IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2012 002216

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
*Section 67 of the **Coroners Act 2008***

Inquest into the Death of: DANIEL COLIN McKITTRICK

Delivered On:	26 November 2014
Delivered At:	Coroners Court of Victoria 65 Kavanagh Street, Southbank Victoria 3006
Hearing Dates:	9 and 10 December 2013
Findings of:	JUDGE IAN L GRAY, STATE CORONER
Representation:	Ms D Foy, Counsel for St Vincent's Hospital Mr R McCluskey, Counsel for North-West Mental Health Service Mr A Imrie, Counsel for the Chief Commissioner of Police
Counsel Assisting the Coroner:	Ms J Burns, Senior Legal Counsel

I, JUDGE IAN L GRAY, State Coroner, having investigated the death of DANIEL COLIN McKITTRICK

AND having held an inquest in relation to this death on 9 and 10 December 2013

at the Coroners Court in Melbourne

find that the identity of the deceased was DANIEL COLIN McKITTRICK

born on 23 February 1987

and the death occurred on 12 June 2012

at

from:

1 (a) MULTIPLE INJURIES SUSTAINED IN A FALL FROM A HEIGHT

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

BACKGROUND

1. Daniel McKittrick (**Daniel**) was born on 23 February 1987 and was the much loved son, and only child, of Brian and Michelle McKittrick. Daniel also had a stepsister, Joanne (born in 1970) and a step brother, Mark (born in 1968), who lived with their biological mother, Elizabeth (previous wife of Brian McKittrick).
2. Daniel died on 12 June 2012, aged 25, at approximately 4.15pm after he jumped 21.28 metres[1] from an eight-floor car park situated at Immediately prior to Daniel's death, Victoria Police Critical Response Team (**CIRT**) negotiators were negotiating with him in an attempt to secure his personal safety.
3. Brian McKittrick described Daniel as a person with a great sense of humour and quick wit who enjoyed bike riding, jogging, swimming, reading, music, films and video gaming (where he competed at state level).
4. Daniel had a history of depression and anxiety from his late teen years for which he sought treatment through psychologists and medical practitioners.
5. Daniel's stepbrother Mark, who had been diagnosed with schizophrenia, took his own life when Daniel was in Grade One. Daniel worshipped Mark and was devastated by the loss of his brother.

1 Inquest Brief page 4, statement of LSC Scott Harris

6. At the end of 2004, Daniel completed his schooling at Melbourne Grammar School and commenced studying Business Systems at Monash University, which he later changed to a Science degree.

7. Over the next few years, Daniel combined studying with working in the IT industry, where it is reported he was outstanding. Daniel designed nationwide IT systems and was head-hunted by competing firms.

8. At the beginning of 2012, Daniel and a work colleague decided to set up their own firm to subcontract to a larger company selling electricity supply. Daniel was disappointed when the business venture failed, and he became very depressed. Without any prompting from Daniel, his parents provided ongoing financial support during this uncertain period. Also during this time, Daniel was very concerned about his mother Michelle's deteriorating health after being diagnosed with cancer.

9. In 2012, Daniel's mental health deteriorated to the point where he presented at three separate hospitals and was admitted and treated as a voluntary inpatient on two of those presentations.

10. At the time of his death, the known stressors in Daniel's life were:

    - His mother, now deceased, had terminal cancer.
    - He was due to face the Academic Unsatisfactory Progress committee.[2]
    - His business venture failed.
    - He owed approximately $3,200 to a friend and had reached his limit on a number of credit cards.[3]

THE CORONIAL INVESTIGATION

11. *The Coroners Act 2008* (**the Act**) sets out the role of coronial system in Victoria. This role is to independently investigate certain deaths, to establish, if possible, the identity of the deceased, the cause of the death and the circumstances in which the death occurred.

12. The cause of death refers to the medical cause of death. For coronial purposes, the circumstances in which a death occurred refers to the context or background and surrounding circumstances, but is confined to those circumstances sufficiently proximate and causally relevant to the medical cause of death and not merely all circumstances which might form part of a narrative culminating in death.

2 Inquest Brief page 32
3 Inquest Brief page 37

13. A Coroner's role is also to contribute to the reduction of the number of preventable deaths and the promotion of public health and safety and the administration of justice.

14. Detective Sergeant Steven Martin was the coroner's investigator assisting me; he prepared the coronial brief and assisted me with my investigation.

IDENTITY

15. On 13 June 2012, Daniel was visually identified by his sister in law, Ms Gabrielle Fischer.

16. There is no dispute about Daniel's identity. I find Daniel's identity to be Daniel Colin McKittrick, born on 23 February 1987.

MEDICAL CAUSE OF DEATH

17. On 14 June 2012, Dr Yeliena Baber of the Victorian Institute of Forensic Medicine conducted an autopsy on Daniel's body and found no evidence of significant natural disease that may have contributed to his death, and no evidence of third party involvement.

18. Dr Baber determined the cause of death to be *1(a) Multiple injuries sustained in a fall from a height.*

19. Post mortem toxicology testing revealed the presence of low levels (0.01mg/L) of Olanzapine (Zyprexa),[4] consistent with Daniel being administered 5mg Olanzapine at the Royal Melbourne hospital prior to 9.00am on 12 June 2012.

WAS AN INQUEST MANDATED?

20. Section 52 (2) of the Act provides that it is mandatory for a Coroner to hold an inquest into a death if the death or cause of death occurred in Victoria and a Coroner suspects the death was as a result of homicide, or if Daniel was, immediately before death, a person placed in custody or care, or if the true identity of Daniel is unknown.

21. Daniel's death is not consistent with homicide. Daniel's identity and the medical cause of death are also not in dispute. However, the circumstances of Daniel's death, by virtue of section 3 of the Act, are that he was a person who a member of the police force was attempting to take into custody[5] by apprehending him under section 10 of the *Mental Health Act 1986.* Therefore, the circumstances of Daniel's death are such that it was

4 The evidence reveals that from the 1 June 2012 Daniel had been prescribed 10mg daily of zyprexa (Olanzapine) and 10mg daily temazapam (for sleeping)

5 The evidence reveals that from the 1 June 2012 Daniel had been prescribed 10mg daily of zyprexa (Olanzapine) and 10mg daily temazapam (for sleeping)

mandatory, and appropriate, for me to conduct an inquest. This matter was also managed in accordance with Practice Direction 1 of 2012 '*Opening inquests into police contact deaths.*'

INQUEST

22. On 9 and 10 December 2013, an inquest was held where the following witnesses gave evidence:[6]

    - Dr Andrew Walby, St Vincent's hospital.
    - Associate Professor Bosanac, Director of Clinical Services St Vincent's Mental Health, St Vincent's hospital.
    - Acting Senior Sergeant Ed Lappin.
    - Mr Michael Bruce, Manager, Consultation Crisis and Liaison Service, Inner West Mental Health Service with the Royal Melbourne hospital.
    - Detective Sergeant Steven Martin, Coroner's Investigator.

23. The scope of the inquest included examining the circumstances prior to Daniel's death, which included interactions with:

    - St Vincent's hospital in Melbourne on 11 June 2012, where he was triaged and then allowed to leave without assessment.
    - Royal Melbourne hospital on 12 June 2012 where he was triaged, admitted, assessed as a voluntary patient and then left the hospital.
    - Victoria Police at the car park situated at , in particular, the actions of the CIRT.

24. At the conclusion of the evidence, Mr Brian McKittrick provided me with a photograph of Daniel and a touching summary of his life which demonstrated how loved and popular he was.

25. Also at the conclusion of the inquest, I invited written submissions from interested parties. I received submissions from Brian McKittrick,[7] North-West Mental Health

6 There were no suppression orders made in relation to evidence given at the inquest
7 Submissions received from Brian McKittrick via email dated 8 February 2014

Service[8] and St Vincent's hospital.[9] The Chief Commissioner of Police did not make any submissions.[10]

26. I confirm that in light of the inquest evidence, I advised[11] all interested parties that I did not need submissions in relation to the RAPID database owned by the Department of Health.[12] Mr McKittrick did make a submission on the topic. It appeared to him that the actual efficiency of operation of the RAPID system is less than adequate in helping to prevent occurrences similar to those that lead to Daniel's death. Mr McKittrick submitted:-

> *"I had the impression—and I may have misinterpreted this—that as the operation of the RAPID system was outside of the control of the organisations involved in this case, such as St Vincent's Hospital, Melbourne and The Royal Melbourne Hospital, and rather the responsibility of the Victorian Health Department, that it was outside the aegis of this Inquest. I would have thought that a recommendation could be made even if the Health Department had not been directly involved in this Inquest, if that is what has become clear from this inquiry."*

27. The RAPID system is, of course focused on public mental health client information management. The sharing of relevant information is raised by Mr McKittrick and was the subject of the evidence of Mr Michael Bruce (statement dated 5 December 2012).

28. In his statement Mr Bruce said:-

> *"In respect to Daniel's attendance at St Vincent's Hospital Melbourne on the night previous to him being brought to the Royal Melbourne Hospital. There is no record in the Victorian Mental Health Data Base of Daniel's attendance at St Vincent's Hospital in Melbourne. Generally if Daniel had been assessed either partially or in full by St Vincent's mental health service then this should have been entered in the Victorian Mental Health Data Base which is accessible by all Victorian public mental health services. It is likely that Daniel left the St Vincent's Hospital Emergency Department without having been seen by the mental health service. This can only be clarified by contacting St Vincent's Hospital.*

8 Submissions received from North-West Mental Health Service via email dated 24 June 2014
9 Submissions received from St Vincent's Hospital via email dated 7 July 2014
10 Email from Jason Neuendorff, Senior Solicitor, Victorian Government Solicitors Office dated 20 June 2014 that stated submissions would not be filed on behalf of the Chief Commissioner of Police
11 Transcript pages 79–84
12 RAPID stands for Redevelopment of Acute and Psychiatric Information Directions and is the Victorian public mental health client information management system

Unfortunately there is no system in place that ensures communication between Emergency Departments other than directly calling another Emergency Department. As outlined above there is an electronic means of communicating for mental health presentations but this requires the patient to have been seen by mental health services.

I would certainly support the value of other Emergency Departments being aware of patients that have left an Emergency Department without having been seen. This information if known would indicate the increased likelihood of the patient leaving at subsequent hospital presentations."[13]

29. This case demonstrates that there would be a clear benefit and value, and potentially system improvement, if one Emergency Department was aware that a patient had left another Emergency Department with out having been seen and attended to.

30. I have obtained further submissions on this point and I intend to make a recommendation on the issue. Further submissions were received from the Department of Health[14] and St Vincent's hospital.[15] These were informative and constructive (I refer to these submissions in paragraph 92 under my Comments). The submissions assisted me to formulate an appropriate recommendation. I will make a recommendation because there would be a clear public benefit in a system of communication between service providers that would pick up a case like this when the patient has left one hospital Emergency Department without having been seen by its mental health service. I agree with Mr McKittrick's proposal and note the comment made in Mr Bruce's final paragraph (refer to above). In making the recommendation, I do not suggest that such a notification would necessarily have made a difference to the outcome in this case.

31. This finding draws on the totality of the material the product of the coronial investigation of Daniel's death. That is, the investigation, inquest brief and the statements, reports and testimony of those witnesses who testified at inquest, and any documents tendered through them. All this material, together with the inquest transcript, will remain on the coronial file. In writing this finding, I do not purport to summarise all of the evidence, but refer to it only in such detail as appears warranted by its forensic significance and the interests of narrative clarity.

13 Statement of Mr Michael Anthony Bruce, Inquest brief page 105-106
14 Correspondence from Leanne Beagley, Director Mental Health, Department of Health, dated 17 October 2014
15 Correspondence received from Legal Council, Paula Chatfield of St Vincent's Hospital, dated 15 October 2014

CIRCUMSTANCES OF DANIEL'S DEATH

29 May 2012, St Vincent's hospital, Sydney

32. Daniel's first admission as a voluntary in-patient was at the St Vincent's hospital in Sydney on 29 May 2012. Daniel was assessed as having anxiety and a possible first episode of psychosis and was treated with 5mg of Olanzapine[16] and 10mg of Temazepam.[17]

33. On 1 June 2012, at discharge, Daniel was diagnosed with 'Brief Reactive Psychosis' because he had shown signs of improvement.

34. Upon discharge, St Vincent's hospital provided Daniel and his father with a follow up plan that included a week supply of Olanzapine and a referral to the North Western Mental Health Services in Melbourne where an appointment was later scheduled for 12 June 2014. I am satisfied that St Vincent's hospital, Sydney did all that could be reasonably expected on Daniel's discharge.

35. Immediately upon returning to Melbourne, Daniel, together with his father, attended the Coburg Medical Clinic to secure a referral to psychologist, Mr Nigel Denning and a prescription for Olanzapine.

36. I note Mr McKittrick's submissions that he is firmly of the opinion that the 13 days that elapsed between Daniel being released from St Vincent's hospital in Sydney to the follow-up consultation with a psychiatrist at the North Western Mental Health Services in Melbourne was too long. Mr McKittrick's submissions noted and appreciated the principle of patient's rights, but his main concern was that mental health patients often underestimate the negative aspects of their current mental state and are more likely not to contact the service to request an earlier appointment. Mr McKittrick also appreciated the reason for the delay in the obtaining an appointment for Daniel was related to limited financial and personnel resources, and urged me to make a recommendation that these resources need to be improved to reduce the likelihood of similar tragedies in the future.

37. I agree with Mr McKittrick that there was delay in getting an appointment for Daniel with North West Mental Health Services. I agree also that there is a risk that patients will underestimate the seriousness of their current mental state. In this case, Daniel did engage with health care providers within the 13 day "gap" period. In the circumstances, I

16 Anti-psychotic medication
17 Sedative

am not satisfied that it was an unacceptable delay that warrants adverse comment or a specific recommendation. The service did provide interim telephone follow up with Daniel where he was asked questions about whether he was undergoing suicidal ideation and he replied that he was not. The only issue raised by Daniel was that he was having difficulty sleeping, and he was advised to visit his general practitioner for additional medication and to discuss his difficulty sleeping.[18]

4 June -9 June 2012 - Mr Nigel Denning – Psychologist

38. On 4 June 2012, Mr Denning saw Daniel and noted that he appeared fine, was managing his medication and had made an appointment to see a psychiatrist. His overall impression was that Daniel was distressed, anxious and was suffering from delusions. Results of a K10 Anxiety risk assessment tool were not critically elevated.[19]

39. On 8 May 2012, Mr Denning saw Daniel for the purpose of maintaining support until his psychiatrist appointment. Mr Denning noted that Daniel told him that he was seeing family and gave the appearance that everything was all right.[20]

40. On Saturday 9 June 2012, Mr Denning received a phone call from Daniel, in which Daniel told him he was out with a friend. Mr Denning formed the opinion that Daniel had been drinking and told him that drinking was not a good idea due to his high levels of stress and anxiety. Daniel told Mr Denning that he was okay because he was with a friend. Mr Denning assumed he rang for support as he had also rung him from Sydney. During this call, Daniel was keen to know if Mr Denning was able to read his thoughts. Mr Denning went through anxiety management techniques to help Daniel manage his delusions.[21]

41. Daniel did not attend his scheduled appointment with Mr Denning on 11 June 2012.

18 Inquest Brief page 105
19 Inquest Brief page 53
20 Inquest Brief page 53
21 Inquest Brief page 54

11 June 2012 - St Vincent's hospital, Melbourne

42. On 11 June 2012, Daniel had a second presentation to hospital, this time to the St Vincent's hospital Emergency Department in Melbourne. This presentation was because of events that evening, at approximately 7.04pm, where Daniel had telephoned 000 and stated that someone had slashed his car tyres and was hanging around his apartment. At 7.36pm, Daniel rang 000 again and asked if police were coming because he was nervous that someone was trying to hurt him.

43. Shortly thereafter, at approximately 7.45pm, police from the Brunswick Police Station attended the apartment and Daniel told them that he was suffering from psychosis, was hearing voices and had ceased his prescribed antipsychotic medication because they made him feel unwell.

44. Whilst the police members did not form the belief that Daniel fitted the criteria to be apprehended by virtue of section 10 of the *Mental Health Act 1986*, they sought assistance from Ambulance Victoria and he voluntarily went by ambulance to St Vincent's hospital. This was an appropriate action by the police officers concerned.

45. At approximately 8.57pm, Daniel was handed over to the St Vincent's hospital Emergency Department and was triaged[22] as a category 3 patient in accordance with the Australasian Triage Scale - Mental Health Triage tool (**triage tool),** and referred to the psychiatric triage service.[23] The triage tool category 3 provides:

    - an indicative time of 30 minutes for a person to be reviewed by a clinician: and
    - as a general management principle that a person should have 'close observation' as a means of supervision. Close observation being defined as regular observation at a maximum of 10 minute intervals and that the patient should not be left in the waiting room without a support person.[24]

46. Whilst waiting for assessment Daniel was requested to sit, without a support person, in the Emergency Department waiting room. At 10.45pm, the allocated psychiatric triage staff member went to look for Daniel but could not find him. Consequently, a handwritten note was made in the medical records to that effect that it appeared that Daniel had left the hospital without being seen by a mental health clinician. The hospital did nothing further to contact Daniel.

22 Triage as a concept is designed to sort patients into priorities in terms of their urgency to be seen
23 The St Vincent's hospital mental health team is co-located within the emergency department and provide assistance with patients who on arrival in the emergency department are determined to require a mental health assessment – Transcript page 12
24 Transcript page 20 and Exhibit 3

47. Dr Walby, Director of the St Vincent's Emergency Department and Professor Bosanac, Director of Clinical Services, Mental Health Services of the St Vincent's hospital both gave evidence at the inquest in relation to Daniel's triage in the Emergency Department and the circumstances of him leaving voluntarily without being assessed by a mental health clinician on this night. Importantly, they gave evidence about changes to the hospital's clinical guidelines, since 11 June 2012, to ensure that patients or their families are contacted in similar circumstances to offer that further advice or assistance and to endeavour to re-engage the patient.[25]

48. .Dr Walby's evidence was

> *"that Daniel was placed in a chair that was in front of the triage nurse so that she was able to keep a close eye on him. But the triage nurse is the only person who is able to really watch them. We do have clerical staff sitting at desks but it is not expected that the clerical staff are observing patients. That's not their role. The triage nurse is unable to - because the triage nurse needs to continue triaging, is unable to keep observation on a patient the entire time that they're sitting in the waiting room."*[26]

49. Dr Walby's evidence was that it is good practice when a person, in similar circumstances to Daniel, presents on their own to the Emergency Department and they are triaged as a category 3 that they offer to ring somebody to be with them while they wait to be assessed because *"it is difficult for us to provide that sort of observation.*[27]*...I certainly think in hindsight that particularly with the outcome I think there is no question in my mind that that would have been appropriate."*[28]

50. Whilst I do not criticise any of the individual staff at the St Vincent's hospital for the way in which they triaged Daniel on 11 December 2012, I note Dr Walby's evidence that the process for the hospital's management team for reviewing its policies in relation its management of mental health patients is ongoing. The hospital should, if it has not already done so, ensure that persons presenting on their own for mental health issues are given every opportunity to ensure someone they trust is contacted to be with them whilst waiting to be assessed. I intend to recommend accordingly.

51. I note, and commend, St Vincent's hospital for its concessions, through counsel, Ms Foy that:

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25 Transcript page 67
26 Transcript page 23
27 Transcript pages 23-26
28 Transcript page 26

"It wishes to express its sincere regret that it did not take steps to contact Mr Brian McKittrick about the departure of his son Daniel on the night of 11 June 2012. The hospital believes that whilst it was not mandatory to do so the circumstances of Daniel's presentation with the benefit of hindsight behoved the hospital to make telephone contact with Mr McKittrick him of Daniel's attendance and departure and to offer further advice or referral if requested"[29]

52. Dr Walby also stated that allowing Daniel to leave without assessment on this night

"Obviously in hindsight I personally think this was a lost opportunity[30]*....I think I concede that I do think this was a missed opportunity and I think in this circumstance if perhaps I had been involved at some point perhaps I would have made a call and I believe that communication with family members about any patient who's in the emergency department, if those family members are not present in the emergency department I think it's really important that we do make communication with other family members if it is important; if of course the patient agrees that we make contact with those family members. We do frequently have patients who specifically request that we make no contact with their family to let them know they're in the emergency department."*[31]

53. Associate Professor Bosanac's evidence was that, since 11 June 2012, the hospital put new clinical guidelines in place. The lesson was quickly learnt. If Daniel had presented with the new guidelines in place, in the same circumstances, and was referred to a mental health clinician and subsequently left without seeing the clinician

"that an attempt would have been made to contact Mr Daniel McKittrick and also Mr McKittrick Senior and/or contacting his regional mental health service to facilitate continuing - to attempt to facilitate further assessment and follow up Whilst not specified in the policy, as soon as practicable. It may well be on that - as soon as it was discovered that he was not there."[32]

54. However, such contact, if made, would not have compelled Daniel to return to the Emergency Department. At best, if the hospital contacted Daniel's father, all they could have done was to advise him of Daniel's attendance and departure and offer advice on what steps to take to have him assessed.

29 Transcript pages 2-3
30 Transcript page 31
31 Transcript, page 32
32 Transcript page 73

55. In light of Dr Walby's evidence that statistics showed that "*between 5-10% of patients leave an ED. The majority of them have left by two hours and the majority of those are males between 20 and 40 years of age*",[33] I agree that Daniel's attendance and his subsequent departure from the Emergency Department constituted a missed opportunity to assess him and offer him potentially valuable mental health assistance.

56. In September 2014 I wrote to the Department of Health, St Vincent's hospital, Victoria Police and Mr Brain McKittrick. I advised that I was considering a recommendation as follows:

That the Department of Health commission a review, the purpose of which is to identify opportunities and their feasibility for notification systems between health services. The review should include the relevant departments representing mental health Emergency Crisis Assessment and Treatment services and Emergency Departments, in conjunction with the relevant hospitals (St Vincent's and Royal Melbourne). The scope of the review should include:

a. Opportunities within existing service specific or state wide electronic patient information system to enable timely notification to other services of mental health patients who are triaged but who left without assessment and/or treatment;

b. Alternative methods aimed at enabling timely notification of mental health patients who are triaged who left without assessment and/or treatment, to other services.

57. The department of Human Services and Victoria Police advised that they do not wish to respond to the proposal. The Department of Health and St Vincent's hospital both provided constructive and informative responses.

58. In its response, St Vincent's outlined a number of considerations which it submitted would have to be taken into account in the event of a recommendation of this nature being made and to aid with its implementation. Each submissions drew my attention to the realities of the current system of triage, use of the RAPID System, access to RAPID, practical issue and ethical issues.

33 Transcript pages 29-30, lines 30

59. The submission stated:

> *"If in Mr McKittrick's case, it had been recorded on RAPID for example that he has been found on the Northern Melbourne train tracks, such information would be a harbinger of the acuity of risk posed to him at that time. However this information, whilst not recorded in RAPID, was likely communicated to the Royal Melbourne Hospital ("RMH") staff when Mr McKittrick was taken to its Emergency Department – the information was already likely known by staff as Mr McKittrick was taken to the RMH Emergency Department pursuant to the provisions of section 10 of the Mental Health Act 1986. Further, St Vincent's could not have entered the fact of the Northern Melbourne railway tracks incident because Mr McKittrick was found there some hours later after he left the St Vincent's Emergency Department."*

60. St Vincent's stated by way of summary that it:

> *"supports the proposal for the Department of Health to conduct a review to identify opportunities for notification systems between Victoria health services (Australia wide would be preferable but I am assuming the proposal is limited to Victoria). Such a review would need to take into account the fact that non-mental health clinicians will be involved in the care of a mental health patient at the point of presentation to an Emergency Department. Therefore, such a review must take into account the fact that RAPID is not accessible to such staff. The governance and ethics of clinicians using such information and recording it ought to be part of such a review and consideration ought to be given to the busy demands of an Emergency Department and the heavy administrative requirements already placed on staff."*

61. I am grateful for the assistance and information provided by this submission. I commend St Vincent's for it offer to assist the Department of Health in implementing a recommendation along the lines proposed.

62. I accept that the proposed view would need to take into account the matters raised in the St Vincent's submission, in particular the matters set out in paragraph 14:

> *"Such a review would need to take into account the fact that non-mental health clinicians will be involved in the care of a mental health patient at the point of presentation to an Emergency Department. Therefore, such a review must take into account the fact that RAPID is not accessible to such staff. The governance*

and ethics of clinicians using such information and recording it ought to be part of such a review and consideration ought to be given to the busy demands of an Emergency Department and the heavy administrative requirements already placed on staff."

12 June 2012, Royal Melbourne hospital

63. On 12 June 2012, Daniel had a third hospital presentation at the Royal Melbourne hospital. Prior to this presentation, at 6.23am, police were called to the North Melbourne rail yards because Daniel had been observed near railway tracks. Daniel was delusional and suicidal. He was arrested for his own safety under Section 10 of the *Mental Health Act 1986* and conveyed by ambulance to the Royal Melbourne hospital. This was also an appropriate action on the part of police officers.

64. At 8.30am, Daniel left the responsibility of the police on handover to Royal Melbourne hospital medical staff. Daniel was assessed and a decision made, and supported by a number of senior psychiatrists, to admit him voluntarily with the proposed plan that should his mental state deteriorate or should he attempt to leave the Emergency Department, he was to be recommended under Section 12AA of the *Mental Health Act 1986.*

65. Whilst waiting for a bed to be available, Daniel was escorted by a psychiatric nurse to get some fresh air outside, and once outside he left the hospital. It should be noted that whilst Daniel left the hospital without the permission of the hospital, his status was that of a voluntary patient.

66. Upon Daniel leaving, legal documentation to have him recommended under section 12AA of the *Mental Health Act 1986* was initiated and he was reported as a missing person.

67. The critical issue in this inquest was how Daniel was able to leave the hospital on this occasion without treatment.

68. Daniel's presentation at the Royal Melbourne hospital was such that on triage he was not considered an immediate suicide risk, despite the fact that he was brought in by police pursuant to section 10 of the *Mental Health Act 1986* from the North Melbourne railway yards in circumstances where it was clear he had suicidal ideation.

69. In my opinion, the triage at the Royal Melbourne hospital should have placed greater weight on that immediately preceding event. However, despite this, I am not satisfied that the care and arrangements undertaken by the hospital were deficient; the triage

assessment was conducted by a very experienced psychiatric nurse who, in good faith, had reasonable grounds to believe that Daniel wanted psychiatric help, wanted to be in hospital and would therefore be likely to be compliant. These are difficult judgement calls by the relevant clinicians and nurses – in this case a nurse of considerable experience whose evidence I accept.

70. This appeared to justify voluntary assessment, at that point, although with the benefit of hindsight and in the light of the North Melbourne railway yards incident, involuntary admission at the Royal Melbourne hospital may have been justified.

71. Mr Michael Bruce, a registered psychiatric nurse and the manager of the ECATT[34] service based in the Royal Melbourne Emergency Department gave evidence in relation to the policies and procedures at the hospital and of a meeting with Daniel's family on 29 June 2012, regarding their concerns with Daniel's management. Mr Bruce's evidence was that after reviewing Daniel's medical records, at the time of him leaving the hospital there had been no mental health diagnosis.[35]

72. Mr Bruce's evidence was that when a patient first comes into the ECATT an attempt is made to obtain as much information as possible to assess the risks for the patient, including the risk of absconding and the best way to treat them.[36]

73. I accept Mr Bruce's explanation of they way Daniel was managed and note his evidence:

> *"the main principle underlying the Mental Health Act is that patients should be managed in the least restrictive environment. Part of that is the capacity or the consideration and the capacity for patients to make decisions about their own treatment. In order to certify someone which then puts them compulsorily under the Act you would look for a number of indicators, and one of the key indicators in that is that the person is unable to unwilling to consent to psychiatric treatment or a mental health plan. And I think this was the critical differentiating factor for Daniel, that he was agreeable to coming into hospital. He had some insight into having a mental illness, not knowing the degree of that at this point in time. For us they're usually pretty clear indicators that we don't need to invoke the Mental Health Act and as much as possible you involve people voluntarily in their own treatment. And in part not certifying someone is*

34 ECATT is a specialist psychiatric service within the emergency department and its function is to take referrals or patients that present to the emergency department that may have psychiatric concerns
35 Transcript page 17, lines 8-9
36 Transcript page 18

actually, it's empowerment in their own treatment process and that's a desirable process for anyone".[37]

Under the Mental Health Act, the general principle that care should be provided in the *"least possible restricted environment and least possible intrusive manner consistent with the effective giving of that care in treatment"* is a key and entrenched principle. I accept that it informed the decision-making in relation to Mr McKittrick.

74. Mr Bruce noted that Daniel was not resistant to going to the hospital with the police, was very willing to be involved with the assessment by the psychiatric nurse and after the psychiatric nurse communicated to him that he had determined that he needed psychiatric admission, he was willing to be admitted.

75. I accept Mr Bruce's evidence that Daniel's situation was rare in that

> *"what is more typical for psychiatric presentations who abscond is they generally will not give you any warning, they're not generally people we've escorted to the front of the emergency department for a breath of fresh air or a cigarette. It tends to be the more unpredictable spontaneous, often inside the emergency department, they do a runner right through the emergency department then out through the exit points".*[38]

76. I also accept Mr Bruce's evidence based on his expertise and experience that when determining whether a mental health patient, in circumstances such as Daniel spending an extended period in a small cubicle, is likely to leave without treatment they will generally observe increased level of agitation, such as pacing and verbalising they want to leave.

77. Daniel, in effect, did none of that in the five hours he was in the Emergency Department and presented as someone willing and compliant. He did not dispute his need to be in hospital when the psychiatric nurse advised him that a bed had become available. I therefore accept Mr Bruce's evidence that these indicators, collectively, reasonably informed the hospital that Daniel was someone at extremely low risk of leaving without treatment.

78. I also acknowledge Daniel's family does not make any criticism of the psychiatric nurse who took Daniel outside. On the contrary, they believe this nurse was good, and praised him, at the inquest, for the caring approach he took to Daniel.

37 Transcript page 26
38 Transcript page 29

79. I make no adverse comments about the actions of the psychiatric nurse because his actions were taken in good faith, well intentioned, in accordance with Daniel's request and consistent with hospital practice at the time. In particular, I note as at 12 June 2012 the hospital had a practice of taking patients outside for a smoke or fresh air. Mr Bruce's evidence at the inquest was that at the time of Daniel's presentation, it was usually at the clinician's discretion based on the clinical presentation of the patient they were assessing as to whether they would be able to leave the Emergency Department.[39]

80. Since this incident, and in direct response to Daniel's death, the Royal Melbourne hospital has appropriately reviewed this practice and introduced "Guidelines for the Management of Mental Health Patients in the Emergency Department (June 2012)[40] which provides that whilst its is preferable to manage mental health patients in the least restrictive manner. It should be recognised that ECATT patients who have voluntary status can still represent a significant risk of leaving the Emergency Department with an adverse outcome. Mr Bruce's evidence was that if Daniel was to present under the new guidelines, he would be assessed in the same manner by a psychiatric nurse, and then it would be made clear that he would not be able to go outside the Emergency Department.[41]

> *"Daniel would be told that, it would be documented in his notes and everyone would be aware of that.*
>
> *If Daniel expressed a desire to leave how would that be managed?---Well, it would depend on who he expressed it to but normally what would happen is the ECAT clinician would be called back to see Daniel, unless Daniel had actually said that to the ECAT clinician. In this case [...] would have a discussion with Daniel and find out why he wanted to leave and [...] would reiterate to Daniel that's not possible."*[42]

81. I commend the Royal Melbourne hospital for the open manner in which it engaged with Daniel's family after his death by way of its written correspondence and meetings.

39 Transcript page 22
40 Inquest Brief, pages 466-468
41 Transcript page 25
42 Transcript pages 25-26

Victoria Police negotiators at car park

82. Shortly after leaving the Royal Melbourne hospital, Daniel was observed by a number of Origin Energy staff on the roof level of the multi level car park at , Melbourne. The police attended because of 000 calls.

83. The car park was contained and controlled for traffic. CIRT including trained negotiators, Ambulance Victoria, the Metropolitan Fire Brigade including a High Angle rescue team and the Police Search and Rescue unit attended.

84. Communications continued with Daniel from a distance of approximately 7.5 metres (three car widths), and no attempt was made to physically approach him.

85. Acting Sergeant Lappin gave evidence at the inquest of the police response to the incident. I accept Acting Sergeant Lappin's evidence that all attending police complied with Victoria Police protocols, procedures and expectations in dealing with a critical incident of this nature. I am also satisfied that the attending police did all that they could to secure Daniel's personal safety, in the circumstances.

CONCLUSION

86. Having considered all of the evidence, I find that Daniel McKittrick died on 17 December 2011, aged 25, as a result of multiple injuries sustained in a fall from a height. I am satisfied that Daniel intended to take his own life.

COMMENTS

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

87. Daniel did not leave a suicide note; however, the evidence strongly indicates that he intended to take his own life. The exact reasons for this are not entirely clear, however, there was one missed opportunity to assess and treat him in the period leading up to his death.

88. Since this incident, St Vincent's hospital, Melbourne has changed its policy so that it would have proactively followed up Daniel after he left without assessment and/or treatment. This is an appropriate response.

89. It is not open on the evidence to find that, even if Daniel had been assessed by a mental health clinician at St Vincent's on the night of 11 June 2012, he would have necessarily

been detained as an involuntary patient of St Vincent's hospital, or that the tragic incident on 12 June 2014 would have been avoided.

90. Since this incident, the Royal Melbourne hospital has also changed its clinical guidelines, and now would not have allowed Daniel to leave the Emergency Department.

91. I note the submissions received from the Department of Health and St Vincent's hospital (referred to at paragraph 31).

92. In its letter, the Department of Health advised that it "*welcomes Judge Gray's attention to notification systems between services and is broadly supportive of the proposed review*". The letter drew my attention to a number of issues which "*may impact on the feasibility of any opportunities to implement notification systems between services*". The letter sets out those issues. I accept that issues such as those nominated are real and need to be taken into account. I note also that as the letter points out, in Daniel's case, "*increased levels of information sharing between services/hospitals would not have assisted as he left the Emergency Department of St Vincent's Hospital prior to being seen by a mental health clinician. In these circumstances no registration on CMI (Client Management Interface) would have occurred*".

93. The issues raised by the Department of Health are not insignificant but, as noted earlier, this case justifies further work being done by way of a review of the potential to maximise information sharing in the interest of reducing the risk of outcomes such as this. The issues raised by the Department may not be insurmountable after careful review and consideration of the options for change.

RECOMMENDATIONS

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

1. I recommend that St Vincent's hospital review, or continue to review, relevant procedures and protocols to ensure that it is clear to hospital staff that they need to ensure that persons presenting on their own in relation to mental health issues are given every reasonable opportunity to ensure that someone they trust is contacted to be with them while they are waiting to assessed, and if necessary, are assisted in making the contact.

2. I recommend that the Department of Health commission a review, in conjunction with relevant hospitals (St Vincent's and Royal Melbourne) of the systems of communication between service providers (Emergency Departments) for the purposes of providing early communication and notification between Emergency Departments about patients who

have attended an Emergency Department seeking or requiring mental health treatment or advice, but who leave that Emergency Department without being seen by a relevant medical practitioner. In short, I recommend a consideration of what aspects of the RAPID (or other) communication system could be improved by creating a notification system between Emergency Departments.

Pursuant to section 73(1) of the **Coroners Act 2008**, I order that this Finding be published on the Court website.

I extend my condolences to the family of Daniel McKittrick.

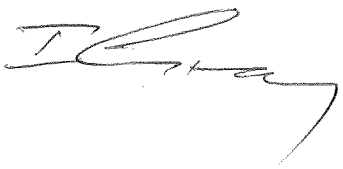
I direct that a copy of this finding be provided to the following:

Mr Brian McKittrick, Senior Next of Kin

Chief Commissioner Ken Lay APM, Victoria Police.

Detective Sergeant Steven Martin, Coroner's Investigator, Victoria Police.

Signature



JUDGE IAN GRAY

STATE CORONER

Date: 26/11/14