IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2011 0761

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of:	**JAMES LESLIE KUTI**
Delivered On:	1 May 2014
Delivered At:	Coroners Court of Victoria Level 11, 222 Exhibition Street Melbourne 3000
Hearing Dates:	1 May 2014
Findings of:	CAITLIN C ENGLISH, CORONER
Police Coronial Support Unit	Leading Senior Constable King Taylor

I, CAITLIN ENGLISH, Coroner having investigated the death of JAMES KUTI

AND having held an inquest in relation to this death on 1 May 2014
At Coroners Court MELBOURNE
find that the identity of the deceased was JAMES LESLIE KUTI
born on 7 October 1994
and the death occurred on 27 February 2011
at 168 Sladen Street, Cranbourne 3977
from:

1 (a) MULTIPLE INJURIES AS A RESULT OF HIGH SPEED IMPACT (TRAIN)

in the following circumstances:

1. James Kuti (James) was 16 years of age when he died. James was born to Lorelle Orwin and Leslie Kuti, one of two siblings, his older sister Kerryn, and two half siblings, Chris and Karl. He was living in a child protection residential placement at 96 Jesson Crescent Dandenong at the time of his death and was subject to a Custody to Secretary Order.

2. Due to James' 'in care' status, his death was reportable to the Coroner in accordance with Section 11 of the Coroners Act 2008 (Vic). Subject to Section 52 (2) of the Coroners Act 2008 (Vic) the Coroner must hold an inquest into a death if the deceased was, immediately before death, a person placed in custody or care.

3. James was 11 years old when his parents separated and he remained living with his mother until he was 13. At 13 James was placed in the care of Department of Human Services (DHS). When James was 15 he was diagnosed with psychosis and medicated with monitored fortnightly Resperidone depot injections.

4. The Custody to Secretary Order James was subject to was extended on 9 April 2010 and remained in force until 8 April 2011. James was a dual child protection and disability services client. James was also subject to a Community Treatment Order, which on 16 July 2010 at a scheduled review of the Mental Health Review Board was continued for a further 12 months.

5. James medical history included attention deficit hyperactive disorder, schizophrenia and a borderline intellectual disability.

6. Associate Professor Brendan Murphy, Lead Consultant Psychiatrist, Southern Health Early Psychosis Service, was responsible for James' mental health and provided the following history of Southern Health's medical management of James;

7. James was cared for by the Southern Health Mental Health Program from April 2010 until his death in February 2011. He had a diagnosis of schizophrenia in the context of a first-degree family history, an intellectual disability and cannabis use since 13 years of age. He presented to Southern Health's Mental Health Program in April 2010 with a first psychotic episode of several months standing. He was initially treated in the inpatient unit before being managed as an outpatient, firstly by Southern Health's Child and Adolescent Mental Health Service (CAMHS) and subsequently by Southern Health's Recovery and Prevention of Psychosis Service (RAPPS). RAPPS is a multi-component, phase-specific, early intervention service for young people experiencing psychosis and part of the Victorian Department of Human Service initiative to provide intensive treatment to all young persons over the age of 16 presenting with a first episode of psychosis. He was treated from an early stage with intramuscular antipsychotic medication, but continued to have unremitting auditory hallucinations that appeared to fluctuate with his ongoing cannabis use. He was regularly assessed in addition to being linked in with both the Adolescent Recovery Centre and the Eastern Region Mental Health Association group program. Regular liaison occurred with his Wesley Youth Services worker and with DHS. While he had a previous history of antisocial behaviour and violence, there was little evidence of this during his time with the service. There were no episodes of self harm and his illness was not characterized by suicidal ideation.[1]

Events prior to death

8. A police investigation was conducted into the circumstances of James' death.

9. In September 2010, James had an altercation with his brother at home and police were contacted. An intervention order was made by Dandenong Magistrates Court until March 2011 which prohibited James from being at his mother's home address but allowed for family contact outside of that prohibition.

10. James had resided at a child protection residential placement, Jesson Crescent Residential Care Unit (RCU) since April 2010.

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[1] Statement of Associate Professor Brendan Patrick Murphy, 11 August 2011, Inquest Brief.

11. In February 2011 staff at James' residential placement recorded that he "*had been making efforts to contribute to the running of the home and that there was improvements in the form of his ability to socialise and his overall demeanour.*"[2]

12. On 28 February 2011 James went for an afternoon outing with residential staff returning at 4.45 pm.

13. At 7.00 pm James contacted his mother by telephone and then requested a lift to Dandenong train station by Jesson Crescent RCU staff stating that he was going to Narre Warren. It was arranged with James that he would be collected from outside Centrelink in Dandenong by residential care staff at 9.30 pm. This arrangement was made as a strategy not to support James visiting Ms Orwin's home given the Intervention Order he was subject to.[3]

14. At 7.15 pm, James was driven to Dandenong train station by Jesson Crescent RCU staff, with arrangement for his collection at the Dandenong Centrelink at 9.30 pm. James attended his mother's residence. Lorelle Orwin states she told James to leave when he "turned up at [her] house to see his sister and I told him that he had to go back to the residential unit because he wasn't allowed to be here because of the intervention order". Ms Orwin states that James asked her "why is that other boy staying here? Why do I let him stay?"[4] to which she asked what he was talking about and that no one was staying there. Ms Orwin states that she did not understand what he meant by this.

15. At 9:30 pm, James contacted the RCU and requested to be picked up from Lorelle Orwin's home, but Jesson Crescent RCU staff told him the agreement was to pick him up at Dandenong Centrelink building and he stated he would call them when he arrived at Dandenong Station.

16. Lorelle Orwin reports after James' sister gave him some cigarettes, he left the house at approximately 10:05 pm. It is reported that James left, with the intention to return to the Jesson Cresent RCU as planned.

17. At 10.45 pm, Lorelle Orwin telephoned Jesson Crescent RCU staff and asked to be notified when James returned as she was concerned about his welfare.

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[2] Overview of Wesley Children Youth and Family Services involvement with James Kuti December 2008 – February 2011, Inquest Brief.

[3] Statement of Emma Orchard, Unit Manager, Adolescent Protective Team Child Protection, Department of Human Services, 15 April 2011, Inquest Brief.

[4] Statement of Lorelle Orwin, Inquest Brief.

18. Closed Circuit Television (CCTV) footage of Narre Warren train station depicts James arriving at the station at 10.11 pm. James checked the train information times for the platform at 10.12 pm, walked to the edge of the platform at 10.13.30 pm and jumped off into the path of the oncoming 1106 V/Line Traralgon train at 10.13.42 pm. Victoria Police and Ambulance Victoria attended the scene 410m further east of the point of impact where James was deceased.

Post Mortem Examination

19. A post mortem examination was conducted by Dr Yeliena Baber Forensic Pathologist at the Victorian Institute of Forensic Medicine on 28 February 2011 where the cause of death was formulated and the following comments made:

> *"On external examination, multiple injuries were identified consistent with the history provided. Examination of the post mortem CT scan showed transaction of the lumbar spine and multiple other bony injuries including multiple skull fractures. Post mortem toxicology was performed and showed respiradone and hydroxyrespidradone within therapeutic ranges."*

Review of care

20. The Coroners Prevention Unit (CPU)[5] were directed to review James' care leading up to his death. Their review found as follows;

> *"After reviewing the records available, it is apparent that the care Mr Kuti was receiving when being managed and engaged with numerous mental health and protective services, was comprehensive and appropriate. There is evidence to suggest appropriate levels of communication between services and Mr Kuti's family. Additionally, Mr Kuti's medication was altered and increased to account for his deteriorating mental health on multiple occasions…The care and services provided by all the agencies involved were comprehensive, appropriate and were supported by high-level communication and collaborative care arrangements and monitoring."*

[5] The Coroners Prevention Unit is a specialist service for coroners created to strengthen their prevention role and provide them with professional assistance on issues pertaining to public heath and safety.

Findings

I find that James Kuti unfortunately took his own life by jumping into the path of an oncoming train and sustaining multiple injuries. I am satisfied that the care provided to James in the circumstances leading up to his death was appropriate.

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

Lorelle Orwin

Professor Jeremy Oats, Chair Consultative Council on Obstetric and Paediatric Mortality and Morbidity

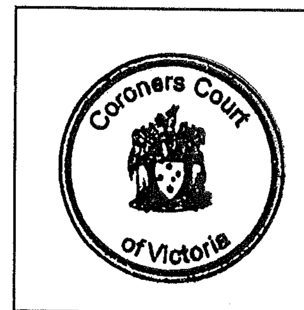
Susan Van Dyk, Medico Legal Officer, Monash Health

Michael Averkiou, Department of Transport

Dr Mark Oakley Browne, Chief Psychiatrist

Bernie Geary, Child Safety Commissioner

Signature:



CAITLIN ENGLISH
CORONER
Date: 1 May 2014