QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INVESTIGATION

CITATION:	**Non-inquest findings into the death of Mitchell James Follent**
TITLE OF COURT:	Coroners Court
JURISDICTION:	BRISBANE
DATE:	6 November 2019
FILE NO(s):	2016/3441
FINDINGS OF:	John Lock, Deputy State Coroner
CATCHWORDS:	CORONERS: Dual diagnosis of intellectual disability and mental health, first admission for psychosis, Root Cause Analysis, deficiencies in discharge planning, recommendations implemented, communication with family, whether capacity for a finding of suicide

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Background

1. Mitchell Follent, aged 22 years, was admitted to the Ipswich Hospital Mental Health Unit (MHU) on 5 August 2016, and discharged on 15 August 2016. He died on 20 August 2016, with CCTV footage showing Mitchell as deliberately leaning over and then falling from a 3rd floor balcony head first, landing on his head. Cause of death at autopsy was identified as being due to head injuries.

2. This was Mitchell's first mental health admission. He had a history of acquired brain injury and epilepsy/seizures from a young age, and more recently cannabis use. The mental health admission followed a referral from Mitchell's GP for investigation of possible "psychosis", with his mother having noted a deterioration in his self-care over the last three months and unusual behaviours in recent days (talking to himself, inappropriate laughing), prompting his mother to take him to the GP.

3. During admission to the MHU, Mitchell appears to have been assessed as having experienced "likely drug-related/post-ictal psychosis", which was said to have resolved during the admission. He was discharged with a new anti-psychotic medication, as well as continuation of his other medications related to his epilepsy. It appears he was non-compliant with his medications post-discharge and took his own life five days later at his place of residence, where he had been living with the assistance of disability support funding.

4. Mitchell was provided financial support through Disability Services Queensland. This included in-home accommodation support by Focal Community Living and community access support by Focal Community Living and FSG Mental Health Services Australia. The services provided to Mitchell by FSG included building capacity around accessing the community, managing household tasks and working towards identified goals. At the time of his death he was residing in a large unit complex run by Churches of Christ.

Autopsy Examination

5. An external post-mortem examination including CT scan found multiple serious injuries.

6. Toxicology testing noted the presence of escitalopram (antidepressant) greater than usual therapeutic range but less than potential fatal range. Lamotrigine (anticonvulsant) was found at a greater than usual therapeutic but less than potentially fatal range. Levetiracetam (anticonvulsant) was found in a greater than usual therapeutic range and a low level of olanzapine (antipsychotic) at a low level. Cannabinoids were also present.

Investigation

7. The following material has been reviewed in preparing this finding:

    I. Form 1 - Police report of a death to a coroner
    II. Autopsy report
    III. Letter of concerns
    IV. Letter from Disability Services Queensland
    V. Records of FSG
    VI. Medical records West Moreton Hospital and Health Service
    VII. Medical records - Ipswich Hospital Mental Health Service
    VIII. Medical records - CIMHA

IX. Medical records - Primary Riverlink
X. Statement of Dr A Guptar, Clinical Director, Community and Acute Mental Health
XI. Statement of RN Merryl Houghton, Dual Diagnosis Coordinator
XII. Statement of Dr David Mendels
XIII. Statement Dr S Kamaland
XIV. Statement of social worker W Brown
XV. Statement of R.N. Craig Lawler
XVI. Statement of Dr Terry Stedman
XVII. Statement of Dr S Shah
XVIII. Statement of Dr Abeyasinghe
XIX. Statement of Dr A Yu
XX. Letter from WMHHS on outcome of open disclosure meeting
XXI. Root Cause Analysis report from WMHHS
XXII. Clinical incident recommendations - evidence of completion
XXIII. Multidisciplinary team meeting notes
XXIV. Expert report of Dr Paul White

Presentation at Ipswich Hospital

8. On 23 July 2016 Mitchell had two seizures and was brought in by ambulance to the emergency department at Ipswich Hospital. The diagnosis was grand mal epilepsy. He discharged himself against medical advice.

9. On 5 August 2016 his mother attended at his unit to take him to a prearranged appointment for an EEG and to see his neurologist. She reported that her son had become increasingly weird and elevated during the day, prompting her to take him to see his GP. The GP agreed the behaviour was unusual and referred him to Ipswich Hospital for a mental health assessment with a diagnosis of “psychosis?”

10. Mitchell presented with his mother to the emergency department (ED) and was triaged as a category three and assessed by the mental health nurse soon after arrival. He was assessed by the psychiatric registrar within 40 minutes. His mother gave a history of him being more neglectful of his self-care and there had been a significant change in his behaviour in that he was laughing to himself and was unable to hold a conversation.

11. The assessment considered Mitchell appeared to be experiencing auditory hallucinations and he laughed in response to his “voices”. There were no clear delusions but it was difficult to discern thought content at that time. The differential diagnosis was drug induced psychosis, organic delusional disorder (epilepsy related), and primary psychotic process. Prior to admission to the Mental Health Unit (MHU) he was awaiting a physical screening in the ED by the Senior Medical Officer. The diagnosis was post-ictal (altered state of consciousness after an epileptic seizure) psychosis.

12. An Involuntary Treatment Order (ITO) was made. Security were required to take Mitchell to the MHU and he was restrained on two occasions. Medication prescribed included diazepam 10 mg (PRN - when necessary), olanzapine 10 mg and lorazepam 2 mg when necessary.

13. Mitchell was seen by the psychiatric registrar on 6 August 2016. He was seen to be disorganised, was not settled and was entering other patients’ rooms. PRN olanzapine and lorazepam were taken orally.

14. There was an unwitnessed fall where Mitchell sustained a 2 cm laceration to his nose. One-to-one observations were commenced. The diagnosis was likely mechanical fall, secondary to sedation. Vital observations were normal. X-rays revealed no evidence of a fracture to the nose.

15. Mitchell was seen by the on-call consultant psychiatrist at 6:00pm. For most of the day he had been acting bizarrely but he had progressively improved throughout the day. The impression was likely complex partial epilepsy with status ellipticus the previous day, query psychosis related to seizure, and injury to nose, secondary to decreased level of consciousness and hemianopia. The plan was to continue his usual anticonvulsants and antidepressants and to contact his neurologist for advice. One-to-one visual observations were ceased, and neurological observations were to continue every two hours and he was to be monitored closely in between.

16. The on-call consultant psychiatrist reviewed him again on the morning of 7 August 2016, noting there was not much change from the previous day.

17. Mitchell was reviewed by the medical officer on 8 August 2016 regarding a complaint of right shoulder pain of two days' duration. An x-ray showed a fracture of the distal aspect of the right clavicle. He was booked into an appointment with the fracture clinic for 22 August 2016. There was a plan for a collar and cuff sling. He could not remember injuring his shoulder but remembered being held down by security.

18. Mitchell's treating psychiatrist reviewed him on 8 August 2016 noted he was feeling quite well. The plan was to refer him to Alcohol and Other Drugs Services (AODS) and for discharge. This was reviewed after concerns expressed by his mother.

19. Discussions with the neurologist he attended on 9 August 2016 reported that on the day of the EEG he appeared to be drug intoxicated rather than the psychotic or paranoid.

20. On 10 August 2016 Mitchell told the Dual Diagnosis Coordinator that he used cannabis for his epilepsy.

21. Further psychiatric reviews took place on 10 August and 11 August 2016. It was noted he continued to improve. There was a plan for psychological review in relation to past bullying, trauma and related to anger. Mitchell's mother stated that Mitchell had improved mentally but felt he was lonely and depressed and he had withdrawn from friends and family and neglected his activities of daily living. She felt there was inadequate support from the nongovernment organisations.

22. On 13 August 2016 Mitchell was granted overnight leave to stay with his father. They returned as planned on 15 August 2016 with a report that leave had gone well. He presented as pleasant and cooperative. He was reviewed by the treating psychiatrist. His behaviour was calm. There were no abnormalities noted in thought or perception and Mitchell indicated he was willing to comply with medication. It was considered he was ready for discharge.

23. The plan was to speak to his father regarding the possibility of Mitchel staying with him. There was no follow-up plan with a mental health service. His father was unable to collect his son but stated he would meet him at his unit after work. He was discharged and was believed he was planning to take a bus home. Instead he took a taxi to his unit. His mother had not been advised of the discharge.

24. On 18 August 2016 Mitchell made a call to 000 saying he had an injury to his shoulder. He had forgotten about the fracture to his clavicle sustained during the earlier hospital admission. Queensland Ambulance Services (QAS) officers who attended noted the air was thick with cannabis smoke and he told them he had not been taking his medication and preferred to medicate himself with cannabis. QAS officers counselled him about this.

Root Cause Analysis

25. The Root Cause Analysis (RCA) conducted by West Moreton Hospital and Health Service (WMHHS) noted the history of spontaneous intra-cranial haemorrhage at age six requiring two craniotomies for evacuation and clipping in 2000 and 2001. As a result there were significant cognitive changes following surgery. Epilepsy, with frequent seizures occurred from the age of 12.

26. Mitchell started seeing a psychiatrist for major depressive illness and anger management issues in 2007. His behaviour had become disruptive. He had learning and language difficulties and school was difficult. From age 14/15 he resided in multiple foster homes. His current residential circumstances had been stable for five years and he received assistance from nongovernment organisations as well as his mother. He was seeing his father more regularly in recent times.

27. The RCA noted there were a number of incidental findings. Given the history of seizure it was noted there was no formal neurological examination undertaken or referral made to the medical team during the presentation to ED or subsequent admission to MHU to exclude any organic condition that could have contributed to his presentation, for example delirium.

28. It was noted he had also been physically restrained in the ED on two occasions. Security completed an incident report. The incident was not reported to the electronic PRIME Clinical Incident.

29. The unwitnessed fall on 6 August 2016 did not result in the completion of a Falls Assessment and Management Plan, which would have been indicated.

30. The RCA noted that despite the number of static and dynamic risk factors, risk for suicide, self-harm, aggression, vulnerability and absconding were assessed as low. The RCA considered that the number of static risk factors alone in the case would have justified the allocation of a higher risk rating, particularly in the areas of aggression and vulnerability.

31. The RCA considered that due to the known history and the complexity of the case, more comprehensive assessment was needed to inform decision-making in relation to the safety and well-being of the patient on discharge. The RCA also noted his mother had expressed concern about the level of support Mitchell had in the community. Mitchell told the social worker he had plenty of support. However, no collateral information was recorded by way of contact with the nongovernment organisation about his behaviour or functioning in the community.

32. The RCA noted that although there was a recommendation for a psychology review regarding past bullying, trauma and anger there was no evidence of contact with the MHU psychologist during the admission.

33. On discharge arrangements had been made for a Webster-pak to be collected from a local pharmacy and he had been referred to his GP. He had an appointment at the Mater Hospital and the fracture clinic. The RCA considered that follow-up by the Acute Care Team would have been appropriate, at least in the short-term, given the possible first episode psychosis and the commencement of a regular dose of antipsychotic medication.

34. The RCA noted he had a complex medication regime and there was no verification through assessment that he would be able to manage his own medication. According to QAS on 18 August 2016 he informed he was not taking his medication and preferred to use cannabis.

35. The RCA noted there was a delay in forwarding the discharge summary to the GP and the ITO had not been formally revoked.

Summary of RCA Findings

36. The RCA team noted that for presentations where an organic cause may have contributed to an altered mental state, there needs to be a medical assessment by the medical team, which includes a neurological assessment. There had been two episodes of restraint in the ED, which had gone unreported in terms of being clinical incident. Mitchell sustained injuries to his shoulder and nose during his contact with a health service. During his admission to the MHU he experienced a fall. The RCA team noted that the monitoring and follow-up actions in relation to these events, was not always consistent with the standards reflected in the health service procedures and accepted protocols.

37. Formal risk assessment needs to be both documented and comprehensive, and include static, dynamic and protective factors, with a corresponding plan that addresses the risks identified. Greater attention to documenting the risk assessment would have been important, as the risk assessment supports decision making in relation to the discharge plan, particularly in light of the limited protective factors.

38. Mitchell was discharged in the absence of sufficient support, when he was not able to safely self-care, which increased the likelihood of poor adherence with medication. This may have led to altered thought processes and perceptual abnormalities relating to epilepsy, cannabis use and/or psychosis.

39. The RCA team considered a comprehensive meeting with all stakeholders involved should occur as part of the discharge planning for patients identified with high and complex needs, to ensure that an adequate discharge plan is in place. Referral was also required to the most appropriate mental health team for a period of follow-up. The RCA team considered that the issues around discharge planning were a root cause in this case. The RCA team noted existing recommendations from a previous RCA and concurred that those recommendations were apposite to this case as follows:–

    - The Mental Health Unit is to develop a process to ensure that a comprehensive, multidisciplinary discharge plan is developed and documented for all presentations, particularly those where there is complexity, including voluntary presentations. The plan would involve all relevant stakeholders (including patient and carers) from the mental health service, including the Acute Care Team where referrals are made for follow-up. The role of each service provider, including community-based service providers will be outlined in the plan. The plan should also describe the recommended strategies, including information

about management of deterioration, and the processes for handover of care to all identified service providers.

- The Mental Health Unit is to develop a process to ensure the completion of the Consumer Care Review Summary, Consumer End of Care/Discharge Summary, Recovery Plan and/or Family Support Plan, Personal Safety Plan/Family Support Plan, follow-up appointments, and copies of relevant documents to other key stakeholders are completed at the point of discharge.

40. In conclusion, the RCA team stated this was a high and complex needs patient. There were organic issues, mental health issues, substance use issues, social issues, occupational issues, and compliance issues. Further assessment medically, and in relation to cognition, functioning, activities of daily living, substance use and risk, would have provided a more stable platform for discharge planning, particularly as the patient resided alone. Multiple stakeholders were involved, which required good communication and coordination of care. This was a complex case which presented many opportunities for assessment and intervention, as well as providing many missed opportunities.

Open Disclosure

41. An open disclosure meeting was held on 25 January 2017 after the provision of the RCA report. In attendance was Mitchell's mother. The hospital acknowledged at the meeting there were a number of interventions that were not performed to the expected standard. Mitchell's mother was advised that improvements would be targeted through clinical practice development in the relevant clinical areas to addressee shortcomings. In addition, issues regarding the adequacy of discharge planning and a lack of mental health follow-up after discharge were discussed. These issues were subject to existing recommendations as highlighted by the RCA.

Outcome of recommendations of RCA

42. WMHHS have advised that the two recommendations covering discharge planning and completion of discharge documentation have been completed.

43. The process for discharge planning by the Adult Mental Health Unit (AMHU) is documented and available to all staff in a Mental Health and Specialised Services (MHSS) procedure *"Acute Mental Health Unit and Older Person's Mental Health Service: Discharge planning."* All mental health services are required to follow the revised mental health clinical documentation and use the standard mental health clinical form is contained within the user guide.

44. Clinical staff are now also supported in the completion of a comprehensive discharge planning through a discharge planning checklist. This had been updated. Staff are required to upload the checklist to the electronic Consumer Integrated Mental Health Application (CIMHA).

45. In a statement provided to the Coroners Court RN Craig Lawler stated at the time of discharge Mitchell was denying any suicidality or self-harmed thoughts and there was a plan for him to be supported by his father following his discharge. He was settled in mood and behaviour and was denying any concerns at that time. He also wanted to be discharged. RN Lawler considered him to be a low risk. He states that since Mitchell's death all AMHU progress notes are now written in the CIMHA, which means the whole medical record is easier to access and can help to assist with continuity of care. The database also contains a more comprehensive risk assessment, which is completed for each patient on discharge.

46. MHSS has developed CIMHA Local Business Rules, which are reviewed periodically to ensure that staff are confident in completing the suite of clinical documentation in CIMHA that are required for discharge.

47. The Clinical Director for Community and Acute Services has ensured an increased focus on discharge planning and quality of discharge documentation. The hospital has indicated that this heightened governance and support has resulted in substantial performance improvements. The completion of end of episode/discharge summary within 48 hours of discharge is a key performance indicator and has risen from 26% in November 2015 to in excess of 75%.

48. MHSS and Quality Improvement Coordinators have implemented a quarterly clinical documentation audit as part of efforts to continually improve compliance with clinical documentation including discharge planning and summaries.

49. The Clinical Development Facilitator (CDF) for the AMHU and the Older Person's Mental Health Unit developed a discharge planning action plan involving a dedicated discharge nursing documentation audit, local business rules for discharge and staff education plan. The CDF undertakes an audit every three months of discharge documentation.

50. The CDF had initiated a weekly recovery group for patients and staff to work on the development of their recovery plan. These plans are uploaded to CIMHA once completed.

51. AMHU works closely with the Floresco Centre, Aftercare to provide transition support for people leaving the inpatient unit and requiring longer term community services. The inclusion of all relevant stakeholders in discharge planning has also been enhanced by the engagement of a carer representatives specific to the AMHU.

52. Dr Guptar, the Clinical Director, Community and Acute Mental Health also provided a statement. The Optimisation Project was initiated in July 2017 with the aim to address a range of systemic and cultural matters to promote a sustainable and effective work place culture and to enable the provision of quality, recovery oriented acute inpatient services. The Institute for Health Care Improvement - Framework for Safe, Reliable and Effective Care was adopted.

53. As a result a number of initiatives and improvements that support improved care formulation and discharge planning were commenced including:
    - Review of the multidisciplinary case review meeting held weekly improving integration between the inpatient unit and follow-up service.

- Review of referral processes with the Acute Care Team was completed to ensure the provision of critical and accurate information.

- Review of admission, leave and discharge processes ensuring the multidisciplinary team have a clear guide of the standards required for each of these transition points. Prior to Mitchell's death there were three part-time consultants totalling 1.5 full-time employees. Consultant psychiatrist resources has now been increased with two full-time positions allocated to the adult acute inpatient unit ensuring that medical review is occurring in a timely manner. This has been supported with the implementation of designated ward round times for both treating teams. There remains one consultant on call over the weekend.

- Review of the nursing shift to shift handover and daily multidisciplinary meeting has been completed and a standardised format to this verbal hand over process implemented to ensure the transfer of critical clinical information.

- Use of the Patient Flow Manager database as a journey board in the main staff station providing a large scale visual reference point for care and discharge planning.

- Timely completion and quality of discharge summaries remain a priority and is an ongoing focus. Performance against the 70% statewide KPI for completion within 48 hours has improved significantly.

Report of Dr Paul White

54. Dr White is a consultant psychiatrist and expert in the treatment of person with a dual diagnosis of mental illness and intellectual disability. Dr White was requested to provide an opinion with respect to a number of issues.

Adequacy of the discharge planning and risk assessment leading up to and at the time of discharge

55. Dr White stated it is documented in the clinical notes that Michael's symptoms resolved quickly. His admission was brief. His case was discussed at a multidisciplinary team meeting. It was not documented who participated in this meeting but typically this would include the psychiatrist, registrar, resident medical officer, nurse unit manager, clinical nurse in charge of the shift, as well as any allied health team members such as occupational therapists, social workers and psychologist.

56. Mitchell was reviewed by the social worker who suggested referral to the Richmond Fellowship but Mitchell felt his support were adequate. Dr White stated that ideally if there were concerns about the level of support at home, there would be contact with the team leader of the NGO's that are already in place. This would allow further clarification of current level of support and any gaps. It would also be an opportunity to collect further collateral about his function, daily activities, and any acute changes in his behaviour and function. In addition, although Mitchell does not appear to have an adult guardian or appointed substitute decision-maker, his mother being his next of kin and regular source of support, would become the substitute decision-maker in relevant matters should Mitchell not have capacity to make decisions. There was documentation that his mother had expressed concerns about the level of support but

there appears to have been no further assessment or information collected or documented.

57. Dr White noted there were no documented functional assessments. Typically these would be completed by an occupational therapist and would provide the most comprehensive source of data to inform the level of support required in the community.

58. A risk assessment was completed prior to accessing leave and prior to discharge. This assessed Mitchell's risk of self-harm and harm to others and absconding risks. There was no other risk assessment documented. Dr White stated a risk assessment needs to be part of a broader risk management framework. Completing a risk assessment in itself does not address any risk issues in itself. The emphasis needs to be on identifying patient needs and implementing a management plan to address those needs.

59. Dr White noted the needs identified by the treating team included management of epilepsy, follow-up of fractures, short-term accommodation and supports, were addressed. There was no additional needs identified by the documentation by the treating team at the time of discharge. There was no specific follow up plan involving specialist mental health services on discharge. There was no specific instructions to the GP about management of psychosis.

Adequacy of communication in planning with Mitchell's family, in context of their role for providing him with support post discharge

60. Dr White noted there was communication and planning involving Mitchell's family documented during several points during his health care trajectory. During the admission, these were mostly done by telephone. Towards the end of the admission, it appeared the communication was mostly with Mitchell's father. It is unclear what communication occurred between his parents. It is clear that his mother was his primary next of kin and he had a regular support and contact with her and ideally she should have been involved in discharge planning.

Any issues regarding interagency communication and planning between mental health and disability services regarding Mitchell's safety and well-being post discharge

61. Dr White stated it is unclear whether there was communication with his nongovernment organisations at any point during his healthcare journey, including for the purpose of discharge planning. It is noted the unit social worker saw one of Mitchell's support workers at the unit, but it did not appear the social worker approached the support worker for a discussion at that point, or at a later point.

62. There was liaison with his private neurologist and a discharge plan documented to address his epilepsy.

63. A discharge summary was completed with summary of care to his GP but there was no specific advice about the management of psychosis or any reference to management of his new medication that was prescribed to treat psychosis.

Whether (with the benefit of hindsight) there were any missed opportunities to provide health and/or disability services to Mitchell that may have resulted in a different outcome for Mitchell

64. Dr White noted that according to the RCA Mitchell had an acute presentation to the ED following two seizures on 23 July 2016. His stay was brief and he discharged against medical advice. There was no medical notes provided to review. The ED might have taken this opportunity to refer to a General Medical team to review his epilepsy management and review his social supports.

65. The second admission on 5 August 2016 presented another opportunity. Dr White was unable to see any notes from the ED clinicians which detailed a medical workup. The potential significance of epilepsy and seizure activity seems underemphasised. There is no documentation the ED referred him for review by the General medical or neurology team prior to referring to the psychiatry registrar.

66. There were signs of deterioration in Mitchell's self-care and function prior to the presentations to the ED. It is unclear whether this was due to poor seizure control and/or due to other reasons, such as marijuana use, medication non-compliance, or a deterioration in his mental health. Potentially, the disability support workers could have alerted their team leader of these changes so that the significance could have been discussed with his general practitioner. It appears the treating team did not factor this into discharge planning.

67. Dr White stated the attendance of QAS on 18 August 2016 may have been a missed opportunity for further medical review and intervention. In essence he was medication non-compliant and using marijuana and these factors could have led to worsening control of his epilepsy and possible re-emergence of psychotic symptoms.

Any other comments that may assist the coroner to understand the circumstances of Mitchell's death, and to identify way to help prevent deaths from happening in similar circumstances in the future

68. Dr White stated the information provided does not clearly capture systemic factors that were of significance in Mitchell's care. It does not capture the extreme stresses and work load of emergency departments or mental health units. References to bed occupancy and pressures on community mental health are absent. It would be useful to again emphasise the need to communicate with family members and between systems. The balance between patient confidentiality and risk management is often obscure. Better communication has been a previous recommendation of the Coroners Court in other matters. It remains apposite.

Conclusions

69. Mitchell Follent has died after he deliberately fell from a height from the balcony of the unit he was residing in. The issue as to whether he had a mental capacity to form an intention to take his own life needs to be considered.

70. Suicide has been defined as[1]:
    a. *Voluntarily doing an act for the purpose of destroying one's own life while one is conscious of what one is doing*.

71. It has been said elsewhere[2] that *a coroner cannot make a finding that a deceased person died by suicide if the person lacks the mental capacity to form an intention to end their life. The deceased may have lacked capacity if they were mentally ill, intellectually impaired, psychotic, extremely distressed, under the influence of alcohol or drugs or very young.*

72. In practice, the issue of whether the deceased lacked capacity to form an intention to take his or her own life does not often arise, largely because most people suicide alone or in private and there is little or no evidence as to what the person was thinking at the time. More often there is other collateral evidence such as previous threats to suicide or notes left (or as is more frequently now occurring social media messages) indicating the intention.

73. In Mitchell's case there was a long term history of intellectual disability and epileptic seizures. He had most recently been treated in the Ipswich MHU with a diagnosis of post-ictal psychosis. There was no suicide note or message on social media left.

74. As the RCA noted Mitchell was discharged in the absence of sufficient support, when he was not able to safely self-care, which increased the likelihood of poor adherence with medication. This may have led to altered thought processes and perceptual abnormalities relating to epilepsy, cannabis use and/or psychosis. Two days prior to his death QAS attended his premises where there was a heavy smell of cannabis and he said he was not taking his medication. At the scene there was found a large amount of pills in the main bedroom and vomit. Toxicology analysis revealed the presence of cannabis and greater than therapeutic levels of anticonvulsant, antidepressant and antipsychotic medication prescribed to him.

75. Mitchell could have well been suffering from a psychotic state due to prescribed medication drug use, cannabis use, post-ictal psychosis and/or a combination of those conditions.

76. In those circumstances although MitchelI's action were always likely to end his life, I am unable to determine whether Mitchell had capacity at the time to form an intention to take his own life.

[1] *R v Cardiff City Coroner, ex parte Thomas* [1970] 1 WLR 1475 at 1478
[2] *Suicide Reporting in the Coronial Jurisdiction,* Coronial Council of Victoria Consultation paper, 23 April 2014

77. A coronial investigation, independent expert review and RCA noted a number of deficiencies with respect to discharge planning and implementation. Those deficiencies have been the subject of extensive consideration and reflection and a number of recommendations have been implemented since Michael's death which should ensure events in similar circumstances will not occur in the future.

Findings required by s. 45

Identity of the deceased:	Mitchell James Follent
How he died:	Mitchell died as a result of a fall from a balcony at his residence 5 days after his discharge from hospital as a result of his first admission for a psychotic event. It was uncertain if this was drug induced or post ictal in the context of seizures. An open finding remains as to whether Mitchell had the capacity to form an intention to take his own life or whether he was in a psychotic state at the time.
Place of death:	141-147 Jacaranda Street NORTH BOOVAL QLD 4304 AUSTRALIA
Date of death:	20 August 2016
Cause of death:	1(a) Multiple injuries 1(b) Fall from height

I close the investigations.

John Lock
Deputy State Coroner
CORONERS COURT OF QUEENSLAND
6 November 2019