IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2010 00500

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of: JESSE ROSS SANGSTER

Delivered On:	17 August 2012
Delivered At:	MELBOURNE
Hearing Dates:	20, 21, 22, 23 March 2012 and 24 April 2012
Findings of:	CORONER K.M.W. PARKINSON
Place of death/Suspected death:	Belgrave South, Victoria.
Counsel Assisting	Mr S. Milesi of Counsel. Instructed by Ms Sarah Gebert, Solicitor - Coroners Court of Victoria.
Appearances:	Mr N. Goodenough of Counsel for the family. Dr P. Halley of Counsel for Eastern Health Service. Mr B. Ihle of Counsel for Chief Commissioner of Police. Mr S. Cash of Counsel for Ambulance Victoria.
Delivered On:	17 August 2012

I, KIM M. W. PARKINSON, Coroner having investigated the death of JESSE SANGSTER

AND having held an inquest in relation to this death on 20, 21, 22, 23 March 2012 and 24 April 2012

at MELBOURNE

find that the identity of the deceased was JESSE ROSS SANGSTER

born on 8 June 1981

and the death occurred on 3 February 2010

at Belgrave Hallam Road, Belgrave South, Victoria

from:

1a. MULTIPLE INJURIES SUSTAINED IN A MOTOR VEHICLE COLLISION (DRIVER)

in the following circumstances:

1. An inquest was conducted into the death of Jesse Ross Sangster on 20, 21, 22, 23 March 2012 and 24 April 2012.

2. The following witnesses gave evidence in the proceedings: Victoria Police - Senior Constable Tippett, Leading Senior Constables Wright, Barkway, Maddern and the Investigating Officer, Leading Senior Constable Knight; Eastern Health Chandler House Community Mental Health Service - Dr Nuala Moran, Psychiatrist; Dr Thomas Paterson, Psychiatric Registrar and Ms Michelle Fletcher, Mental Health Case Worker; Eastern Health In patient Unit, Dr Jose Segal, Psychiatrist; Ambulance Victoria Paramedics, Mr Clint Hick and Mr Sean Gubbels and from Mr Charles Williams, a witness to the collision. Independent expert opinion was obtained by the court from Associate Professor John Richard Newton who also gave evidence in the proceeding.

3. I have been assisted by the submissions of the parties in this matter and in particular by the submissions of counsel assisting and have drawn from those submissions during the course of this finding where appropriate.

4. Jesse Ross Sangster, was 28 years old at the time of his death. He died on 3 February 2010, as a result of multiple injuries sustained in a motor vehicle collision in which he was the driver.

5. Dr Matthew Lynch, Forensic Pathologist reported that a post mortem CT scan revealed haemopericardium and right haemothorax. Jesse had a post mortem Ethanol (blood alcohol concentration) of 0.13g/100ml (ethanol vitreous humour 0.16/100ml). Therapeutic concentrations of his prescribed medication were detected, otherwise no illicit substances were detected in the blood sample[1]. Dr Lynch reported that the cause of death was multiple injuries sustained in a motor vehicle collision (driver).

Background and mental health history

6. Jesse was diagnosed as having Bipolar Affective Disorder when he was 16 years old. He was later also diagnosed as having Cluster B (antisocial and borderline) personality traits[2]. Jesse also had a long standing substance abuse problem involving alcohol, prescription and illicit drugs.

7. Jesse resided at Belgrave Heights where he lived next door to his mother Denise Sangster-Greenwood, who had provided him extensive support and assistance. She had been actively involved in seeking assistance and treatment for her son, both before and after his diagnosis with Bipolar Affective Disorder. Her involvement in Jesse's care was actively encouraged by mental health clinicians over a number of years, as she had often been able to intervene and to assist her son when he was distressed. Ms Sangster-Greenwood liaised with mental health services as to any decline in his mental health and had been instrumental in his admission to hospital for mental health treatment or for substance rehabilitation on a number of occasions.

8. The clinicians and the expert witness, Associate Professor Newton, agree that the treatment and management of Jesse's mental illness was complicated by his personality difficulties and his longstanding poly substance abuse[3].

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[1] Exhibit 32 Inquest Brief - Report dated 5 February 2010

[2] Exhibit 31- Medical Records

[3] T197.2 – 198.5; T107-10 and Exhibit 14.7

9. He was admitted to hospital and treated for mental health issues on numerous occasions following his initial diagnosis of Bipolar Affective Disorder in 1998. These admissions resulted from suicide attempts, persecutory delusions and homicidal ideations and often complicated by a background of sustained substance abuse including amphetamine, benzodiazepine, marijuana, prescription medication and alcohol.

10. Much of the treatment during the course of his admissions, after the initial management of his florid psychosis, was directed to substance abuse issues. The focus of those treating him was on the need to encourage him to take responsibility for his drug use and behaviours in order to reduce his long term risk to himself and others.

11. While it is apparent there were extended periods when Jesse functioned well and neither suffered significantly as a result of his mental illness nor as a result of substance abuse, there appears to be an inextricable link between his mental illness and drug abuse. On occasions when his mental illness was manifest it was often combined with abuse of illicit and non-illicit substances.

12. Jesse reported that he self medicated for his mental illness and this resulted in abuse of alcohol and drugs. Whilst this possibility was acknowledged by Dr Segal, he expressed some doubt as to the accuracy of this description. He stated that it was his view patients often used self medication as an excuse to justify their substance use.

13. It is clear however that whatever the motivation, Jesse's mental illness was exacerbated by his substance use.

14. Jesse did not readily accept treatment for his substance abuse. Counselling and treatment was made available to him and from at least 2008 he was under the supervision at Chandler House Adult Community Mental Health Clinic, a dual diagnosis service for people with co-morbid psychiatric illness and substance abuse. By late 2008 Jesse had been diagnosed and notified as being a drug dependent person.

15. In early 2009 much of Jesse's treatment was focussed around dealing with his substance abuse. In May 2009 he refused inpatient detoxification recommended to him by Eastern Health Alcohol and Drug Services.

16. Jesse had a history of contact with police and the criminal justice system, predominantly relating to driving offences, including exceeding the prescribed concentration of alcohol. In June 2009, Jesse was detained by police, having made threats to kill himself and police, following a motor car accident. Police conveyed Jesse to Maroondah Hospital Emergency Department for assessment as an involuntary patient. On that occasion he was not admitted.

17. On 9 August 2009, he was admitted to Maroondah Hospital after what is described in medical records as an 'impulsive' attempt to hang himself whilst intoxicated. He was discharged from hospital on 11 August 2009[4].

18. He was readmitted to Maroondah Hospital on 18 August 2009 with a deterioration in his mental state, described by Dr Moran as possibly as a result of having missed his medication[5]. He was discharged from hospital on 26 August 2009.

19. He reported another suicide attempt in November 2009 whilst feeling very stressed, however he was not admitted or transported to hospital on that occasion.

20. His compulsory mental health community treatment order was reviewed and continued by the Mental Health Review Board on 2 December 2009[6]. This order requires that a patient undergo treatment for mental illness, medication and attend for appointments with clinicians as arranged. Shortly afterwards he failed to attend for an appointment at Chandler House for review.

21. On 12 December 2009, he attended at the Dandenong Hospital as a result of complications arising from injected drug use.

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[4] Exhibit 4 Statement Dr Nuala Moran dated 12 February 2010

[5] Exhibit 4 Statement Dr Nuala Moran dated 12 February 2010

[6] Exhibit 28 Statement Dr Thomas Paterson dated 10 March 2010

22. On 13 December 2009, police again took Jesse to Maroondah Emergency Department for assessment as an involuntary patient for suicidal ideation. He was assessed, but not admitted to the hospital on that occasion.

23. On 16 December 2009, he cancelled an appointment at Chandler House, which was subsequently reorganised and replaced with a home visit by Dr Paterson.

24. On 6 January 2010, he failed to attend a scheduled follow up appointment.

25. On 14 January 2010, he failed to attend a psychiatric consultant's review.

26. On 15 January 2010, he failed to attend a psychiatric consultant's review. During this period he continued to be a person under a compulsory community treatment order, however no steps were taken to revoke or otherwise enforce the order.

27. In the period 1998 up to, but not including the admission on 23 January 2010, Jesse had 12 in-patient admissions upon public hospital mental health services. Dr Moran reported[7] that Jesse suffered from Bipolar Affective disorder and was also considered to have Cluster B (antisocial and borderline) personality traits. The treatment history is attenuated by depressive illness relapse, including manic and psychotic events, often but not always reported as being attenuated by substance abuse.

28. A number of clinicians noted that Jesse posed a serious risk not only to himself but also to others by continuing to drive while substance affected. He was also at serious risk of death from self-harm or from his risk taking behaviour[8].

The events of 23 January 2010

29. On 23 January 2010, following a siege at his home at which armed police attended, Jesse was conveyed by the police to the Maroondah Hospital and admitted as an involuntary patient. This followed threats to kill his family, delusional behaviour and the seizure by armed response police of a weapon at his premises.

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[7] Exhibit 4

[8] Dr Paterson T353; Dr Jose Segal T144.21; Associate Professor Newton Exhibit 14 page 9.

30. He remained an involuntary patient from 23 January 2010 to 29 January 2010. His psychotic symptoms appeared to improve within a few days and by 25 January 2010, he was assessed by Dr Jose Segal, consultant psychiatrist, as having been drug intoxicated rather than having had a relapse of his mental illness[9].

31. Jesse was moved to a lower supervision unit within the hospital. By 28 January 2010, his condition had again deteriorated and he reported that he had engaged in intravenous illicit substance use and alcohol abuse while on that ward.

32. He remained on the low dependency unit and the psychotic features appeared to resolve. Dr Segal's evidence was that the speed with which the symptoms resolved suggested to him that they were largely substance related and not principally arising from a bipolar relapse. Associate Professor Newton agreed that this conclusion was reasonable, although he noted that it is difficult to determine with exactness the catalyst for the event.

33. On 29 January 2010, Dr Segal noted that Jesse was no longer intoxicated with substances nor was he presenting in a manic or psychotic state and decided that he no longer met the criteria under the *Mental Health Act 1986* for detention as an involuntary patient. It was decided to discharge Jesse, under the continued care and supervision of Chandler House Community Mental Health Services. The clinicians were struggling to identify the most appropriate approach to the treatment of Jesse's mental health and substance dependency issues. They had formed the view that it would be appropriate to approach his treatment in a manner focused upon requiring Jesse to take some responsibility for his behaviour and his substance use.

34. Jesse was discharged into the community on Friday, 29 January 2010, without the support of his Case Manager, Ms Michelle Fletcher, as she was not working over the weekend. There were no direct discussions with the case worker as to the ongoing management plan or requirements for care. The level of handover was a telephone message left at Chandler House advising of the discharge. Ms Fletcher did not become aware of his discharge until Monday, 1 February 2010, when she contacted Jesse by telephone to follow up his progress in hospital.

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[9] Statement Dr Segal Exhibit 9 dated 22 February 2010

Ms Fletcher stated that she usually expected to be advised of a patient's discharge and that she was surprised Jesse had been discharged after 6 days[10].

35. In view of the intervention orders relating to family members who were Jesse's usual supports and the absence of his mother interstate, there was in practical terms little or no supervision or assistance available to Jesse in the community over that weekend period or until a home visit by the clinician on 2 February 2010.

36. Jesse was discharged with the following medication: Sodium Valproate 1gm twice daily; Diazepam 10mgs twice daily; Fluoxetine 40mgs daily; Olanzapine 10mg nocte. The medication is notable because it reflects an ongoing treatment regime for psychiatric disorder.

37. Ms Fletcher undertook a home visit on Tuesday, 2 February 2010. At that attendance she noted that his mental state was unstable, observing elevation of mood and appearing deluded and that his risks had increased and his compliance with medication was erratic. Jesse admitted using alcohol but denied current drug use.

38. Ms Fletcher observed that risk issues appeared quite high of potential re-offending in view of his manic presentation and presenting with documented early warning signs of relapse[11]. Her evidence was that when she became aware he had been discharged from hospital on the previous Friday, she spoke to him by telephone on 1 February 2010. In that conversation she described that he was 'quite tangential and gave a rambling account of why he had recently been hospitalised'. She stated that Jesse's conversation was quite hard to follow with themes of paranoia about the police and others and his safety and that he believed that the police had one of his mobile phones and had taken information from it via a device. He denied any current drug use, but admitted to using alcohol to control his mind.

39. At a home visit on 2 February 2010, Ms Fletcher stated that his conversation during the visit was focused upon themes of the mafia and believing that police had bugged his house, showing Ms Fletcher where in the house he believed that the listening devices had been installed.

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[10] T210.7 and T197.16

[11] Exhibit 13 - Statement of Ms Michelle Fletcher dated 30 March 2011 and T196-199.

40. Ms Fletcher stated:

> *"He said his phone was also tapped. He spoke of 'seeing Chopper Reid during the siege last week'. He was quite tangential and his conversation was difficult to follow at times almost rhyming words during conversation. Heavy grandiose themes evident. At this point Jesse admitted only taking his medications occasionally. He was unable to tell me what tablets he had been discharged on. He appeared to be presenting quite manic during this visit. He made several calls to the police while I was present to try to retrieve items he believed they had stolen. Risk issues appeared quite high at this time of potential re-offending in view of his manic presentation and presenting with documented early warning signs of relapse. These include as documented on his file, being thought disordered, tangential, irritable, disorganised, grandiose, paranoid and agitated and not taking his medication. As Jesse's treating Dr was not on duty I planned to speak with* Dr *Tom Paterson tomorrow along with continuing to liaise with Dirk from Corrections".*

41. Ms Fletcher's evidence was that ideally Jesse would have been immediately assessed by a doctor for admission to the inpatient facility[12].

42. Jesse's treating doctor, Dr Sylvia Jones, from Chandler House, was not on duty on 3 February 2010, so Ms Fletcher consulted with the Registrar at Chandler House, Dr Thomas Paterson about Jesse's presentation and her concerns.

43. Dr Paterson was unavailable to visit Jesse at home due to other appointments. Chandler House Consultant Psychiatrist, Dr Moran, was on leave and there was no consultant available at Chandler House.

44. Dr Paterson advised Ms Fletcher to contact the CATT team to arrange close monitoring at home. However when she contacted the CATT team they advised they would not attend due to reported risks associated with multiple drug users at the premises on previous occasions. CATT suggested an admission to contain the risks. This information was conveyed to Dr Paterson.

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[12] T199.25-200.6

45. Dr Paterson spoke to Dr Segal, Consultant Psychiatrist with Eastern Health, at about 4.00pm on 3 February 2010. Dr Paterson raised his concerns about the appropriateness of ongoing management of Jesse in the community.

46. Dr Segal, having treated Jesse during his admission in January 2010, was firmly of the view that the recent admission was most likely due to the effects of substance abuse and that this exacerbation was also likely to be the result of substance use. Dr Paterson's evidence was that he also concluded that it was likely this relapse was again due to substance abuse.

47. Whilst these conclusions may have been reasonable having regard to Jesse's history, it is inconsistent with the information conveyed by Ms Fletcher who had attended at Jesse's home and made personal observations of his affect and demeanour. It is also of note that post mortem toxicology results did not identify the presence of any illicit substances and identified alcohol and therapeutic prescribed medication.

48. Dr Paterson and Dr Segal agreed that Jesse's use of alcohol and history of substance abuse placed him at significant long term risk of an adverse outcome. By adverse outcome they were referring to risk of death[13].

49. After discussing and discounting a number of options, Dr Segal advised that a consultant review should be arranged at Chandler House with Dr Jones, for the following day, 4 February 2010, with a view to considering an involuntary admission along with other treatment or intervention options.

50. Dr Paterson stated that:

> *"The final outcome of this discussion was for me to arrange a consultant review in the community the following day at Chandler House by consultant Dr Sylvia Jones, with a view to consider an involuntary admission and detention in the high dependency unit to enforce sobriety in order to assess Mr Sangster's mental state without the continual complicating effects of poly-substance abuse".*[14]

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[13] T353.31-354
[14] Exhibit 28 - Statement of Dr Paterson page 6 paragraphs 5 and 6

51. Victoria Police had no knowledge of these developments in their subsequent dealings with Jesse on 3 February 2010.

52. When Jesse was admitted to Maroondah Hospital on 23 January 2010, Ms Sangster-Greenwood stated she was advised that Jesse would be in hospital for some time, in the order of weeks, and that she should take a break. She then travelled to the Gold Coast to stay with family. Police then obtained an interim intervention order in relation to his mother and two of his brothers.

53. When Jesse was discharged on 29 January 2010, his family were not notified of his discharge. His family became aware of his discharge on 30 January 2010, when Jesse attempted to make contact with them. His mother was interstate at this time and did not return until after his death.

The events of 3 February 2010

54. On 3 February 2010, Jesse was at his home with his friend Nicholas Yates and they both consumed alcohol. There is no evidence that they consumed any illicit substance. Ms Fletcher spoke to Jesse by telephone at approximately 12.40pm and attended to deliver medication. She then left the premises. During that afternoon, Jesse made numerous calls to the Belgrave Police Station in relation to the events of 23 January 2010. Police report that his speech was slurred, he was abusive and angry and he sounded irrational. During these telephone conversations, he demanded return of the weapon, which had been seized on 23 January 2010 and retained by police. I am satisfied that there was no basis, arising from the telephone calls alone, for police response or intervention at that time.

55. At approximately 9.00pm that evening, he telephoned emergency services and requested an ambulance as he had cut his arm. An ambulance was despatched as were two police units as the ambulance service had a notation from previous occasions that Jesse may be a risk to the safety of ambulance officers.

56. Sergeant Hall of Belgrave Police, who had been one of the officers who spoke to Jesse earlier in the evening, advised the attending police of the contact he had and that there may be a need to detain Jesse for assessment under s10 of the Mental Health Act.

57. When the police and ambulance attended the address, police first assessed him from a distance by engaging him in conversation. Jesse was abusive and belligerent. They formed the view that Jesse was intoxicated but that he was not a danger to the ambulance officers. The ambulance officers assessed his injury as a minor laceration and treated it at the scene.

58. The police and ambulance officers then considered Jesse's mental state and concluded that he was intoxicated. They formed the view that he was not threatening or posing a risk of suicide or harm to himself or others. They did not form the view that he was suffering from a prevailing mental illness. The police and ambulance officers actively considered the issue of whether application of s10 of the Mental Health Act was appropriate and concluded that there was no basis for that intervention.

59. A short time after the police and ambulance left, Jesse, in company with Nicholas Yates, drove his red Holden Commodore sedan to Belgrave South where a collision occurred at approximately 11.45pm on Belgrave-Hallam Road, Belgrave South. The evidence is unclear as to the purpose of the journey or to where he was intending to travel.

60. The vehicle had been travelling at high speed in a north-west direction just prior to the collision and Jesse lost control by drifting out to the left, narrowly missing a vehicle travelling in the opposite direction. He failed to regain control, most likely overcorrecting, before leaving the highway on the right and colliding with the embankment and then a pole on the north-east side of the road. It appears that Jesse was not wearing a seat belt at the time of the collision. There was evidence of pre-impact braking in gravel on the side of the road on which the collision occurred. Mr Yates sustained non-life threatening injuries. Jesse sustained multiple injuries and was deceased at the scene.

61. Police report that the road was dry and in good condition and there were no vehicle deficiencies, environmental or road features, likely to have caused or contributed to the collision.

62. Police searched the vehicle after the collision and no illicit substances or drug paraphernalia was located.

63. The driver of the oncoming vehicle, Mr Charles Williams stated that he had observed Jesse's vehicle coming towards him and that he had commented upon his speed and erratic driving as their vehicles approached one another. He stated:

> *"As the car was coming towards us I could see both his head lights but as he got closer to me I could see that his car was now on an angle I could feel the metal from his car against my side of the car."*

64. It is clear from the evidence that it was merely fortuitous that there was no collision with the vehicle occupied by Mr Williams and his passengers.

65. Mr Williams evidence was that when he first approached the vehicle after the collision the passenger stated that 'I think my mate has just killed himself'[15]. The context of this assertion is not available from Mr Yates and it might reasonably be interpreted to mean a number of things and not only signalling an intentional act. In view of the pre-impact braking and the apparent attempt to correct the vehicle out of the collision, the evidence does not support a finding that the collision was a deliberate act on Jesse's part, with the intention of taking his own life. It is likely that the collision was unintentional.

66. The evidence does not support a finding that by his conduct on this evening that Jesse intended to take his own life.

The experts opinion in relation to treatment and management in the period 23 January to 3 February, 2010

67. Associate Professor Newton stated that he agreed with the clinicians assessment that his Axis 1 disorder was likely not the predominant reason for Jesse's presentation on 23 January 2010 and that the predominant driver was far more likely to have been substance use. He agreed however as did Dr Segal, that it is difficult to distinguish between the contributing factors or to isolate which of the factors, substance use or recurrence of bipolar disorder, was in fact predominant.

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[15] Mr Williams at T175.3

68. He stated:

> *"So bipolar affective disorder is characteristically a relapsing, remitting disorder that has quite prolonged periods quite often of remission where there's non evidence of it in day to day life and periods where it is in relapse and periods where it is actively driving affect behaviour, cognition"*[16].

69. In view of the numerous attempts to manage Jesse's illness with short term inpatient stays and community follow up and in the context of his substance abuse issues, he felt that the change in treatment approach by the clinicians, directed as it was to attempting to have Jesse take more responsibility for his substance use and own well being, was appropriate. This decision however was made in the context of a lack of immediately available alternative treatment options. Associate Professor Newton expressed the view that this was a path, which might have been explored earlier and with more precision[17].

70. During the course of the proceedings, evidence was given of the existence of specialty co-dependence units in some public mental health regions in Victoria. These units, called *Community Care Units* (CCU) and *Secure Extended Care Units* (SECU)[18] were designed to treat patients with co-morbidity of mental illness and substance dependency. The SECU target group is described as:

> *"People with unremitting and severe symptoms of mental illness or disorder and associated behaviour disturbance who meet criteria for voluntary admission. As the most restrictive treatment setting SECU's are intended to target people with the most difficult and serious disturbance who are unable to be safely or adequately treated in less restrictive settings. Typically SECU residents are a high risk to themselves or others and frequently have co-morbid conditions including drug and alcohol problems, acquired brain injury or intellectual disability".*

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[16] Associate Professor Newton at T239.10

[17] Associate Professor Newton T250-251.15 and T266.21-267 and Exhibit 14

[18] Department of Human Services (Mental Health Branch) Program Management Circular Doc. No. PMCO7021

71. Associate Professor Newton was of the opinion that SECU admission may well have been an appropriate treatment option for Jesse, however there was a limitation upon availability of such treatment to a person like Jesse.

72. His evidence was:

> *"Typical patients who enter the secure extended care unit would be people who are a risk to the community or at risk to themselves by direct – and I think to answer your question, by direct effect of their mental illness on their risk issues and I think with Mr Sangster, why wasn't he admitted earlier in the piece? When people have clear cut need for that long term extended care and although Mr Sangster had a number of admissions, and would therefore you would be beginning to think that this man was – may benefit from that kind of more prolonged period of extended care, he hadn't yet had the level of extended illness that would typically lead to an admission there which would be somewhat longer. I think also people who have prolonged periods of remission as you have just described, wouldn't be the people you would first think of as being suitable candidates for a secure extended care unit and where the risk issues are primarily associated with substance use and intoxication, then that would also be a hurdle. It wouldn't be a barrier but it would be a hurdle for people thinking that that would be a good use for one of the extended care beds I think[19]."*

73. He accepted that there was likely to be a different approach to admitting to this type of unit, someone with florid mental illness[20].

74. His evidence was that substance use and bipolar affective disorder often go hand in hand and that there is merit in a combined approach to treatment[21]. Associate Professor Newton discussed the value of availability of a combination treatment facility for dual diagnosis patients which might be located not necessarily within the mental health system. He accepted the need to manage both the mental health and substance abuse issues because they are in his description 'so closely intertwined' and warrant an integrated approach[22].

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[19] T241.13-242.5.

[20] T242.10

[21] T242.27 and T255

[22] T243

75. He commented that whilst the use of SECU beds would not be inappropriate for a person in Jesse's situation, that in the face of scarce resources access is prioritised and he stated:

> *"With a scarce resource you tend to triage and prioritise the people who will most obviously fit, they can most clearly fit the criteria and get the most obvious benefit and in that case then it would be the people with very prolonged, troublesome, distressing, ongoing psychotic symptomatology."*

76. Associate Professor Newton observed that one of the movements within mental health over the last few years is for that artificial distinction between mental health services and drug and alcohol services, to be broken down and that this: *"allows for the reality of our clinical situation which is the two go hand in hand very often and they go hand in hand with often the most challenging patients and the ones who present us with the most treatment difficulties."*

Relevant Mental Health Act provisions and conclusions in relation to the involuntary treatment provisions of the Mental Health Act as they applied or were applied to Jesse

77. Section 10 of the Mental Health Act provides a power to police to detain a person who appears to be mentally ill if they believe on reasonable grounds the person has recently attempted suicide or to cause serious bodily harm to themselves or another or is likely to do so. Police are required to arrange, as soon as practicable, for an examination by a medical practitioner or an assessment by a mental health practitioner. Pursuant to section 9 of the Mental Health Act the patient is assessed for involuntary treatment.

78. The criteria contained in Section 8 of the Mental Health Act is to be interpreted having regard to the s3(1) definitions which provide that ***mental disorder*** includes mental illness; and that ***mental illness*** has the meaning given in section 8; and pursuant to the principals of treatment and care set out in s6A of that Act. Section 8 provides:

> **8 Criteria for involuntary treatment**
>
> (a) the person appears to be mentally ill; and
>
> (b) the person's mental illness requires immediate treatment and that treatment can be obtained by the person being subject to an involuntary treatment order; and

(c) because of the person's mental illness, involuntary treatment of the person is necessary for his or her health or safety (whether to prevent a deterioration in the person's physical or mental condition or otherwise) or for the protection of members of the public; and

(d) the person has refused or is unable to consent to the necessary treatment for the mental illness; and

(e) the person cannot receive adequate treatment for the mental illness in a manner less restrictive of his or her freedom of decision and action.

Note

In considering whether a person has refused or is unable to consent to treatment, see section 3A.

(1A) Subject to subsection (2), a person is mentally ill if he or she has a mental illness, being a medical condition that is characterised by a significant disturbance of thought, mood, perception or memory.

(2) A person is not to be considered to be mentally ill by reason only of any one or more of the following—

(a) … (j)

(k) that the person takes drugs or alcohol;

(3) Subsection (2)(k) does not prevent the serious temporary or permanent physiological, biochemical or psychological effects of drug or alcohol taking from being regarded as an indication that a person is mentally ill.

79. The criteria in Section 8 is applied on the basis that each of those factors is required to be present and continuing in the ongoing assessment of need for the person to be detained as an involuntary patient. The criteria in Jesse's case was interpreted to mean that once his psychosis had resolved and the issue was largely one of substance abuse, that he was no longer amenable to involuntary detention or treatment pursuant to the Mental Health Act. The legislation was applied by clinicians with a view to the least restrictive form of treatment.

80. The following factors were known to apply to Jesse:

- He had a diagnosed Axis 1 mental illness since age 16 or 17 years;
- He had multiple hospital admissions over a period of years;

- He had a recent history of psychotic relapse;
- He had a recent and abiding history of substance abuse;
- He had a recent history of failure to comply with medication regimes;
- He had a recent history of violence and threats of violence directed against others;
- He had recent history of endangering the public whilst driving and driving when unauthorised;
- He had a significant recent history of self-harm including suicide attempts.

81. Whilst the clinicians formed the view that much of his difficulty including relapsing psychotic episodes were driven by illicit substance use, their evidence was that one often drives the other, and that it was difficult to identify just which was the predominant influencing factor at any one time.

82. The fact that the distinction was not able to be easily drawn or identified suggests that Jesse was requiring of more extensive observation and containment for the purpose of accurately identifying the prevailing issues.

83. As Jesse was not amenable to treatment in the community, refused to undertake inpatient detoxification, was a danger to himself and to others by his risk taking and substance affected behaviour, and was often not compliant with medication even when on a community treatment order, it is difficult to understand why the most appropriate and necessary mode of care for someone in his situation, could not involve his longer term involuntary detention in a SECU facility.

84. The understanding and application of the Mental Health Act appears to have been that if the patient was not floridly symptomatic of mental illness, then even in circumstances of a diagnosed and abiding mental illness, that person does not meet the definition for involuntary status.

85. Once Jesse's psychosis had resolved, despite an acknowledge likelihood of resumption of substance use, resulting in a likely relapse in mental health instability, the opinion of the clinicians was that he could not be involuntarily detained in a mental health facility. This was the evidence of Dr Segal and Dr Paterson and to some extent also that of the expert[23].

86. As the evidence identified, CCU and SECU were designed to treat patients with co-morbidity of mental illness and substance dependency. This would appear to have been the type of facility which may have benefited Jesse. Particularly in light of the observations of Dr Paterson and Dr Segal, that it was his intention to have Jesse assessed on 4 February 2010, again for admission on an involuntary basis.

87. Even had consideration been given to the SECU option, it was however again the evidence of the clinicians, that mental illness is a prerequisite for this unit and he would need to have been floridly mentally ill before he would be considered for admission.

88. Dr Segal's evidence was that there is, to his knowledge, no mechanism available to appropriately deal with the issue of the interaction between mental health issues and substance abuse by way of the provisions of the Mental Health Act. He stated:

> *"Then what mechanism do you see might be appropriately available to deal with that issue?---There is none.*
>
> *What might be appropriately available from your point of view? Because what I see with Jesse is a revolving door? ---Correct.*
>
> *12 admissions?---Yes.*
>
> *Plus numerous attendances by clinical care in the community, numerous drug and alcohol attempts, attendances by Jesse himself at his own initiative at Narcotics Anonymous on a regular basis, so there have been indications of attempts by this man to deal with the substance abuse issue. There have been recurrent admissions to psychiatric facilities on a very short term basis but there doesn't seem to have been any pattern of ongoing lengthy and directed care. Directed in the sense that he has to comply and he's required to be*

[23] T342.29, T255 and T258

there?--- OK. Well, let me frame my answer as such. Um, the literature on bipolar disorder and antisocial personality disorder makes it abundantly clear that co-morbid poly-substance abuse is a recognised phenomenon, however our Mental Health Act is designed to treat the bipolar disorder and if required enforce care for that.

But not the substance abuse?---But not the substance abuse. There's nothing under s.8 of the criteria that can authorise me sectioning a patient because they booze and take drugs. In fact, it's an exclusion if memory serves, under s.4 I think, that you cannot apply the Act for illicit drug and alcohol use.

But does that - that criteria or that distinction operates - - -?---Yes.

- - - where there's no impact upon or no association with a mental illness?---Well, you can have someone whose bipolar disorder is quite stable. Um, and in terms of the act you've executed the Act, you've provided the care and the treatment and the bipolar's under condition and yet the patient continues to choose to abuse illicit substances, and you then have to deal with the impact of that. And that - - -

Having an impact when they so choose, to use that expression - - -?---Yes.

When they choose to use illicit substances - - -?---Yes.

- - - it then has an impact upon their mental health?---Yes.

So in those circumstances are you still saying that the provisions of the Mental Health Act would not enable you to act?---Yes, I'm saying that exactly" [24].

89. The evidence in this proceeding identifies that there was a revolving door in terms of psychiatric care available for Jesse. He was admitted for short stays in public psychiatric facilities, usually co-located in major public hospitals. In so far as there were any available co-dependency units, they, as with their hospital mental health unit counterparts, appear to exist to treat the most floridly symptomatic patients and were not available or utilised for Jesse's treatment.

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[24] T120.15

90. The evidence in this case is that clinicians interpret the provisions of the Mental Health Act to mean that once florid symptoms resolve, the patient is ineligible for involuntarily detention under that Act. It is not at all clear from reading of the Act, how the 'florid' requirement arises from the legislation. However, if that Act is generally interpreted in that manner, this raises a serious question as to the capacity of authorities pursuant to that Act, to protect the health and safety of not only the patient, but also the community.

91. As the evidence in this case has established, it is a circular argument and the result is that there are no facilities able to accommodate a person in Jesse's situation of co-morbidity, on an involuntary basis.

Substance Dependency – Relevant Legislative Provisions and the capacity to detain a person diagnosed with a severe substance dependence absent a mental illness or disorder

92. At the time of Jesse's death the legislation relevant to the detention and treatment of substance dependent persons was the *Alcoholics and Drug-Dependent Persons Act 1968* ("ADDP Act"). The *Severe Substance Dependence Treatment Act 2010* ("SSDT Act") came into effect in Victoria on 1 March 2010, a short time after the death of Jesse Sangster.

93. Both Acts provide for periods of detention and compulsory treatment of people with severe substance dependence in a treatment centre. The evidence was that no such treatment facility exists within the Eastern Health Region, and that of the practitioners who gave evidence, anecdotally they knew of a facility at St Vincent's Hospital, although admission under the ADDP Act (and now under the SSDT Act) was extremely limited and none had considered Jesse Sangster a candidate for such admission.

94. St Vincent's hospital unit, with a limited bed capacity, is the only gazetted treatment centre in the state of Victoria and it is understood that there is one bed only allocated to receive patients pursuant to the provisions of the SSDT Act.

95. The evidence of Dr Segal was that the application of the SSDT Act and its predecessor, the ADDP Act, is difficult and burdensome because they are based upon a Court order. He was also of the opinion that compulsory treatment was usually unsuccessful. These factors and the very limited number of places available for involuntary treatment, resulted in this not being regarded as a realistic option for treatment of someone such as Jesse.

96. The evidence of the practitioners who appeared before the Coroner, Associate Professor Newton, Dr Segal[25] and Dr Moran, whilst not specialists in the treatment of substance abuse disorder or dependence, was generally that in their opinion involuntary treatment of substance abuse and dependence problems was not likely to be successful, and that a voluntary treatment regime was preferred.

97. The problem was that a voluntary approach had not been successful when applied to Jesse over a number of years and after multiple admissions to psychiatric units and voluntary largely outpatient drug rehabilitation treatment facilities.

98. It is apparent from Jesse's treatment history that he was regularly discharged from mental health services after short admission periods and discharged himself from rehabilitation facilities. What was apparent and recognised by clinicians, at least in the latter period of Jesse's treatment, was that he was a significant risk to himself and the community as a result of his high risk behaviour. Counsel Assisting submitted:

> *"Rather than seeing this as an inevitability and something that might only be rectified by a deliberate change of lifestyle on Jesse's part, it may have been prudent, had such facilities existed and been available, to deal with his co-morbid mental illness and substance abuse conditions within a combined involuntary regime to compliment the current voluntary facilities."*

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[25] T114.20, T115-116

99. I agree with this submission. It recognises that not only is the patient concerned at risk, but also members of the community going about their ordinary day to day business. That was certainly the case with Jesse Sangster and it appears that there is an inadequacy in our capacity as a community to address these risks.

Findings as to cause and contribution

100. I find that Jesse Sangster died on 3 February 2010, as a result of injuries sustained in a motor vehicle collision in which he was the driver.

101. I find that no other vehicle or person caused or contributed to the collision.

102. I find that the alcohol consumed by Jesse that day and the previous day, affected his judgment, including his decision to drive and the manner in which he drove, as well as his capacity to maintain proper control of the vehicle and that this was a significant contributing factor to the death.

103. I find that death was unintentional. The evidence does not support a finding that Jesse intended to take his own life.

104. I find that Jesse's mental illness, coupled with his personality disorder and substance abuse disorder, were matters which contributed to his poor, and at times entire lack of impulse control and that it is likely his conduct on the evening of 3 February 2010, was symptomatic of these interrelated factors and his ongoing mental illness. I find therefore that his mental illness was a contributing factor to his death.

105. I find that Jesse's failure to accept long term drug and alcohol detoxification as a voluntary in patient was a contributing factor to his death.

106. I find that the decision to discharge Jesse from involuntary status and to discharge him from in-patient care on 29 January 2010, was in the context of the clinicians understanding of the provisions of the Mental Health Act and the availability of alternative treatment options, a reasonable clinical decision.

107. The attending police and ambulance officers concluded that Jesse was not amenable to the provisions of s10 of the Mental Health Act on 3 February 2010. I am satisfied that this was a reasonable conclusion to be drawn in the circumstances and having regard to the information to which they were privy.

108. I find that the decision by police and ambulance officers that there were no grounds on 3 February 2010, to detain Jesse pursuant to the provisions of s10 of the Mental Health Act was, in the context of the information available to them at the time, a reasonable policing decision.

109. I find that the circumstances in which Jesse was discharged from in patient psychiatric care on 29 January 2010, without immediate involvement of his case-worker, absent family notification and without any formal interventions over the weekend period, resulted in Jesse being at large to resume excessive alcohol consumption. In the face of his lack of impulse control as discussed earlier, he resumed his characteristic engagement in risky behaviour, (as anticipated by clinicians) such as driving whilst intoxicated. This sequence of events and factors contributed to the death.

110. I find that had Jesse been detained on an involuntary basis for treatment of his substance abuse issues together with his mental health issues, that his death may have been prevented.

111. I find that the lack of availability of long term and involuntary in-patient facilities for persons suffering with mental illness and substance abuse disorder, resulted in Jesse not receiving treatment which was likely to benefit him and which if implemented may have resulted in more effective management of Jesse's mental health issues, including his substance dependency and abuse issues. Had such facilities been available his death may have been prevented.

COMMENTS

I make the following comment(s) connected with the death including matters relating to public health and safety and including any notification to the Director of Public Prosecutions under 67(3) of the Coroners Act 2008.

1. Providing mental health services to a patient such as Jesse is a challenging task for clinicians. The task is made more difficult within a paradigm of significant demands for mental health services, limited in-patient beds and lack of available alternative treatment facilities for those with co-morbidity.

2. However it is clear from the evidence in this case, and in particular my conclusions at paragraphs 70 to 99 herein, that there is an inability in the current public mental health system to effectively intervene to detain and compulsorily treat patients such as Jesse who are suffering with the co-morbidity of mental illness and substance abuse disorder.

3. This inability may be driven by the lack of available in patient beds or alternative treatment facilities. It may also be that the manner of application of the provisions of the Mental Health Act and the SSDT Act is driven by the knowledge of the clinicians as to inadequate or insufficient availability of in-patient beds or alternative in-patient treatment facilities.

4. From Jesse's admission between 23 and 29 January 2010, it is apparent that clinicians considered that Jesse's psychotic behaviour was largely drug induced. This meant that that they regarded their capacity to detain him under the Mental Health Act as limited to the period when he was exhibiting florid psychotic symptoms. Once the immediate florid mental health issues had appeared to resolve their interpretation of the Act was there was no longer any basis to detain him. As a result he was discharged back into the community, vulnerable to the same conditions that lead to his deterioration and admission on 23 January 2010.

5. I note that the operation of the SSDT Act is to be reviewed in 2015. The observations of clinicians in relation to the feasibility of use of this Act and the limited availability of inpatient beds would be relevant matters to be considered in that review.

6. It is of serious concern that the family, as beneficiaries of the protection of the interim intervention order did not receive any advice or notification of Jesse's proposed release from hospital on 29 January 2010.

7. Police responsible for the intervention order and for investigating the siege incident were notified by the hospital that Jesse had been discharged. However the family and in particular, the protected parties pursuant to the intervention order, were not notified of the discharge by either the police or by the hospital and there was no process in place to ensure that they were so advised.

8. The family of the patient ought to be entitled to know of the intention to discharge a patient, particularly when they have been intimately involved in his care and support and where they are protected persons pursuant to an Intervention Order made by a Court. This is an important matter from the point of view of safety of the order beneficiaries, which requires addressing both by the mental health system and by Victoria Police.

9. The Eastern Policing region in co-operation with the area mental health service have introduced a program known as the Police Acute Response Triage Service ("PARTS") which utilises police and mental health workers to attend upon incidents involving people with mental health issues. This program appears to address some of the issues which arose in this proceeding as to communication and information sharing between police and mental health services and provides for joint attendance and intervention at incidents. It is to be encouraged.

RECOMMENDATIONS

I make the following recommendation(s) connected with the death under s72(2) of the Coroners Act 2008:

1. That integrated dual diagnosis services in the public health system for those with mental illness and substance dependency be expanded by the provision of additional inpatient facilities.

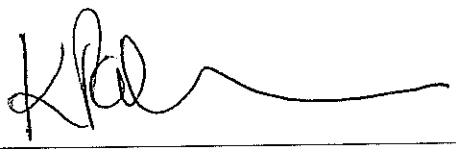
2. That the operation of the provisions of the Mental Health Act and the SSDT Act be enhanced by the provision of additional long term inpatient voluntary and involuntary public treatment beds for persons with co-morbidity mental illness or disorder and alcohol and drug dependency.

3. That the provisions of the Mental Health Act be amended to provide for the express power for mental health practitioners to detain persons who are diagnosed with substance abuse disorder and mental illness and that the Act be amended to enable for greater flexibility to enable assessment and treatment even when initial or florid psychotic symptoms have resolved.

4. That a formal process be adopted by public mental health services in Victoria to ensure that families involved in the care and support of a mental health patient, or who are intervention order beneficiaries, are notified when a patient is proposed to be released from in patient mental health admission. In so far as this may require an amendment to any Act of Parliament, including the Mental Health Act 1986 (Vic) or the Privacy Act 1988 (Commonwealth), that amendment ought to be considered.

5. I direct that a copy of these findings be provided to the Family, the Interested Parties; Associate Professor Newton; The Honourable Mr David Davis MLC, Minister for Health (Victoria); The Honourable Ms Mary Wooldridge MP, Minister for Community Services (Victoria); The Office of the Chief Psychiatrist, Dr Ruth Vine; The Secretary, Department of Health (Victoria); The Secretary, Department of Human Services (Victoria); The Chief Commissioner Victoria Police.

Signature:



KIM M. W. PARKINSON
CORONER
Date: 17 August 2012