TRANSCRIPT OF PROCEEDINGS

CORONERS COURT

K O TAYLOR, Coroner

MAG-LFR 43 of 2005 COR-564/05(2)

IN THE MATTER OF AN INQUEST INTO THE CAUSE AND CIRCUMSTANCES SURROUNDING THE DEATH OF KYLIE DANIELLE HOOYMANS

MAROOCHYDORE

- ..DATE 07/07/2006
- ..DAY 2

FINDINGS

<u>WARNING</u>: The publication of information or details likely to lead to the identification of persons in some proceedings is a criminal offence. This is so particularly in relation to the identification of children who are involved in criminal proceedings or proceedings for their protection under the *Child Protection Act* 1999, and complainants in criminal sexual offences, but is not limited to those categories. You may wish to seek legal advice before giving others access to the details of any person named in these proceedings.

07072006 D.2 T11-12/LP M/T MARO 03/1011 (K O Taylor, Coroner) CORONER: These are my findings. I find that the deceased was Kylie Danielle Hooymans. I find that she died as a result of being suspended from her neck by a rope attached to an overhead beam at her residence. I find that she died on the 13th of March 2005. I find that she died at her residence at 7 Oakwood close, Tewantin. I find the cause of death was (a) asphyxiation due to (b) hanging.

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By those findings I have discharged the duty prescribed by section 45 of the Coroners Act.

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I also have duties prescribed by sections 46 and 48 of the Coroners Act.

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Section 48 requires me to determine whether there are grounds founding a reasonable suspicion that a person has committed an indictable offence or any other offence and if so, to report it to the relevant authority or agency. I am satisfied there are no grounds for such a suspicion and that this section has no application to the circumstances of this case.

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Section 46, although as to its empowering component, subsection (1), is expressed in discretionary terms, does require me to consider whether the circumstances justify a comment of the kind described in that subsection. It is a comment to be made whenever appropriate. In my view, a comment, whether a criticism or a suggestion, is only appropriate if it can be useful to achieve the purposes intended by section 46. That is not to say that a comment

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07072006 D.2 T11-12/LP M/T MARO 03/1011 (K O Taylor, Coroner) should be made only if there is a likelihood of it being acted upon but a comment is only justified if, in practical terms, it can be acted upon.

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Section 46 refers to things that relate to (a) public health or safety; or (b) the administration of justice; or (c) ways to prevent deaths from happening in similar circumstances in the future. There is nothing in the circumstances of Kylie's death which in any way relates to the administration of justice.

In circumstances such as this it is neither easy nor useful to attempt to separate the criterion described as that which relates to public health and safety from that described as that which relates to ways of preventing deaths from happening in similar circumstances in the future. Here the very issue of public health or safety involved is whether or not Kylie's death might have been prevented by a course of management of her illness different to that adopted. I shall not embark on any course of attempted distinction but, rather, adopt a global approach to those issues which might fall into one or the other category.

Professor de Leo expressed concerns he says are common to health services throughout this State or this nation. They are concerns which he says arise from shortage of beds and restricted admission criteria. He also expressed concern that admission assessments are done by trained nurses rather than psychiatrists. These are concerns which go to public policy

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07072006 D.2 T11-12/LP M/T MARO 03/1011 (K O Taylor, Coroner) which is thoroughly debated in the public forum. They do not go to systemic failures which might warrant a useful comment here.

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Kylie's family are concerned that Dr Ramaswamy increased the dosage of medication prescribed for Kylie in the course of a telephone conversation. I have considered whether or not any comment on that is justified. I am satisfied that it is not. Professor de Leo drew attention to the difference between an ideal world and the real world. From my experience, both in this and other jurisdictions, I am aware that it is quite common for medical practitioners to consult by telephone and such consultations often involve a variation of previous recommendations as to treatment program including medication.

It appears to me that it is a practice which, in practical terms, is essential to the service provided by medical practitioners to their patients. I do not doubt that in some circumstances such a practice may be unlawful, dangerous or otherwise inappropriate but I am satisfied that is not the case here.

On the evidence here, I am satisfied that each of the health care providers who attended to Kylie did so in a dedicated and professional manner and that both the assessment of Kylie's illness and the treatment program prescribed, including management at home, conformed with accepted orthodox practice. I see no point in the private professionals pointing towards the public professionals, or vice versa. I am a little uneasy

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07072006 D.2 T11-12/LP M/T MARO 03/1011 (K O Taylor, Coroner) about a certain element of haphazardness attached to mutual consultation. However, after careful consideration, I am unable to settle upon any useful comment available on the evidence.

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In my view, the main matter of concern arising from the evidence received at this inquest, is the understandable lack of awareness on the part of Kylie's family as to the interrelationship of the mental health services involved in Kylie's care. Kylie's family was charged with the heavy responsibility of attending to Kylie's day to day needs, of supervising her treatment program and even of assessing the effectiveness of that program. They had no experience or training. They were in an environment as foreign to them as it would be to any other family not experienced or trained in mental health and they were further burdened by anxiety and stress.

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On the evidence, I am satisfied that the decision to allow Kylie to be cared for at home, rather than admitted to hospital, was a decision properly available in the exercise of professional clinical judgment. But I am also satisfied that essential to the effectiveness of such a management plan, is an appropriate level of awareness on the part of those who were to undertake her daily care, Kylie's family.

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I am satisfied that the following comment is appropriate. It is my view that Queensland Health should ensure that in respect of each health service district, there is a district specific brochure distributed to all mental health service

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07072006 D.2 T11-12/LP M/T MARO 03/1011 (K O Taylor, Coroner) providers for redistribution to patients or their families which clearly outlines the mental health services available, both private and public, the manner in which they interact or complement each other and a guide to the criteria which determines the most appropriate service for their needs.

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I shall finally make a brief comment. In the course of my investigation and in the course of this inquest, it has become clear that the contribution of some standard medications to suicide is a matter of investigation and debate in appropriate circles. It is for that reason that I referent the circumstances of this death to Professor de Leo, in his capacity as Director of the Australian Institute of Suicide Research and Prevention. I have nothing further to add to that debate.

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And again, finally, with the Court's condolences offered to the family of Kylie, the inquest is closed.

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