can bear the load of the person pulling against

[9] Delta-9-tetrahydrocannabinol (the active form of cannabis) was detected in post mortem blood at a level of ~8ng/mL

[10] The Coroners Prevention Unit was established in 2008 to strengthen the prevention role of a coroner, the CPU assists coroners with research in matters related to public health and safety. The Unit also reviews the medical care and treatment administered to patients in matters referred to it by a coroner where concerns have been identified. The CPU is comprised of health professionals with training and skill in a range of areas including medicine, nursing, public health and mental health. Any review undertaken by the CPU on behalf of the Coroner is intended to provide clarity to matters that are in dispute and assist the Coroner to determine whether further investigation is warranted, including by way of expert report, or whether there is sufficient material on which to finalise the investigation.

[11] Coroners Prevention Unit review of "Ligature-involved suicide among the Victorian Mental Health In-Patient Units for the period 1 January 2000 – 31 December 2017", dated 29 January 2018.

it (usually by using body weight) to tighten the ligature and achieve strangulation.

- **Ligature strangulation**. This involves the person manually tightening the ligature using their hands or other parts of their body (for example, tying the end of the ligature to their feet and tightening it by straightening their legs).

41. These two ligature-involved suicide methods are linked by a common prevention issue: how the person obtained and used a ligature to suicide in the controlled environment of an inpatient mental health unit.

42. In this most recent review, the CPU identified 75 ligature-involved suicides in Victorian inpatient psychiatric units between 2000 – 2020[12]; the majority (72 of 75, 96.0%) were hangings. As of 28 January 2021, Coroners had completed their investigations and delivered their Findings for 59 of the 75 relevant deaths. The CPU identified 17 Findings in which Coroners made recommendations about ligature points. In Findings where recommendations about ligature points were not made, Coroners often commented on related issues. In most cases the Coroner noted that the health service had taken steps to eliminate ligature points and reduce hanging risk.

Conduct of my Investigation

43. The investigation and the preparation of the Coronial Brief was undertaken by Senior Constable Thomas Gillam on my behalf.

INQUEST

Direction Hearing/s

There were 3 Court hearings listed to aid in the advancement of my investigation:

- Directions Hearing 6 November 2020 – Senior Constable (SC) James Kett, PCSU, appeared to assist.
- Mention Hearing 18 August 2021 – SC Kett, PCSU, appeared to assist.
- Directions Hearing 18 November 2021 – SC Kett, PCSU, appeared to assist.

[12] And included the death of Jamie Kowalewsky at Northern Hospital on 7 May 2018.

Interested parties in this investigation actively provided material such as additional statements, expert opinions, and submissions for consideration. At the last Directions Hearing it was agreed by all parties that provision of further material would be sufficient for the court to make a determination and finding by way of a Summary Inquest.

Submissions/material received from Maurice Blackburn Lawyers

44. On behalf of Caryn Kowalewsky, Maurice Blackburn Lawyers consistently submitted that the care provided to Jamie by NorthWestern Mental Health (NWMH) throughout his admission in April 2018 was inadequate and as such his death was preventable. They sought and provided to the Court expert opinions from Forensic Psychiatrist Dr Michael Giuffrida (**Dr Giuffrida**) and Consultant Forensic Psychiatrist Dr Jacqueline Rakov (**Dr Rakov**). The latter expert did not provide a written report/expert opinion and I was provided only with notes/comments taken during a zoom conference.

45. In his report/expert opinion dated 15 April 2019, Dr Giuffrida opined that Jamie should have been assessed as high risk and ought to have been admitted to the High Dependency Unit with at least initially continuous arms-length observation, with the frequency of engagement and monitoring to continue at 15-minute intervals to detect any deterioration in his mental state. He was also critical of the pharmacological treatment plan, in that the failure to adequately manage Jamie pharmacologically probably contributed substantially to his suicide risk. It was his view that if he had been treated with adequate doses of the antidepressants as described in his report along with the antipsychotic medication Olanzapine, that there would have been a substantially reduced likelihood of Jamie acting on his suicidal ideation.

46. Apparently due to time constraints, Dr Rakov only provided an "expert opinion" by way of notes from what I was advised was a zoom conference with Maurice Blackburn representatives. Although not in a format that would be acceptable to any Court as an expert opinion, I note that Dr Rakov was also of the opinion that Jamie should have been assessed as high risk. She was of the view that even as a medium risk patient, it was possible for more restrictive management such as for more frequent observations be utilised. Dr Rakov was critical of the lack of attention to Jamie's substance withdrawal and thought it would have been appropriate to put him on a withdrawal plan

to help manage his symptoms which could cause agitation, irritability, mood swings, hallucinations, and insomnia. However, she did not agree with Dr Giuffrida's opinion that Jamie's anti-depressants should have been increased in that short time frame, or an anti-psychotic used at anti-psychotic doses without further exploration of psychotic symptoms. With reference to both Dr Giuffrida and Dr Rakov's opinion, it was submitted that it was open for Jamie to have been made an involuntary/compulsory patient and be housed in the High Dependency Unit with adequate supervision.

47. In addition to the expert opinions, Maurice Blackburn submitted that Ligature Safety is of significant concern at NWMH. Whilst it is was noted it was commendable any steps were taken by NWMH to mitigate risks in relation to the door ligature points, more needs to be done. Accordingly, they submitted that a recommendation be made to an appropriate person or body such as the Chief Psychiatrist of Victoria to further investigate the use of door ligature points in hospitals.

Submissions/Materials from Melbourne Health – NorthWestern Mental Health (NWMH)

48. K & L Gates Lawyers on behalf of Melbourne Health had been cooperative with my investigation and in their final submission they detailed the materials provided to the Court. Of significance was the letter from NorthWestern Mental Health Director of Operations, Peter Kelly who stated, "ligature safety in acute mental health inpatient units, and in ensuite bathrooms in particular is a complex and evolving issue." Consideration had been given to the therapeutic aspect of the rooms along with privacy and dignity for the patients. For a room to be stripped of fittings such as furniture and equipment that could be seen as ligature points, can create a custodial environment and be seen to be detrimental to the patient. NWMH has strenuously sought government funding to improve the ligature safety of its buildings and facilities. They also have in place a ligature safety audit tool, have updated rooms when funding has been available, has strongly advocated for more funding to improve existing rooms and has ensured that all new rooms are built to the highest possible standard. Whilst cost prohibitive for NWMH to update their 219 existing acute rooms (estimated at a cost between $4.38 to $6.57 million), the 98 new mental health beds have ligature safety as the "first order"

issue for the architectural design of these new beds. NWMH has also submitted capital grant applications to the Victorian Health Building Authority (VHBA) and the Department of Health for a further upgrade of the Royal Melbourne Hospital and Sunshine Hospital Adult Acute Psychiatry Unit. It was submitted that NWMH has taken a proactive approach to managing and improving ligature safety.

49. In relation to the psychiatric management of Jamie, a further statement was provided by Dr Goswami which sought to clarify some issues around concerns raised by Jamie's family. Jamie had been admitted under the care of Consultant Psychiatrist Dr Goswami whilst at NWMH.

50. An expert opinion was also provided from Professor Nicholas Keks (**Professor Keks**) providing an overall assessment of the treatment provided to Jamie whilst at NWMH. This expert opinion was extensive and stated that Dr Goswami's management was entirely consistent with clinical practice that would have been adopted by the majority of competent psychiatrists in the circumstances.

51. NWMH submitted that Dr Goswami, as an experienced Consultant Psychiatrist made his assessments based on firsthand clinical observations and the weight of his assessments should be higher than those assessments made years after the event from the written record alone, noting that care must be taken to hindsight reasoning.

52. NWMH submitted that the *Mental Health Act* 2014 requires the least restrictive means to be used and that to apply an involuntary order on a patient who was compliant would be inappropriate and possibly counterproductive.

53. Finally, they submitted that at its highest, there is a difference of opinion between experts as to how Jamie should have been managed at the time and that does not justify any criticisms of the clinicians involved in the care provided to him.

54. A Summary Inquest was held on 3 August 2022. No witnesses were called. I was Assisted by Sergeant Tracy Weir (**Sergeant Weir**) from the Police Coronial Support Unit who provided a Summary of the investigation and the issues identified as depicted above. Sergeant Weir made the following Submissions in Conclusion:

Ligature Safety

55. Whilst the family maintain that ligature safety at NWMH is still a real and live issue, NWMH have provided extensive material explaining that funding is the primary issue to upgrade the current 219 acute beds which is cost prohibitive. They have indicated that 98 new mental health beds have been allocated to NWMH, and ligature safety is a "first order" issue, with reference to a new design of approved fittings and fixtures. NWMH have also acknowledged that they are continuing to make grant applications where appropriate to the Victorian Health Building Authority (VHBA) and the Department of Health to further upgrade the Royal Melbourne Hospital and Sunshine Adult Acute Psychiatry Unit. They continue to take a proactive approach to managing and improving ligature safety.

Psychiatric Management of Jamie Kowalewsky

56. Both interested parties, through their legal representatives, Maurice Blackburn and K & L Gates, provided expert opinions to support their client's point of view. Professor Keks provided an extensive expert opinion supporting the assessment and subsequent treatment of Jamie at NWMH. He was of the view that risk management of Jamie, assessed as being medium risk, was consistent and appropriate in the circumstances. He was also supportive of Jamie being admitted on a voluntary basis. Dr Guiffrida and Dr Rakov were critical of the assessment of medium risk of Jamie believing he should have been either admitted as an involuntary patient or at least should have had more frequent observations in the Low Dependency Unit. Professor Keks was provided with the extensive opinion of Dr Guiffrida, and notes from a zoom conference call with Dr Rakov. Neither the report or notes provided caused Professor Keks to change or qualify his opinions. Effectively, the experts have differing opinions regarding the assessment and treatment in these circumstances.

Observation time

57. On Sunday 29 April 2018, Jamie had maintained the Clinical Risk Assessment and Management (CRAAM) rating as medium risk with 60-minute observations. At 12.39pm, Ms Kowalewsky stated she received a phone call from Nurse Chandravathy stating that Jamie was teary and did not want her to come in that day. Nurse

Chandravathy provided 2 statements, and in neither statement did he describe Jamie as teary, however he did state that after this phone call at 12.39pm he again went and checked on Jamie in his room and found him to be anxious. Whilst Jamie denied any risk to himself, Nurse Chandravathy convinced him to come out of his room and was standing near the nurse's station and in the communal area. The timing of this interaction is from the statement provided from Ms Kowalewsky as times were not nominated in either statement provided by Nurse Chandravathy.

58. If it is accepted that at 12.39pm, Nurse Chandravathy did check on Jamie in his room and that Jamie was later seen at the nurse's station and in the communal area – it is possible that this occurred between 5 and 10 minutes later, that is, within a 15-minute observation window. Being on 15 minutely observations would therefore not have altered the visual sightings of Jamie and thus not have influenced the outcome.

COMMENTS

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

1. Risk is not inanimate but fluid and often labile necessitating vigilance by mental health clinicians to behavioural changes whether that be through their own observations of their patient or from those conveyed to them by a patient's family member or loved one. In Jamie's case there was a response to the concerns conveyed by Ms Kowalewsky by nursing staff and additional tactics employed to monitor Jamie as a result of nursing staff's own observations.
2. In a custodial or institutional type setting such as a LDU in a mental health facility, eliminating access to means of self-harm is recognised as a significant suicide prevention method. The identification of ligature points has, and continues to be, a significant challenge to our mental health facilities. In my investigation into Jamie's death NorthWestern Mental Health has been open and transparent about these challenges including about what they are continuing to do to confront them and hopefully eventually eliminate them.
3. In the circumstances I make no adverse comment against Northern Health in this matter.

4. Similarly, I have determined that Recommendations constructed with the aim of preventing like deaths are not required in this investigation as I am satisfied that appropriate restorative and preventative measures have been considered and/or implemented in response to Jamie's death.

FINDINGS

1. I find that Jamie Andrew Kowalewsky born 3 October 1990, died on 7 May 2018 at Northern Health – Northern Hospital 185 Cooper Street, Epping Victoria 3076.

2. I find that the management of Jamie Andrew Kowalewsky's mental ill health at NWMHS was reasonable and appropriate in the circumstances.

3. And I further find that the evidence of an increasing risk to Jamie Andrew Kowalewsky proximate to his death was not observed to be in a category of being clear or cogent such that it should have equated to a decision to manage him in a more restrictive manner in the high dependency unit.

4. I accept and adopt the medical cause of death as ascribed by Dr Heinrich Bouwer and I find that Jamie Andrew Kowalewsky died from global cerebral ischaemic injury in the setting of hanging in circumstances where I find that he intended to take his own life.

5. AND I am unable to find with any degree of certainty that the death of Jamie Andrew Kowalewsky was preventable.

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

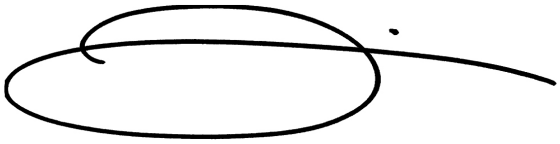
I direct that a copy of this Finding be provided to the following:

Maurice Blackburn Lawyers on behalf of Ms Caryn Kowalewsky

K & L Gates Lawyers on behalf of Melbourne Health

Dr Neil Coventry, Chief Psychiatrist

Signature:



AUDREY JAMIESON

CORONER

Date: 13 December 2022

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.