OFFICE OF THE STATE CORONER

FINDING OF INQUEST

CITATION:	**Inquest into the death of a Community Mental Health Patient**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Brisbane
FILE NO(s):	COR 326/03
DELIVERED ON:	9 November 2005
DELIVERED AT:	Brisbane
HEARING DATE(s):	4 and 5 May 2005
FINDINGS OF:	CA Clements, Deputy State Coroner
CATCHWORDS:	CORONERS: Inquest, hanging of young man receiving psychiatric care in the community after revocation of involuntary treatment order, assessment of suicide risk.

REPRESENTATION:

Counsel Assisting:	Mr S Hamlyn-Harris
Bayside Health District Services:	Ms L Gill

This is the inquest into the death and circumstances of a Community Mental Health patient.

I must deliver my findings pursuant to the provisions of the *Coroners Act 1958.* I do so, reserving the right to revise these reasons should the need or the necessity arise.

The purpose of this inquest, as of any inquest, is to establish, as far as practicable –

The fact that a person has died:
The identity of the deceased person:
Whether any person should be charged with any of those offences referred to in section 24 of the Act; and
Where, when and in what circumstances the deceased came by his death.

It should be kept firmly in mind that an inquest is a fact finding exercise and not a method of apportioning guilt. The procedure and rules of evidence suitable for a criminal trial are not suitable for an inquest.

In an inquest there are no parties; there is no charge; there is no prosecution; there is no defence; there is no trial. An inquest is simply an attempt to establish facts. It is an inquisitorial process, a process of investigation: These observations were confirmed by Justice Toohey in *Annetts v McCann* ALJR at 175.

A Coroner's Inquest is an investigation by inquisition in which no one has a right to be heard. It is not inclusive of adversary litigation. Nevertheless, the rules of natural justice and procedural fairness are applicable. Application of these rules will depend on the particular circumstances of the case in question.

In making my findings I am not permitted, under the Act, to express any opinion, on any matter which is outside the scope of this Inquest, except in the form of a rider or recommendation.

The findings I make here are not to be framed in any way which may determine or influence any question or issue of liability in any other place or which might suggest that any person should be found guilty or otherwise in any other proceedings.

All proceedings before this Court are sad proceedings. At this stage I express my sympathy and condolences, and that of the Court, to the family of the deceased in their sad loss.

Summary of the evidence.

On 20 June 2003 at about ten past eleven at night one of the deceased's two male flat mates, came home from work. He discovered the deceased's body in the rear downstairs courtyard of the flat. The deceased had a cord around his neck that extended up to a railing of an upper level veranda. By sitting down,

pressure had been applied around his neck and he had asphyxiated. There was no sign of life from the deceased.

Police attended at the address at twenty past eleven that night and carried out investigations. Ambulance officers attended upon the deceased but there was no opportunity to resuscitate him as he was already deceased. There were signs of rigor mortis and lividity in his body. A cardiac monitor was attached, but there was no electrical activity detected.

Detectives and scenes of crime officers attended and made inspections and inquiries. A note was located on the deceased's bed that appeared to be a "suicide note". Information suggested it was in his handwriting. The police also discovered a large number of plastic bags containing paint residue hanging on the back of the bedroom door. There was also a face mask in the wardrobe with a clear plastic tube attached to it. These items had what appeared to be silver paint in them.

The investigating officer and Detective Stocker determined there were no suspicious circumstances and the deceased had been the cause of his own death. They inspected his mobile telephone. The last missed incoming call displayed on the screen was at 3.46 that afternoon. Police determined this call was from the Redlands Hospital.

The deceased's sister attended at the John Tonge Centre and identified her brother.

At autopsy there was confirmation the deceased had been self mutilating. There were multiple criss-crossing scars over the lower chest and upper abdomen. There were multiple longitudinal scars on the right and left elbow areas and forearms. There was multiple scarring on the left wrist. There was a transverse scar on the upper part of the neck straddling the midline on the front.

Toxicology testing revealed the deceased was taking his anti depressant medication.

Subsequent inquires by police included taking statements from the deceased's flatmates, a friend and from his sister.

One of the deceased's flat mates had known him for about two years. He had been a flat mate for a period of about six months. He told police he thought the deceased had seemed depressed and withdrawn in the two months prior to his death. He thought it related to the break up with his girl friend. The deceased also deferred from university at this time. He knew the deceased had been sniffing paint and noticed he did not seem to go out as much as he used to.

About two weeks before the death, the flat mate saw the deceased come home. He saw he had many cuts on his arms and chest. He helped him to treat these. After that he remembered the deceased had been in contact with the Redlands Hospital Mental Health Unit and had received treatment. He had spent a night in hospital.

On the morning of 20 June 2003 he had not noticed anything in the deceased's manner to suggest there was anything wrong.

The step mother of the deceased's girl friend for a period had known the deceased for about twelve months. She was apparently the last person to see him alive. She was aware he appeared to be depressed in the months leading up to his death. She had sufficient influence on him to initiate his going to a doctor. She later discussed the deceased with the doctor indicating she was concerned for him. She was also aware of self inflicted cuts on his wrists, stomach and rib cage. She told police she had seen a mark around his neck that appeared to be made by a rope.

On 19 June 2003 the deceased had telephoned her and then gone around to her place to talk. She noticed he had a bag with paint and a spray paint tin. He told her he had been sniffing paint. He promised her he would not sniff again. He seemed to her to be more depressed than usual. She tried to make him stay with her for dinner but he refused, said goodbye, and left.

The deceased's younger sister was in contact with him in the months leading up to his death. She was concerned about his well being and was worried about his depression. Her brother had previously been a successful student and was also working as assistant manager at a fast food outlet. He maintained many friendships and appeared to be happy and well. With the benefit of hindsight she recalled in the two months leading up to his death he lost weight and became less communicative. She was still shocked though when he told her he was suffering from depression. This was after Christmas in 2002.

She was aware he had a very close relationship with a girl for over a year. She knew he was devastated when that relationship ended towards the end of April 2003. She saw him on his birthday and recalls he had seen a doctor by that stage and was taking anti depressant medication.

She did not become aware he had been self mutilating until he was admitted to hospital under an involuntary treatment order on 4 June 2003. He was discharged the next day. On an earlier occasion she had also helped her brother when his girlfriend had told her he had taken all of his anti depressant medication. She insisted he attend the Wynnum Hospital where he was monitored overnight. That was on 25 May 2003.

She visited him in hospital on 5 June. She then became aware he had been self mutilating and had been referred to the mental health unit by the general practitioner.

She told the inquest her brother had not wanted to stay in hospital. Her observations of her brother at this time were that he was most unlike himself.

Dr Stevensen reviewed the deceased later that day. His sister was present. The doctor recorded what she perceived as an improvement in his attitude from the previous day. His sister's perception was that her brother was still "down" to use

her language. There appears to have been some confusion regarding the identity of the person who conducted the assessment. The record is clear that this was the psychiatrist (not the occupational therapist) who reviewed the deceased's condition and ordered the involuntary treatment order be revoked.

She told the inquest she had voiced her concerns for her brother. She said the response was that the deceased had indicated to the mental health personnel that he was positive and had made plans for the future.

She indicated she believed he was lying to avoid being returned to hospital.

Another episode occurred later in June when the deceased was apparently at the Sunshine Coast and indicated he had taken poison. This was also referred to the mental health workers who indicated they would try to contact him. It was in the last weeks before his death that his sister was told by a flatmate that the deceased was sniffing paint. Again she referred this to the mental health case worker. The last appointment between the deceased and the case worker was on 20 June. It was noted the deceased had indicated a plan to return to university and to pursue counselling. He ha agreed to stop using paint and to use some strategies to help himself.

Later conversations between brother and sister occurred and she states the deceased had said he had lied and would lie to avoid being kept in hospital.

After his release from hospital on 5 June he drove to the Gold Coast. Again, his sister was involved in seeking him out and offering support to him to return to Brisbane. He had apparently used alcohol and taken pills and was threatening to suicide. After this incident she says she spoke with hospital workers.

After the deceased's death there was a meeting with family members. The deceased's sister expressed her dissatisfaction that her issues were met with the response that the Mental Health Act blocked the treating team from further involving the family.

The Team Leader from the mental health unit at Redlands hospital gave evidence. The access team sees all new patients and case manages people for four to eight weeks. The longer term care is managed by the Redlands Continuing Care Team. Additionally there is the inpatient unit. All are based at the Redlands Hospital. She had not individually met the deceased, although she was the designated team leader.

She went through the records indicating the initial referral on 30 May for an assessment. This was from his general practitioner, who was requesting admission of the deceased to hospital after incidents indicating a risk of self harm.

The psychiatric registrar saw the deceased after an initial discussion with a clinical nurse. A decision was made not to admit him on that occasion. He was referred to the acute care team, involving daily contact. The transcript of evidence details the contacts maintained with the deceased during this period.

Of greatest concern in this inquest is the record that on 6 June 2003 the deceased was spoken to by phone as part of the community based contact and support. He indicated he was angry on the previous night and had taken all his Zoloft tablets together with some alcohol. He was advised to see an accident and emergency department but he declined. He also reported considering driving into a tree but then calmed down and drove to the coast. There was a discussion about how he disliked being in hospital and that he would have to change if he was going to avoid being back in hospital.

There was an arrangement that he would keep phone contact over the weekend by mobile phone. An appointment was scheduled for Monday 9 June.

The comment from the team leader about whether further consideration should have been given to hospitalisation after his declining position after release from hospital was interesting. She emphasized the importance mental health practitioners place on the patient's expressed wishes; the deceased was very clear he did not want to go to hospital, and this seems to have been given a certain priority in decision making regarding how he could best be supported.

On the Monday there was a phone call indicating the deceased was unwell and the appointment was rebooked for Wednesday 11 June.

That same day there were two calls from his sister. She reported the deceased was not sleeping well and expressed suicidal ideation. The second call indicated a discussion between his sister and an aunty and a request he be re-admitted to hospital.

He attended for another appointment and further discussions took place.

On 16 June he saw both the psychiatric registrar and the occupational therapist. It was recorded he was in a positive "bright" mood. The file was case reviewed by the consultant without any major intervention.

Then on 17 June there was a call from his sister expressing concern he had taken off again and was suicidal. Attempts were made to reach him by phone but were unsuccessful. There was an indication of abuse of Panadeine and paint sniffing. There was specific permission sought and given for the mental health people to involve his sister in communication.

It was explained that an involuntary treatment order can last for three days to enable the assessment process initially, but then needs to be ratified by a consultant to extend beyond the three days. It was also clarified that while a patient is voluntary there is no mechanism to enforce the taking of prescribed medication.

The access team is a multi disciplinary team of trained people from different skills backgrounds. It was also explained that if a person does not "fit" within the legislative framework of the Mental Health Act then practitioners can only attempt to persuade and influence the patient to act in a self protective way and to take medication.

Dr Stephensen was a fourth year psychiatric registrar when she saw the deceased for the first time on 4 June 2003. She saw him with the consultant and another resident doctor. The team diagnosis was of major depressive illness with melancholic features. The involuntary treatment order was confirmed by the consultant with a requirement for fifteen minute observations. This was ordered because the deceased was expressing suicidal ideation. Dr Stephensen documented observations at this consultation which was led by the consultant but also involved her and the medical registrar.

The next day, on 5 June, she revoked the involuntary treatment order and discharged him from hospital. This decision was made alone. She explained that although the illness had not resolved, the crisis had passed. He still required ongoing treatment. His sister was present at that time. The deceased was clear he wanted to be discharged. Later questioning confirmed the doctor was aware of bruising to his face and neck area, and she had considered this as part of the assessment of risk.

She explained the basis on which she made the decision. She assessed his mental state as significantly improved. Her notes record he was smiling and making eye contact. He was able to express his feelings and to state a preference for returning home. He was no longer expressing thoughts of suicide and was making plans for the future. There were supports in place and a plan of access team support. He was given medication for ten days with a plan to see his general practitioner the following week. He also had information about the access team who provided immediate support if required as well as daily telephone contact. It was also noted he still needed a CT scan as part of his medical assessment. She noted he indicated he would communicate with his sister.

Dr Stephensen's opinion was that the deceased was no longer exhibiting the signs of illness that required him to be subject to an involuntary treatment order. Accordingly she was required to revoke it. The deceased was now agreeing to treatment in a way the doctor thought the services could be delivered, therefore she revoked the order. She stated the only way he could then be retained in hospital was if he agreed to remain on a voluntary basis. He did not wish to do so. She was satisfied his judgment was not impaired and he was not minimising risks of harming himself or anyone else. She explained this by referring to his refusal to accept treatment on the 4 June, compared with his agreement to cooperate with treatment on a voluntary basis the next day.

There was some discussion about whether the particular anti depressant (Zoloft) was appropriate given the deceased's age. The evidence was there was recent literature which supported the view that serotonin specific reuptake inhibitors, (of which Zoloft was one,) were possibly counter indicated for adolescents. There was some evidence they increase the risk of suicide. The deceased was just twenty at the time, and so it would still have been considered an appropriate medication to prescribe. The initial prescription had been ordered by the general practitioner and the dosage then increased after review by the psychiatric team. It is noted the evidence was that the literature about the possible elevated risk in the adolescent age group was not known in 2003.

The issue of paint sniffing was also raised with Dr Stephensen. She considered paint would have a similar effect as alcohol. Longer term use could potentially cause brain damage and may precipitate illness such as depression, although she had not researched this topic. Subsequent toxicology testing did indicate the presence of volatiles at the time of the deceased's death. Paint sniffing causes intoxication just like alcohol and may therefore distract a person from experiencing the feelings of depression whilst intoxicated.

The final occasion when she saw the deceased was on 16 June. (I note this was four days before his death.) She was rostered to the access team that day and saw him for a medication review. At this time she recorded him to be bright and reactive. He told her the last time he was feeling suicidal was on the weekend and that was in the context of being intoxicated with alcohol. He had not done anything to attempt self harm on the weekend, but this seemed to be from lack of opportunity rather than lack of desire.

It seems curious that despite the very recent expressed thoughts of suicide her impression overall was that he was improving.

She was asked to respond to the deceased's sister's assertion that her brother had told her he had lied to the doctors to get out of hospital. She said it was a problem doctors face by evaluating all the information, from all sources.

Since the time of the deceased's death, doctors have greater assistance to address the task of assessing whether or not a patient meets the criteria for involuntary treatment. In mid 2003 it was simply a question of clinical judgment and experience of the individual practitioner. The mental state of the patient would be considered as well as the collated history from other people involved in the patient's case. Towards the end of 2003 risk assessment guidelines came into place. I note however the subsequent evidence from Dr Kalyanasundaram, the mental health director for the Redlands District that he considered the new assessment tool added nothing to the process undertaken by competent mental health practitioners other than documenting each stage. He also said there had not yet been a review to evaluate whether the process had achieved better mental health outcomes for patients.

There were some notes that were discovered in the deceased's bedroom after his death which were accepted as being in his hand writing. Dr Stephensen had not seen these at any time prior to the inquest. When reviewing them she thought they indicated that at the time he made the notes, he was having thoughts and making plans of suicide. He was describing thoughts of hopelessness and worthlessness, which is consistent with depression. Had the doctor been seeing the patient and became aware of this information, then he would have been assessed as a higher risk of suicide.

The great difficulty remains that despite specialist training and risk assessment tools; there is no diagnostic tool to empirically assess if a person is in imminent risk of suicide. Nor is there any sure method of measuring truthfulness in what a patient is communicating to a practitioner.

Dr Stephensen said the task was multi dimensional and not a static function which must take into account changes. She said it was common for patients suffering from depression, (along the various points of the continuum of the illness) to report thoughts of suicide while still living in the community.

Dr Paul Pun was the psychiatrist who was the consultant at the Redlands Hospital at the time of the deceased's death. He explained that prior to admission the deceased was under the care of the "access" team – the community acute care and intake team. There would be a case manager, who was a mental health professional, supported by other team members. On admission to hospital, a separate team is responsible for the patient.

Prior to admission the deceased's case manager was Ron Sudamalus, a nurse. Dr Mark Rowe was the psychiatrist in charge, and the team leader was Cassie O'Connor.

On admission the case manager still has a continuing role. In the deceased's case, the case manager swapped from Ron Sudamalus to Katherine Ingram after his discharge from hospital. This was due to the rotation of Ron Sudamalus through various positions.

It was Ron Sudamalus and another nurse who attended on the deceased's home and brought him back to the hospital for assessment on 4 June. This was due to suicidal thoughts and refusal to agree to treatment. An initial assessment was made by Ron Sudamalus and the previous registrar, Dr Lee Chen, who noted mood swings, ongoing depression and suicidality. There had been a rapid decline over ten days since a relationship break down with his girlfriend. He was also worried about his mental health because both his parents suffered mental illness and depression.

Dr Pun and the treating team then reviewed the information before the deceased came in to see them. He was demonstrating many indicators of illness including; Psycho motor retardation, no eye contact, low volume monotonous voice, themes of guilt, worthlessness, and hopelessness and continuing suicidal ideation.

Dr Pun thought he was very depressed. – a major depressive episode with melancholic features.

This condition required the continuation of the anti depressant medication and physical assessment to exclude any other illness. An Involuntary treatment order was made under the Mental Health Act. Dr Pun explained this was for an indefinite length of time until reviewed and revoked.

Dr Pun said he expressed surprise when he was informed the deceased had been discharged the next day. He said he was not involved in that decision. He felt the deceased had been significantly depressed when he saw him.

Dr Pun was a fully qualified psychiatrist, thus when he assessed the deceased and made the decision to place him under an involuntary treatment order, the

order was for an indefinite period. This is to be compared with a limited period of three days (72 hours) which can be ordered a psychiatry registrar. But, to revoke the indefinite order, any authorised doctor could do so, including a psychiatric registrar. In this instance, Dr Stephensen, the psychiatric registrar legally revoked the indefinite order made by the psychiatrist Dr Pun the previous day.

There was no written protocol to consult with the senior psychiatrist before the psychiatric registrar made such a decision. Dr Pun stated that he considered Dr Stephensen was quite experienced but he was also surprised he had not been consulted when the treatment plan was being changed quite significantly from one day to the next.

Once discharged from the access team, the deceased's care was passed to the supervising consultant psychiatrist, Dr Mark Rowe, the team leader Cassie O'Connor and the (new) case manager Katherine Ingram.

Dr Pun confirmed the medication which was prescribed was Zoloft, a trade name for the drug sertraline. In June 2003 it was not yet widely known that there were possible increased risks of suicide rates when this drug was prescribed to children or adolescents. However, at age twenty, he thought that even had that knowledge been available at the time, the medication would have been prescribed. He confirmed it was a considered decision balancing the possible risks with the known beneficial effects of the drug in alleviating depression. Sertraline is a drug known as a selective serotonin re-uptake inhibitor, a newer style antidepressant medication with fewer adverse side effects. Most importantly, the group of drugs is safe in overdose circumstances.

A limitation of the drug is that there is a time delay before the drug is fully effective, between four to eight weeks. The other option was electro convulsive therapy if it was thought the depression was very severe. Dr Pun indicated that had the admission continued, there would have been contact with the family to see if this therapy had been helpful to the deceased's father.

The vexed issue of communication with family members was clearly a concern for the deceased's parents. The difficulty was that the deceased had indicated to hospital staff that he was happy for his sister to be communicated with, but did not want his parents involved. His parents' view was that the system failed their son by not retaining him in hospital when he presented on 4 June with deep depression and physical signs of self inflicted harm. Dr Pun of course had ordered he be retained indefinitely, (which was subsequently reviewed by another doctor, the psychiatric registrar.)

On the broader issue of whether the legislative framework assists people with mental illness, Dr Pun acknowledged it is a balancing exercise. On the one hand the protective needs of a person, who may have lost the capacity to care for themselves due to mental illness, must be balanced with a decision which may impact in restricting their personal freedom.

He saw it as an advance that a person could be assisted within the community via a community treatment order. As a policy, Dr Pun said he tried to involve family

members but sometimes this was hampered by a patient's wishes to the contrary. He acknowledged that close family or friends are important sources of information to assist the medical team.

It was also clarified that it is only within the authority of an involuntary treatment order that a person can be required to take medication.

Dr Pun expressed trust in Dr Stephensen's ability to conduct a mental state examination. He said had he been consulted he would have then discussed what might account for such a marked change in mental state in the course of a day. He discussed the decision with Dr Stephensen about a week later.

It was suggested to Dr Pun that the deceased may have presented a more favourable presentation of himself in an effort to get out of the hospital. Dr Pun thought that it was very difficult to falsify objective mental state findings. For example, motor retardation as a sign of depressive illness was present on one day and absent the next. The emotional reactivity of his speech (prosody) had also markedly improved.

It was the very fact of the marked changes that raised in Dr Pun's mind the possibility that the deceased was suffering a mixed affective state. On review of the file since the deceased's death, Dr Pun wondered whether he might have been suffering from bi polar effective disorder, or manic depression. The widely deflecting moods from day to day might be indicators of this disorder. However this was said to be a rare condition and required considered diagnosis. There was insufficient treatment time for the possibility to have been considered.

Dr Pun also confirmed the current regime of risk assessment processes initiated by Queensland Health came into effect in September 2003 in the Bayside region. Nothing in those tools will help a practitioner to assess truthfulness. Clinical judgment and experience is required. Comparing consistency of information and presentations is the most useful way to evaluate truthfulness.

The options which were available for treatment were;

(1) Involuntary treatment in a hospital/or in the community, but only if the deceased was assessed as coming within strict legislative guidelines and remained in such a medical condition.

(2) Alternatively, voluntary treatment could be undertaken in a hospital, or in the community.

Dr Pun could not say whether the use of inhaled paint substances could have interacted with other drugs or what other psychotropic effects it may have caused. However, he stated that dis-inhibition and mood altering would be probable effects of the use of inhalants.

Ron Sudamalus and Mr Sewell, who were nurses with the access team, attended the deceased's home on 4 June for a home visit. They were concerned with his mental health to the extent they brought him to the hospital for assessment.

It was on 4 June that Dr Pun assessed him as requiring indefinite treatment. The next day on 5 June, Dr Stephensen was so influenced by the positive change in his presentation that she revoked that order. But by 6 June a number of disturbing entries are made by Katherine Ingram. She was unable to contact the deceased. At about 2.00pm she spoke with his sister. She reported that the deceased was angry last night, and was driving around Brisbane. He said he wanted to drive into a tree, and he had taken all of his Zoloft as well as cans of rum and coke. He said he could not do it.

The volatility of mood raised concern with hindsight, but apparently not at the time. Dr Pun considered that another option might have been an involuntary treatment order within the community which would have been able to quickly revoke his community leave and bring him back to hospital. This would still require the deceased to fall within the legislative framework for it to be invoked.

When Dr Pun was challenged to respond to this scenario occurring without some action being taken to intervene, Dr Pun merely said, "I don't have any concerns about the mental state examination that was done on 5 June."

He said he was not informed of the deceased's discharge from hospital until the next week. With hind sight he commented that perhaps more experienced clinicians being at the front line of Access Services may be an important consideration, where cases are very complex and high risk. He thought it unfair to expect relatively junior case managers to be able to recognise the subtleties of these sorts of situations.[1]

Dr Kalyanasundaram gave evidence. He is a senior consultant psychiatrist and director of the mental health services in the Bayside Health District.

He explained the way in which the multi disciplinary access team was trained. Although each member might have a different specific skills and training base, all have basic counselling skills. They are then orientated to the mental health issues to assist people with mental health problems. Supervision is provided by a team leader and a psychiatrist and Dr Stephensen.

Dr Kalyanasundaram informed the court as many as forty percent of the general population might think about suicide at some time in their lives, to the extent of contemplating a method, but only one percent of people in fact attempt self harm. Psychiatry is aimed at assisting and intervening to strengthen the person's ties with continuing to live rather than to die. This is consistent with the philosophy of least intervention possible with appropriate care. The doctor indicated that in the deceased's case the Mental Health Act was used to bring him into hospital on 4 June when the signs were very strong that he was at risk. But one problem is that some people are very negative in their response to hospital. The deceased indicated this reaction which created difficulties in establishing an appropriate therapeutic relationship.

[1] Transcript at page 165 , lines 10- 20.

The doctor thought that Katherine Ingram's conversations (as recorded in her notes of 6 June) indicated that she had been able to engage with the deceased to look to the future.

Dr Kalyanasundaram confirmed that psychiatric assessment tools can only assist in protecting a person from self harm. There is no diagnostic mechanism to calculate precisely what the risk might be other then clinical judgment based on assessing the patient and gathering and comparing information. The deceased's clinical management had been reviewed by the hospital by way of the mortality report. He acknowledged that rotation of staff was less than optimal for patient care.

A post mortem examination was performed upon the body of the deceased and a record of this was issued, (now produced as Exhibit 3.) On 21 June 2003 the pathologist Dr A Olumbe together with Dr AJ Ansford, (the pathology consultant) expressed the opinion that the medical cause of death was hanging.

Conclusion

The deceased was a young man of twenty who appeared to be progressing well with university studies and part time employment when he suddenly fell into deep clinical melancholic depression. There was a family history of depressive illness which appeared to trouble him and he did not wish to inform his parents of his illness. He did draw upon the support of his younger sister. His illness developed in the context of a situational crisis when an important relationship ended. It became apparent that he was abusing alcohol and inhaling paint. He was also self-mutilating. These behaviours were unusual for this young man who changed from being socially active to reclusive in personality.

He was prescribed anti depressants. A situational crisis brought him into hospital briefly and he was then discharged home with the Redlands Community Access team following up on his care. A visit from team members discovered that the deceased was still self mutilating and was expressing thoughts of suicide. They intervened to bring him to the hospital for assessment. On 4 June 2003 Dr Paul Pun, who was a fully qualified psychiatrist, ordered he be subject to an involuntary treatment order under the Mental Health Act.

That order was for an indefinite period but could be revoked by another doctor when the deceased was no longer within the scheme of the legislation.

The next day, Dr Stephensen, reviewed the deceased. She had been involved with Dr Pun when he made the initial assessment. The deceased denied feelings of suicidality. He was "bright" in mood and expressive in his communication according to the doctor, although his sister's opinion was that he was still not himself. The deceased did not wish to remain in hospital but indicated he would co-operate with treatment and remain in contact with his sister. The doctor considered it was therefore appropriate to revoke the involuntary treatment order.

Dr Stephensen was less experienced and less qualified than the consultant. There was no consultation between the two doctors, and no requirement that

consultation should occur. There was a later discussion of the decision between the two doctors.

After his discharge on 5 June the deceased did remain in contact with the community based team but his condition was variable and there were documented episodes of him considering and planning methods of suicide. On each occasion mental health practitioners from the access team (who included occupational therapists, nurses and Dr Stephensen) considered that he was demonstrating a continuing involvement in treatment and forward planning sufficient not to require more intervention.

His sister remained concerned, particularly as it was she who was involved in bringing him home on occasions when he had driven away for hours at a time threatening to kill himself in the vehicle. Mrs Lucas also remained concerned and involved in supporting the young man as she could see him openly revealing sniffing volatile substances and showing signs of self harm.

On the day that the deceased died his two flat mates had not noticed anything to alert them to his being in danger. He was discovered at home by his flatmate to have asphyxiated himself by hanging.

I make the following findings –

(a) The identity of the deceased was a Community Mental Health patient.

(b) His date of birth was May 1983

(c) His last known address was Wynnum West.

(d) At the time of death his occupation was student.

(e) The date of death was 20 June 2003.

(f) The place of death was Wynnum West

(g) The formal cause of death was hanging.

This Court has jurisdiction in appropriate cases to commit for trial any person/s which the evidence shows may be charged with the offences mentioned in section 24 of the Coroners Act 1958. The evidence is not sufficient to put any person or persons upon any trial. Therefore no person will be committed for trial.

RECOMMENDATIONS:

Pursuant to section 43 of the Act, the following recommendations are made by way of rider to the formal findings.

I recommend:

1 That the Mental Health Act is reviewed to require consultation between treating psychiatrists or other health professionals if revocation of an indefinite involuntary treatment order is being considered by a second authorised practitioner who was not the initial practitioner who made the order. A protocol be developed, especially where the reviewing practitioner is less experienced than the practitioner making the original order.

2 Review of the Access team structure to ensure sufficiently experienced clinicians are involved to assist patients, as well as continuity of make up of team members to ensure that optimal patient care is available from suitably experienced practitioners, especially in “high risk” potential suicide patients.

3 The circumstances in which the deceased’s initial assessment was undertaken indicated the significance of a face to face visit in initiating that intervention. It is recommended that home visits be considered the appropriate communication wherever there is a strong indicator that a person’s mental health is declining and that the risk of suicide has increased.

Finally I acknowledge the efforts of the deceased’s family in following through the inquest process. The deceased’s younger sister showed remarkable maturity for such a young woman in providing support to her brother and assisting him through his illness. It has been a great sadness to his parents that they were not included in communication with the treating team during their son’s illness. No doubt this may have reflected the deceased’s desire not to worry them as he knew that both were also suffering from depressive illness.

I extend my condolences to the deceased’s family and friends in their sad loss.

Thank you to counsel appearing and assisting in this inquest. The inquest is now closed.

Chris Clements
Deputy State Coroner