FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

Section 67 of the ***Coroners Act 2008***

Court reference: 4973/08

Inquest into the Death of ELIJAH MICHAEL SHELLEY

Delivered On:	1st September, 2011
Delivered At:	Coroners Court of Victoria Level 11, 222 Exhibition Street Melbourne, Victoria 3000
Hearing Dates:	10th March 2010
Findings of:	CORONER JOHN OLLE
Representation:	Mr P Halley on behalf of The Alfred Hospital
Place of death/ Suspected death:	Unit 4, 10 Elm Avenue, Elsternwick, Victoria 3185
PCSU:	Leading Senior Constable G McFarlane

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Court reference: 4973/08

In the Coroners Court of Victoria at Melbourne
I, JOHN OLLE, Coroner

having investigated the death of:

Details of deceased:

Surname: SHELLEY
First name: ELIJAH
Address: Unit 4, 10 Elm Avenue, Elsternwick, Victoria 3185

AND having held an inquest in relation to this death on 10th March, 2010 at Melbourne

find that the identity of the deceased was ELIJAH MICHAEL SHELLEY and death occurred on 6th November, 2008

at Unit 4, 10 Elm Avenue, Elsternwick, Victoria 3185

from
1a. HEROIN TOXICITY

In the following circumstances:

1. Elijah Shelley was aged 28 years at the time of his death. He lived at Unit 4/10 Elm Avenue, Elsternwick.

2. The coronial brief has fully addressed the circumstances of Elijah's death.

3. At inquest I heard evidence of Mr David Perry, Ms Lorraine Harkness and Dr Fran Arcuri.

The Focus Of My Investigation

4. The Medical Management of Mr Shelley at Alfred Health has been the focus of my investigation.

5. A detailed report of Dr Arcuri, Consultant Psychiatrist, has set out, in detail the management of Elijah, in particular in the period prior to his death.

6. In addition Dr Arcuri, gave evidence at the inquest. She was a most impressive witness.

7. Though unable to attend the inquest, Elijah's parents have participated fully through submissions and review of the Brief and transcript of proceedings. I have received and reviewed the detailed submissions of Elijah's father.

About an Inquest

8. The Coroner's Court is different from other courts. It is inquisitorial rather than adversarial. In other words, an inquest is not a trial, with a prosecutor and a defendant. At an enquiry that seeks to find the truth about a person's death - to establish what happened, rather than who is to blame.

9. Coroners consider all the evidence and material that comes before them. Not every issue makes its way to the finding, but everything has been weighed up and analysed.

Background

10. Elijah shared residence provided by MIND Australia, an outreach support group for people living in the community suffering a mental illness.

Mental Health Illness

> *"Elijah had a background history of Borderline Personality Disorder (BPD), complicated by Depression, Anxiety and polysubstance and alcohol abuse/dependence, dating back to early childhood."*[1]

11. In addition, Elijah had suffered a prior episode of drug induced psychosis. Of note:

> *"His history is characterised by long standing intermittent suicide ideation associated with a number of suicide attempts (mainly via overdose, prescribed medication and or heroin), often in a setting of crisis and acute stress. This has warranted multiple contacts and admissions for psychiatric services in Victoria (the Alfred and Monash Medical Centre) and interstate (Queensland), and he has trialled multiple anti-depressants over the years."*[2]

[1] Statement, Dr Fran Arcuri.
[2] Statement, Dr Fran Arcuri.

12. Dr Arcuri detailed the nature and extent of inpatient psychiatric admissions, notably in 2008. Elijah received social support from his case manager from Edith Pardy House.

13. Elijah's final admission to the Alfred emergency department commenced on the 27th October 2008, in a context of alleged suicide attempt via heroin overdose.

The Final Admission

27th October 2008

14. Elijah presented to Alfred Health. He was admitted as a voluntary patient under the care of Dr Arcuri, Consultant Psychiatrist.

15. Thereafter, the treatment team, headed by Dr Arcuri, provided comprehensive care and management. In particular, the members of the treatment team were appropriately engaged. Plans were developed and implemented.

30 October, 2008

16. Elijah had an event of superficial self-harm.

31 October 2008

17. At psychiatric review, Elijah informed Dr Arcuri he had "bit more hope" and that he "wanted to try to live". Dr Arcuri positively engaged with Elijah.

18. Elijah was offered escorted leave with staff.

1st and 2nd November 2008

19. Elijah had escorted leave - improvement was noted.

3rd November 2008

20. On psychiatric review, Elijah described to Dr Arcuri suicide ideation. He had no plan or intent. Elijah's frankness was indicative of the therapeutic rapport developed between Elijah and Dr Arcuri.

21. Staff noted Elijah had "good engagement with the group musically and verbally" and he was observed by staff to be "bright, reactive and spontaneous".

Over the following days

22. Elijah was noted to be engaging in various activities on the Ward. Further, Dr Arcuri observed Elijah become brighter. He was visited by a friend; was eating and sleeping well. Further, Elijah was not requesting medication to alleviate anxiety or agitation.

23. Elijah was granted periods of short escorted leave. Leave periods occurred without incident.

5th November, 2008

24. At review, Dr Arcuri assessed Elijah as low risk of suicide self harm. A trial of two hours unescorted leave was granted, consistent with discharge plan. He attended an AA meeting with a friend.

6 November, 2008

25. Elijah attended a group at Prahran Mission. The visit was part of his occupational therapy group program:

> *"He was noted to be enjoying himself, interacting with co-patients, and spoke of future aspirations regarding employment (statement of Dr Arcuri (Exhibit 4)/see also evidence of Dr Arcuri, transcript page 55, line 1 to 3)".*[3]

26. The treatment plan appeared appropriate

27. The treatment plan including regular episodes of initially escorted and subsequently unescorted leave appeared appropriate. Dr Arcuri's reviews were regular and comprehensive. In all the circumstances, it appeared Elijah was benefiting from the periods of leave.

28. In my view, the plan was both reasonable and sensible.

29. There was no reason to consider an alteration in the plan and/or cessation of leave was necessary.

30. Following the successful group outing at the Prahran Mission, Elijah returned to the ward. He subsequently left on a planned two hours of unescorted leave.

[3]Submission, Alfred Health

31. Elijah returned home sometime between 2.00pm and 3.00pm that day.

32. Elijah, upon his failure to return to the Ward at the stipulated time, was subsequently found deceased at his home.

> *"Elijah was found with a silver foil packet, a sealed syringe, a used syringe, a silver coloured dessert spoon and a pad containing two suicide notes."* [4]

Conclusion

33. Elijah's death is a tragic loss. Though a chronic suicide risk, there was no reasonable basis to consider him at risk of suicide on the 6th November 2008. The clinical judgements exercised by the treatment team headed by Dr Fran Arcuri were appropriate and reasonable.

34. I endorse the conclusion of submissions for Counsel for Alfred Health:

> *"Prior to the unescorted leave on 6th November 2008, Elijah had utilised escorted leave on 1st and 2nd November 2008 and unescorted leave on 5th November 2008, attending an AA meeting on the evening of 5th November 2008, and attending Prahran Mission on the morning of 6th November 2008. All of these outings were successful and as such revealed nothing to suggest that unescorted leave on 6th November 2008 was inappropriate."*

35. Dr Arcuri explained the importance of initially unescorted and subsequently escorted leave. There is no reasonable basis to connect the tragic death of Elijah with the clinical judgements and decisions exercised by staff of Alfred Health and in particular Dr Fran Arcuri.

Post Mortem Medical Investigation

36. On 11th November 2008, Professor Stephen Cordner, Forensic Pathologist with the Victorian Institute of Forensic Medicine, performed an external examination on the body of Elijah Michael Shelley.

37. Professor Cordner found that the cause of death to be unascertained in a setting of intravenous drug self administration.

[4] Senior Constable Bastian

Finding

I find that the cause of death of Elijah Michael Shelley to be heroin toxicity in circumstances in which Elijah committed suicide.

Signature:

John Olle
Coroner

Date: 1/9/2011