IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2010 / 4396

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
*Section 67 of the **Coroners Act 2008***

I, JUDGE IAN L GRAY, State Coroner having investigated the death of Mikael Chandra ROHAN

without holding an inquest:
find that the identity of the deceased was Mikael Chandra Rohan
born on 10 July 1996
and the death occurred on 16 November 2010
at 200 metres south of Cheltenham Railway Station
from:

1 (a) HEAD INJURIES WHEN STRUCK BY A TRAIN

Pursuant to section 67(2) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances**:

1. Mikael Chandra Rohan was 14 years old when he died on 16 November 2010. Mikael's parents adopted him from Fiji when he was three months old. At the time of his death, Mikael lived with his parents and sister and was a student at Brighton Grammar School. Mikael was described by his family as a happy, curious, popular and social boy with a ready smile who enjoyed playing football and cricket. Mikael's father, Peter Rohan, reported having a very close relationship with Mikael throughout his life. Mikael also had loving and positive relationships with his mother, sister, aunt and grandmother. From all accounts, Mikael was a beloved and loving member of the Rohan family.
2. Victoria Police investigated the circumstances of Mikael's death and provided a coronial brief of evidence.

Medical history

3. Mikael had a medical history of separation anxiety with severe sleep disturbances, following his mother's, Anne-Marie Rohan's, hospital admission when he was a young boy. Dr Izzy Osowicki was Mikael's treating psychiatrist from 2007 until 2010 and diagnosed him with an attachment disorder. The frequency of Mikael's appointments with Dr Osowicki fluctuated, but he had seen Dr Osowicki fortnightly between August and October 2010. At the time of his death, Mikael had been prescribed Temazepam 10mg tablets for his sleep disturbances. Mikael had previously been prescribed the anti-depressant Lovan 10mg, as an anxiolytic (rather than anti-depressant).

4. In the months leading to his death, Mikael had been experiencing low or depressed moods, broken sleep and anxiety symptoms. This coincided with Mikael having a sexual relationship with a 16 year old girl in September 2010, resulting in the girl reporting she was pregnant. Mikael was very distressed at the news of the reported pregnancy. In early October 2010, Mikael told his year eight school co-ordinator, who notified the school psychologist. The school psychologist, who had been seeing Mikael since 2009, was not able to find evidence of the girl or pregnancy but notified Mikael's parents. Mr and Mrs Rohan offered Mikael support and arranged a medical appointment for him. The doctor notified the police (due to Mikael's age).

5. On 9 November 2010, Mikael ran away from the family home having left a note in his bedroom stating that adults couldn't help him. Mrs Rohan found him in Mentone, but Mikael ran away from her. Mrs Rohan eventually found him at the Mentone Railway Station. Mikael asked his mother if she was scared that he would jump in front of a train.

6. Mrs Rohan immediately took Mikael to see his GP, Dr Angela Garavalas, but she was unavailable. Mikael was seen by another GP at the practice, Dr Murkies, who contacted Dr Osowicki (who was on leave). Dr Murkies then referred Mikael to the Alfred Hospital Emergency Department, stating she was "seriously concerned" about Mikael and requesting he "see a psychiatric registrar".[1]

7. The Alfred Hospital told Mrs Rohan that they did not have anyone on shift to assess adolescents and suggested that Mikael attend the Monash Medical Centre (Monash). At Monash, Mikael was assessed by a Crisis Assessment Treatment Team (CATT) clinician, a

[1] Letter from Dr Alice Murkies to Alfred Hospital Emergency Department, dated 9 November 2010.

psychiatric nurse. The CATT clinician (Nurse Sebille) was provided with Dr Murkies' letter, which was also faxed to Headspace Southern Melbourne (Headspace)[2] and Dr Osowicki. Nurse Sebille assessed Mikael as:

a. not showing evidence of acute mental health issues or acute psychosis, delusional themes or perceptual disturbance;

b. 'low risk' for suicidality;

c. 'no apparent risk' for self harm; and

d. 'low risk' of absconding.

8. Nurse Sebille's notes state that she "discussed repercussions for his poor behaviour (running away)" with Mrs Rohan, who seemed "perplexed by (her) suggestion". Nurse Sebille did not refer Mikael for senior medical review of her assessments. Nurse Sebille stated that she followed Enhanced Crisis Assessment Treatment Team (ECATT) practice in 2010 and currently, which is to seek a telephone opinion via the on-call Child and Adolescent Psychiatrist only if the primary mental health clinician has concerns about management of the patient. Nurse Sebille's opinion was that there was "no evidence of acute affective illness, psychosis or acute suicidality" and that appropriate professional care and management were already in place, including a booking to attend Headspace the following day.[3]

9. Mikael's school psychologist had referred him to Headspace on 13 October 2010, in the context of distress regarding the reported pregnancy. Mikael attended five counselling sessions with a Youth Mental Health Clinician (Noah Ariel, a Mental Health accredited Social Worker) at Headspace between 13 October 2010 and 10 November 2010. At his appointment on 10 November 2010, Mr Ariel reported that Mikael minimised the reasons for the emergency referral the previous night as him having "nicked off". Mikael next appointment with Mr Ariel was scheduled for 18 November 2010.

10. Mr Ariel and Dr Osowicki consulted during the period of Headspace's involvement with Mikael, deciding that only one practitioner should be treating Mikael at that time (for continuity of therapeutic relationship and stability for Mikael). Mikael and Mr and Mrs

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[2] Headspace is a dedicated Commonwealth Government-funded youth mental health service offering counselling and support services to young people aged 12-25 and their parents/carers.

[3] Statement of Donna Sebille dated 31 March 2014.

Rohan do not appear to have been consulted sufficiently about this decision, though they were advised that Mikael should choose which therapist to continue treatment with. Mikael chose to continue attending Headspace and Mr Rohan terminated Dr Osowicki's treatment of Mikael on 29 October 2010. An appointment was booked with Dr Osowicki for a final session on 16 November 2010, to discuss his transfer to Mr Ariel's care.

11. On 15 November 2010, Mikael told his mother that his girlfriend had broken off their relationship.

12. At approximately 9.15am on 16 November 2010, Mikael attended beside the railway track approximately 220 metres south of Cheltenham Railway Station. Mikael then stepped in front of a city-bound train and was killed when it struck him. The police attended the Rohan family home later that day and obtained a notebook containing letters that Mikael had written to a number of people in his life. These letters indicated that Mikael's actions on 16 November 2010 were planned. Mikael made requests and a guest list for his funeral.

13. Dr Sarah Parsons, Forensic Pathologist performed a preliminary examination and reported that the Mikael's cause of death was head injuries sustained when struck by a train. I accept Dr Parsons' opinion.

14. Having considered all of the available evidence I am satisfied that there are no suspicious circumstances and that no further investigation is required. On the basis of the evidence available to me, I find:

    a. the identity of the deceased was Mikael Chandra Rohan;

    b. Mikael died on 16 November 2010, 220m south of Cheltenham Railway Station, from head injuries when he was struck by a train when he intentionally stepped in front of it.

COMMENTS

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

15. Mr and Mrs Rohan raised concerns about the following matters:

    a. the degree to which parents are engaged with, and included in, the treatment of their adolescent children presenting with psychiatric symptoms; and

b. the competence or qualification of the professionals dealing with Mikael at critical points, such as his assessment by a psychiatric nurse rather than the psychiatric registrar requested by his GP.

16. I referred these issues to the Coroners Prevention Unit[4] (CPU) and sought an expert opinion from Dr Peter Jenkins, Consultant Child and Adolescent Psychiatrist.

Parental engagement in treatment

17. There is evidence of the professionals involved in Mikael's care having shared information about his issues and diagnoses with Mr and Mrs Rohan. The school psychologist told Mikael's parents about the alleged pregnancy. Mr and Mrs Rohan met with Dr Osowicki two to three times per year to discuss Mikael's progress and Dr Osowicki shared information with them. However, Dr Osowicki stated that Mikael was reluctant for him to speak to Mr and Mrs Rohan about specific matters such as their relationships and his relationships outside the family (i.e. with peers and girls). Dr Osowicki advised that in August 2010, Mikael was speaking more openly with him about peer relationships but wanted those discussions kept private and confidential.

18. Mr and Mrs Rohan raised concerns that Dr Osowicki did not tell them that he had diagnosed Mikael with Attachment Disorder, but had told Mr Ariel (for treatment purposes). Dr Osowicki maintains that he diagnosed Mikael with an attachment disorder at the beginning of his therapeutic relationship with Mikael and that he communicated and discussed this diagnosis with Mr and Mrs Rohan from the outset. Dr Osowicki stated that he restated the diagnosis in many sessions with Mr and Mrs Rohan throughout his clinical involvement with the Rohan family.

19. Following Mikael's appointment on 10 November 2010, Mrs Rohan spoke to the Headspace clinician for approximately 20 minutes. They discussed Mikael's chosen support person, his presentation to Monash and her concerns about his absconding and risky behaviours, family therapy options and the merits of child-focused parent-work. The clinician's notes refer to Mrs Rohan refusing family therapy and initially refusing the child-focused parent-work, however later agreeing to discuss it further with Mr Rohan. Mr and Mrs Rohan were concerned that they were not advised after this appointment that Mikael had told the clinician the reported pregnancy had been terminated.

[4] The Coroners Prevention Unit ('CPU') is a specialist service for coroners established to strengthen their prevention role and provide them with professional assistance on issues pertaining to public health and safety.

20. In relation to parental engagement in adolescent treatment, Dr Jenkins opined that:

> *'The engagement and involvement of parents, or carers is generally accepted as crucial to the successful treatment of adolescents however the degree of involvement varies widely according to the clinical situation and the clinical approach taken.'*[5]

21. Dr Jenkins identified the issue of balancing the information sharing with parents and the need to provide a confidential therapeutic space for adolescents to feel they can freely discuss their concerns with the treating clinician.[6] Dr Jenkins advised that clinicians would ensure that, at a minimum, parents are engaged where:

    a. the adolescent's safety or the safety of others is at risk; and

    b. an adolescent has been sexually abused or assaulted (not generally including consensual sexual activity, unless the aftermath significantly impacted the adolescent's well-being).

22. I consider that Dr Osowicki and Mr Ariel's actions in not disclosing some matters that they discussed with Mikael in their therapeutic sessions, such as the family and peer relationships or the pregnancy termination, fits within the scope of confidential therapeutic space in this instance. Issues of greater consequence, such as Mikael's diagnoses and the initial pregnancy report, appear to fit within the scope of issues for which breaching Mikael's therapeutic privacy was warranted. These issues related to treatment plans which Mr and Mrs Rohan were rightly engaged in, including medical treatment for the unprotected sexual relations.

23. Of concern, Mr and Mrs Rohan and Mikael do not appear to have been sufficiently engaged in, or educated on, the possible ways to manage the involvement of both therapists (Dr Osowicki and Mr Ariel) in the last month of Mikael's life. The initial decision was based on Dr Osowicki's unavailability during that crisis period (when the pregnancy was reported) and the need for Mikael to have support at that time. This led to Mr Rohan terminating Mikael's treatments with Dr Osowicki in the period 29 October 2010 to 16 November 2010, on Mikael's decision to continue treatment with Mr Ariel. Unfortunately, this resulted in the loss of a stable and supportive therapeutic relationship with Dr Osowicki, whose long term treatment of Mikael may have enabled him to identify

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[5] Expert Opinion of Dr Peter Jenkins, Consultant Child and Adolescent Psychiatrist, dated 23 December 2013.

[6] Ibid.

the increasing risk to Mikael's mental health. This was possibly a lost opportunity to assist Mikael and may have otherwise provided stability of treatment in a period of increasing risk.

Qualifications of treating clinicians

24. Mr and Mrs Rohan raised concerns that:

    a. Nurse Sebille, who assessed Mikael at Monash on 9 November 2010 and who specialises in adult mental health, was not the appropriate person to assess their adolescent son in crisis, i.e. Mikael was assessed by a nurse when the GP had requested a psychiatric registrar (specifically for adolescents); and

    b. Mr Ariel was not suitably qualified to treat Mikael in his increasing state of crisis.

25. There is no evidence in the brief of senior medical review of Nurse Sebille's assessments by the on-call Child and Adolescent Psychiatrist, or any consequent intervention by Monash. The CPU identified that a senior medical staff member should assess the appropriateness of the assessment and interventions or the requirement for clinical review, following public mental health CATT and community team contacts. Dr Jenkins also considered the appropriateness of Nurse Sebille's assessment and related actions, finding:[7]

    'While Ms Sebille's assessment appears thorough ... it does not appear to have been discussed with the Child and Adolescent Psychiatrist on call...Such a discussion would have most likely focused on the decision to admit or not admit and given that Mikael was denying current suicidal thoughts it is probably unlikely that a different outcome would have been decided on ... Ms Sebille ensured that the outcomes of her assessment were communicated with the practitioners providing ongoing care.'

26. The unit head of Adult Mental Health at Monash (Clayton Campus) has since reviewed the relevant procedures and the clinical notes regarding Mikael's attendance and considered Nurse Sebille's actions correctly and comprehensibly followed Monash's procedures.[8]

27. I accept Dr Jenkins' advice that adolescent risk assessments are inherently complex due to factors including peer group influence and acting impulsively, and rely on the adolescent's engagement with the assessing clinician. I consider that Mikael's 9 November 2010 crisis assessment should have been reviewed by Monash's on-call Child and Adolescent Psychiatrist. It would be preferable that an experienced child and adolescent psychiatrist

[7] Ibid.

[8] Statement of Dr George Camilleri dated 1 May 2014.

conduct or at the very least review all adolescent crisis assessments, but particularly those undertaken by adult mental health clinicians, before a decision is made whether to release the adolescent home. However, I also accept Dr Jenkins' opinion that:

> *'On the whole, the care provided by each of the practitioners involved appears to have been thorough and consistent with the standards of usual clinical practice, however the coordination of care appears to have become confused as more practitioners became involved. ... While the coordination of care including the definition of roles and responsibilities of the practitioners involved is usually straightforward when a general practitioner and psychiatrist alone are involved, but becomes more complex when other mental health practitioners are also involved. This has prompted professional organisations including the Royal Australian and New Zealand College of Psychiatrists to develop guidelines for communication and collaboration between psychiatrists, general practitioners, psychologists and other mental health professionals to assist patient care.'*[9]

28. Unfortunately, Mr and Mrs Rohan's many attempts to obtain support and therapeutic treatment for Mikael in his increasing period of crisis were ultimately and tragically unsuccessful in preventing his death. I accept that this appears to have come down to the rapid increase in risk in the period 10 to 15 November 2010, culminating in the end of his relationship, which Mrs Rohan and Dr Jenkins consider may ultimately have been the precipitating factor in Mikael's actions on 16 November 2010.

29. Mr and Mrs Rohan described Mikael's behaviour on 14 and 15 2010 as reserved. However, Mr Rohan reported that Mikael seemed in good spirits on 12 and 13 November 2010 and that he and Mikael spent a very productive weekend together. However, Mrs Rohan reported that Mikael was distant on the night of 15 November 2010. Mr and Mrs Rohan reported that Mikael was quiet and more reserved on the morning of 16 November 2010.

30. Dr Jenkins explained the complexity of identifying risk, specifically for suicide, in adolescents. Dr Jenkins stated:

> *'... one needs to keep in mind that suicide ideation, and suicide attempts are common events in this age group, and are probably becoming more common, while completed suicide is a rare event. While there is some risk of completed suicide and serious harm*

[9] Ibid.

for all young people who have experienced suicide ideation, and it is important to provide interventions that have the best chance of a successful outcome, it is also important that interventions are not unnecessarily restrictive as this can diminish the chance of successful treatment. Hence risk assessment is an important element in clinical management.

Risk assessment is however inevitably an inexact science that considers a range of individual and contextual factors such as history and mental state examination as well as family and other supports. History is one of the best predictors of risk: individuals who have made previous suicide attempts resulting in significant injury are at higher risk of making a serious or fatal attempt on their life. Conversely individuals who have not previously made suicide attempts, such as Mikael, are generally at lower risk. Unfortunately in Mikael's case, the period between the risk becoming apparent for the first time and completed suicide was very short, thus limiting the potential opportunities to intervene.

Factors in adolescence such as the greater likelihood of acting impulsively ... make the accurate prediction of risk more difficult. In addition, risk assessment depends on the engagement of the adolescent with the assessing clinician. It can be difficult to achieve this particularly in a one-off interview when an adolescent may be prone to provide answers to questions in an effort to achieve a particular outcome, for instance going home from hospital rather than being admitted. ... In addition the predictive value of a risk assessment diminishes quickly over time particularly in the face of new stressors and life events.'

31. Although Nurse Sebille's experience may not have enabled her to assess Mikael's risk level as accurately as an adolescent mental health worker, I consider that Mr Ariel's qualifications and experience in adolescent mental health were appropriate and sufficient to treat Mikael in the period that he did. As mentioned previously, however, it is regrettable that Dr Osowicki's therapeutic relationship with Mikael did not continue in the final month of Mikael's life. However, it would be impossible to determine whether continuing that relationship could have prevented Mikael's actions on 16 November 2010.

RECOMMENDATIONS

Pursuant to section 72(2) of the **Coroners Act 2008**, I make the following recommendation(s) connected with the death:

1. That Monash Medical Centre consider reviewing its Crisis Assessment Review policies to include the requirement for an experienced Child and Adolescent Psychiatrist to review Adolescent Crisis Assessments, particularly those undertaken by adult mental health clinicians, before clinical decisions are made regarding their admission, treatment or otherwise.

I convey my sincerest sympathies to Mikael's family and friends at his tragic passing in 2010.

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

Mr. Peter Rohan, Senior next of kin

LSC David Kealy, Victoria Police

Prof. Jeremy Oats, Consultative Council on Obstetric and Paediatric Mortality and Morbidity

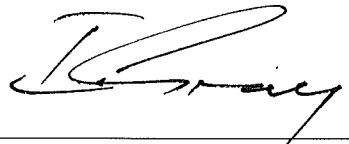
Dr. Ruth Vine, Chief Psychiatrist

Metro Trains

Monash/Southern Health

Headspace National Youth Mental Health Foundation

Signature:



JUDGE IAN L. GRAY
STATE CORONER
Date: 12/6/2014