IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2013 000653

FINDING INTO DEATH WITHOUT INQUEST

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

I, PARESA ANTONIADIS SPANOS, Coroner,
having investigated the death of JUSTIN DAMIEN CONNELL
without holding an inquest:
find that the identity of the deceased was JUSTIN DAMIEN CONNELL
born on 18 September 1975
and that the death occurred on 13 February 2013
at Royal Melbourne Hospital, Grattan Street, Parkville 3052
from:

I (a) MULTIPLE INJURIES (MOTOR VEHICLE IMPACT – PEDESTRIAN)

Pursuant to section 67(1) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances**:

1. Mr Connell was a 37-year old man who lived in Melton with his partner of four years, Ann Matthews, and her teenaged children. At the start of their relationship, Mr Connell had confided that he suffered from depression and anxiety but was not receiving treatment or taking prescribed medication because he felt dizzy and unable to concentrate when he did so.[1]

2. Ms Matthews observed that her partner's mental state deteriorated in the 12 months prior to his death. She reported that his behaviour was increasingly erratic and peculiar. He expressed and sometimes acted upon paranoid and delusional beliefs. Ms Matthews told Mr Connell that he must engage in treatment or she would end their relationship.[2]

3. On 2 October 2012, Mr Connell consulted his general practitioner, Dr Patra, at the McKenzie Street Medical Clinic, and was referred to psychiatrist, Dr Wijesinghe.

[1] Coronial Brief of Evidence, Statement of Ann Matthews.

[2] Ibid.

4. Mr Connell saw Dr Wijesinghe for the first time on 8 October 2012.[3] He reported that he had been watched, followed and threatened for the previous five years due to his "special knowledge" and believed himself to be vulnerable to attack. The psychiatrist diagnosed Mr Connell with schizophrenia, commenced him on abilify (an antidepressant/antipsychotic) and sent a reporting letter to Dr Patra.[4]

5. Upon review on 29 October 2012, Mr Connell reported that he had ceased taking abilify because it made him feel agitated and tense. Dr Wijesinghe prescribed a different antipsychotic, seroquel, and a benzodiazepine, temazepam.[5] He reported the new medication regime to Dr Patra, noting that if Mr Connell did not improve soon, he would require hospitalisation.[6]

6. Mr Connell attended a total of six consultations with Dr Wijesinghe between 8 October and 11 December 2012. He sometimes attended appointments with his partner or family members. Although Dr Wijesinghe did not conduct formal risk assessments he considered Mr Connell's risk of self-harm as mild to moderate. The psychiatrist believed that Mr Connell had a positive response to Seroquel, noting that it was of paramount importance that he comply with medication.[7]

7. In January 2013, Mr Connell and Ms Matthews went on holiday to Lakes Entrance. While there, Mr Connell told his partner that Seroquel made him "feel like he was going to die" and that if he died "it [would be] the tablets". Ms Matthews was not very concerned because she had heard him say things like this about prescribed medications and believed that he just did not like taking medication.[8]

8. On 22 January 2013, Mr Connell was due to attend an appointment with Dr Wijesinghe but he, or someone on his behalf, called to 'cancel or postpone' the appointment.[9]

9. In the first week of February 2013, Ms Matthew's grandchild was born. She and Mr Connell spent much of the day at the hospital. Mr Connell was excited about the new baby, 'full of spirit' and showed no signs of mental illness.[10]

10. On 7 February 2013, Mr Connell told his partner that he was too tired to go to the maternity ward again. When Ms Matthews returned from the hospital that evening she noticed that Mr Connell appeared agitated and unable to relax or sleep.[11]

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[3] Coronial Brief of Evidence, Statement of Dr Wijesinghe dated 18 March 2013.

[4] Coronial Brief of Evidence, Letter from Dr Wijesinghe to Dr Patra dated 10 October 2012.

[5] Coronial Brief of Evidence, Statement of Dr Wijesinghe dated 18 March 2013.

[6] Coronial Brief of Evidence, Letter from Dr Wijesinghe to Dr Patra dated 30 October 2012.

[7] Letter from Dr Wijesinghe to the Court dated 28 November 2014.

[8] Coronial Brief of Evidence, Statement of Ann Matthews.

[9] Letter from Dr Wijesinghe to the Court dated 28 November 2014.

[10] Coronial Brief of Evidence, Statement of Ann Matthews.

[11] Ibid.

11. Between 8 and 11 February 2013, Mr Connell spent most of his time sitting in the dining room as though he was waiting for someone. He told Ms Matthews that he was waiting for the police because he had killed his sibling 32 years earlier. She tried to reason with him over the next few days, explaining that his brother's death had been attributed to 'cot death' and that the police were not going to attend. Mr Connell could not be convinced.[12]

12. On 12 February 2013, Mr Connell was still waiting for police. Ms Matthews was out for the day and upon her return around 5.15pm, she reminded Mr Connell of his appointment with Dr Patra. She thought it odd that he was wearing a long-sleeved jacket, as it was quite warm, and Mr Connell told her that he had cut himself while whittling a stick. He then left for his medical appointment.[13]

13. Mr Connell's consultation with his GP focused on physical health issues. He attended for a prescription for his usual reflux medication and a blood test was ordered to monitor his Type 2 diabetes mellitus. According to Dr Patra, Mr Connell did not appear agitated during the consultation and showed no signs of depression, anger or suicidality.[14]

14. Mr Connell returned home about 6.30pm and reported the outcome of his medical appointment to his partner. He spent the evening in the dining room alone, but did not mention the police to Ms Matthews. She went to bed at about 9.30pm.[15]

15. At about midnight on 13 February 2013, Mr Connell presented to Constable Cameron Lacey at Melton Police Station, stating that he wanted to make a confession. Mr Connell confessed that he had put battery acid in a man's drink about five years earlier and that this may have led to his death. Police checks revealed the man (who had been identified by Mr Connell) was alive. Mr Connell then said he had seen the man a year earlier. Mr Connell went on to confess that he was responsible for his brother's death and that at the age of 10 years he had snapped the neck of a bird. Const Lacey observed that Mr Connell appeared convinced that there was a "court order" for his arrest (there was not) but was unable to explain why he believed this to be the case.[16]

16. Const Lacey formed the view that Mr Connell had a mental illness, and asked whether he had received counselling for the thoughts he was having. Mr Connell reported that he had seen a psychiatrist and that he believed his prescribed medication was too strong and so he had reduced the dosage unilaterally. Const Lacey sought the advice of a colleague about whether he should exercise his power under section 10 of the *Mental Health Act* 1986 [MHA] to detain Mr Connell.[17]

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[12] Coronial Brief of Evidence, Statement of Ann Matthews.

[13] Ibid.

[14] Letter from Dr Patra to the Court dated 27 November 2014.

[15] Coronial Brief of Evidence, Statement of Ann Matthews.

[16] Coronial Brief of Evidence, Statement of C/ Lacey.

[17] Coronial Brief of Evidence, Statements of C/ Lacey and C/ Humphrey.

17. Const Humphrey advised him to ascertain whether Mr Connell was at risk of self-harm.[18] When Const Lacey enquired, Mr Connell pulled back his collar to reveal a two or three-inch laceration on the right side of his neck. It appeared to be a deep cut, sealed with dried blood. Const Lacey had noticed a graze on the left side of Mr Connell's neck earlier. Mr Connell explained that he had used a kitchen knife to slice his own throat – the graze on the left of his neck was his first attempt – and that it had bled copiously and now parts of the right side of his face were feeling numb. When asked if he was feeling suicidal, Mr Connell replied, "Oh no. No, I couldn't do that again".[19]

18. At 1.42am, an ambulance was dispatched to Melton Police Station to attend an incident described as 'Psych, Dangerous Haemorrhage'. On arrival a few minutes later, paramedics were told by police that Mr Connell was 'not in any trouble' but had wanted to 'discuss something' with them.[20] Paramedics were not told what had been discussed, only that cuts on Mr Connell's neck had been noticed and an ambulance called to assess him.[21]

19. On examination, paramedics observed Mr Connell to be alert and calm and his vital signs were satisfactory.[22] He reported a diagnosis of schizophrenia, that he was receiving treatment for depression (having seen his psychiatrist "three weeks earlier") and had unilaterally decreased his dosages of medications including Seroquel. He said he had felt increasingly depressed over the previous week and made the knife wounds at about 10pm but was not having suicidal thoughts at that time.[23] Paramedics considered that Mr Connell should be transported to hospital for a mental health assessment and treatment of his neck wounds. He agreed to accompany paramedics to the hospital.[24] Mr Connell had provided police with his partner's contact telephone number but asked them not to call her due to the late hour.[25]

20. Mr Connell arrived at Sunshine Hospital at 2.22am[26] and was examined by Dr Aveline Loh at 4.36am on 13 February 2013.[27] Dr Loh found Mr Connell alert, oriented and cooperative, with stable vital observations and two superficial cuts to the right side of his neck and one on the left. His neck wounds were sutured with sterile technique and he was given a tetanus vaccination.[28]

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[18] Coronial Brief of Evidence, Statement of C/ Humphrey.

[19] Coronial Brief of Evidence, Statement of C/ Lacey.

[20] Coronial Brief of Evidence, Statement of Sarah Currell dated 20 April 2015.

[21] Ibid.

[22] Coronial Brief of Evidence, VACIS Electronic Patient Care Report, 13 February 2013 #10101.

[23] Ibid.

[24] Coronial Brief of Evidence, Statement of Sarah Currell dated 20 April 2015.

[25] Coronial Brief of Evidence, Statement of C/ Lacey.

[26] Coronial Brief of Evidence, VACIS Electronic Patient Care Report, 13 February 2013 #10101.

[27] Coronial Brief of Evidence, Statement of Dr Loh.

[28] Ibid.

21. Although Mr Connell acknowledged that the self-inflicted cuts were an attempt to harm himself, he denied any suicidal intent, thoughts or plans. Dr Loh was aware that Mr Connell was schizophrenic and that he had reduced Seroquel from 600mg to 200mg without his psychiatrist's knowledge. Mr Connell was noted to be "staring into space" but he denied any psychotic symptoms, visual or auditory hallucinations and insisted that his wounds would require microsurgery (noted as "?strange ideas about health").[29]

22. Dr Loh did not consider that Mr Connell met the criteria for involuntary psychiatric treatment pursuant to the MHA because he was not an immediate risk of self-harm and had consented to the required treatment.[30] She referred him to the Enhanced Crisis Assessment and Treatment Team [ECATT] for assessment of his suicide/self-harm risk and, despite repeatedly denying any such thoughts, Mr Connell agreed to await the assessment.[31]

23. At 6.45am, an ECATT clinician attended the emergency department to assess Mr Connell but found that he had left without apparently telling hospital staff.[32] Later, Dr Loh documented in medical records that there was no need to recommend Mr Connell for involuntary treatment under the MHA as there was "no immediate self-harm risk".[33] Mental health follow-up of Mr Connell was referred to North Western Mental Health Crisis Assessment and Treatment Team [NWCATT].[34]

24. At 7.20am, police were notified and asked to conduct a welfare check but reportedly did not find Mr Connell at home.[35]

25. At 11am, an ECATT psychiatric nurse endeavoured to contact Mr Connell on the telephone number he gave while in the emergency department. Ms Matthews answered the call, was told what had occurred overnight, and confirmed she had not seen her partner at home that morning before leaving for work. She also reported recent deterioration of Mr Connell's mental health and that he had not been taking medication as directed because he was convinced his doctor and chemist were "trying to poison" him.[36]

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[29] Mr Connell's Western Health Medical Records dated 13 February 2013.

[30] Coronial Brief of Evidence, Statement of Dr Loh.

[31] Ibid.

[32] Ibid.

[33] Mr Connell's Western Health Medical Records dated 13 February 2013.

[34] Coronial Brief of Evidence, Statement of Dr Loh.

[35] Coronial Brief of Evidence, Statement of Barbara Backshall.

[36] Ibid.

26. At about 5.30pm, there being no sign of, or contact from, Mr Connell, Ms Matthews, following the advice of a NWCATT psychiatric nurse who called her that afternoon, attended Melton Police Station to report her partner missing.[37]

27. Around 5.50pm, a man later identified as Mr Connell,[38] was observed to be standing on the footpath adjacent to the three westbound lanes of Ballarat Road in Braybrook.[39] Traffic was heavy on Ballarat Road at the time. Witnesses observed Mr Connell step forward as though he was going to walk into the path of a vehicle and then step back. Mr Connell stepped off the footpath a second time and into the path of an Isuzu box truck travelling at or below the posted speed limit of 70 kilometres per hour. The truck's driver applied the brakes but could not avoid a collision.[40]

28. The truck driver and other road users stopped to render assistance. Emergency services were called and Mr Connell was taken by ambulance to the Royal Melbourne Hospital [RMH].[41] On arrival at RMH, Mr Connell had an unrecordable blood pressure, obvious lower limb injuries and a mildly distended abdomen. He was transferred to the operating theatre for an emergency laparotomy during which internal injuries were diagnosed. The incision was packed and dressed and Mr Connell was transferred for angiography to investigate his hyperdynamic heart. He became increasingly haemodynamically unstable and suffered a cardiac arrest which did not respond to resuscitative efforts. Mr Connell died at 9.30pm on 13 February 2013.[42]

29. Senior Forensic Pathologist, Dr Malcolm Dodd, of the Victorian Institute of Forensic Medicine reviewed the circumstances of Mr Connell's death as reported by police to the Coroner, post-mortem CT scans of the whole body [PMCT] and performed an autopsy. On PMCT, Dr Dodd observed fractures to the right arm, multiple right-sided rib fractures and a complex pelvic fracture where injuries were more pronounced on the right than left side. Soft tissue injuries (bruises and lacerations) and signs of medical intervention were evident during his external examination, including two parallel incised wounds on the right lateral surface of the neck and one oblique incised wound to the left side of the neck, each of which had been partially sutured. During autopsy, Dr Dodd noted multiple internal abdominal injuries. He did not find any evidence of natural disease that would have contributed to death.[43]

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[37] Coronial brief of Evidence, Statement of Ann Matthews.

[38] Mr Connell did not have any form of photographic identification in his possession while on Ballarat Road in Braybrook. Police later located part of a prescription label in one of the pockets of clothing he was wearing when taken to the RMH. Mr Connell was visually identified by Ms Matthews on 16 February 2013.

[39] Coronial Brief of Evidence, Statements of Emilia McDonald, Benjamin Templeton and Goran Kovacic.

[40] Ibid.

[41] Coronial Brief of Evidence, VACIS Electronic Patient Care Report, 13 February 2013 #11208.

[42] Royal Melbourne Hospital, e-Medical Deposition Form completed by Dr Lau.

[43] Medical Examination Report prepared by Dr Dodd dated 17 April 2013.

30. Routine toxicological analysis detected morphine and midazolam consistent with emergency medical intervention but no alcohol or other commonly encountered drugs or poisons. Relevantly, no Seroquel (quetiapine) or other antipsychotics were detected.[44]

31. Dr Dodd concluded that the cause of Mr Connell's death was multiple injuries sustained by a pedestrian in a motor vehicle impact.[45]

32. At my request, the Coroners Prevention Unit [CPU][46] reviewed medical records, the coronial brief of evidence prepared by Acting Sergeant Brett Butterworth of Footscray Police and additional statements provided by Drs Patra[47] and Wijesinghe[48] and provided advice about the management of Mr Connell's mental health proximate to his death and identify avenues for prevention intervention.

33. The CPU advised that:

    a. Dr Wijesinghe scheduled the initial assessment of Mr Connell promptly upon receipt of the general practitioner's referral, made a clear diagnosis, initiated antipsychotic and anxiolytic medication, monitored Mr Connell's response to these and changed the antipsychotic prescribed when Mr Connell reported side-effects. Dr Wijesinghe also engaged with Mr Connell's family and partner and reported his diagnosis, treatment and alteration of the treatment plan to Dr Patra.

    b. Contrary to his reported standard practice, Dr Wijesinghe did not attempt to contact Mr Connell by telephone or letter or communicate with his general practitioner after cancellation of the 22 January 2013 appointment. Notably, however, the Royal Australian and New Zealand College of Psychiatrists has no specific guidelines for its members in relation to patient follow up in the context of voluntary outpatient treatment[49] and its procedures regarding treatment 'dropouts'[50] is vague and non-directive.

    c. Dr Patra does not appear to have involved himself in Mr Connell's ongoing mental health treatment and when he saw him on 12 February 2013 was unaware that Mr Connell had not attended an appointment with Dr Wijesinghe since 11 December 2012. Dr Patra described Mr Connell's presentation during their last consultation as 'normal'.[51]

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[44] Ibid.

[45] Medical Examination Report prepared by Dr Dodd dated 17 April 2013.

[46] The Coroners Prevention Unit was established in 2008 to assist coronial investigations and the formulation of coronial recommendations and comments aimed at prevention. The CPU is staffed by independent, highly skilled and experienced clinical medical, mental health and allied health care professionals.

[47] Letters from Dr Patra to the Court dated 1 November 2013 and 27 November 2014.

[48] Letter from Dr Wijesinghe to the Court dated 28 November 2014.

[49] Email from the Royal Australian and New Zealand College of Psychiatrist to the Court date 25 November 2014.

[50] "Quality Assurance Guideline 1: Outpatient psychiatric practice" 1994 available at https://www.ranzcp.org/Files/Resources/qa1-pdf.aspx. See in particular section 3.3.8 at page 8.

[51] Letter from Dr Patra to the Court dated 27 November 2014.

d. Communication of relevant information between services, such as police and paramedics, is important for thorough assessment and continuity of care. Disclosure of (mental) health information by police is guided by a 2010 Protocol[52] which, while emphasing that 'sufficient information' should be disclosed 'in the best interests of the person with mental illness', relies on individual judgments exercised with regard to 'the minimum information necessary to serve the purpose'.[53]

e. It appears that information about Mr Connell's delusional state when he presented to police was not communicated to paramedics and so it did not form part of the information available to Dr Loh when she assessed his mental state. However, it is difficult to fault police for not communicating some relevant information to Sunshine Hospital because the recognition of Mr Connell's symptoms of paranoia and delusional thinking required mental health expertise. On the basis of the information available to her, Dr Loh's assessment of Mr Connell was reasonable in the circumstances.

f. Although it appears that Mr Connell was not closely monitored after his initial assessment at Sunshine Hospital, the response of staff to his disappearance – notification of the area mental health service and police – was appropriate. The NWCATT undertook appropriate attempts to locate Mr Connell and initiate engagement with him.

34. The standard of proof for coronial findings of fact is the civil standard of proof, on the balance of probabilities, with the *Briginshaw* gloss or explication.[54] The effect of the authorities is that Coroners should not make adverse findings against or comments about individuals, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

35. I find that Justin Connell, late of Leicester Crescent in Melton, died on 13 February 2013 at the Royal Melbourne Hospital in Parkville of the multiple injuries he sustained as a pedestrian in a motor vehicle impact. The evidence supports a finding that Mr Connell walked into the path of an oncoming vehicle in circumstances where a collision could not be avoided by any evasive action taken by the driver.

36. It is also tolerably clear that Mr Connell's judgment was impaired immediately prior to the collision such that I am unable to determine to the requisite standard whether he intended to take his own life or harm himself when he stepped off the kerb or whether he was delusional or otherwise suffering the symptoms of mental illness.

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[52] "Department of Health and Victoria Police – Protocol for Mental Health" 2010 available at http://www.health.vic.gov.au/mentalhealth/publications/police-mh-protocol0910.pdf.

[53] Ibid.

[54] *Briginshaw v Briginshaw (1938) 60 C.L.R. 336 esp at 362-363.* "The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences..."

37. The weight of the evidence allows me to find that Mr Connell was not taking prescribed medications as directed and that his mental health had deteriorated significantly proximate to his death.

38. Although the available evidence does not enable me to make any adverse findings or comments against any one person or institution involved in the management of Mr Connell's mental health proximate to his death, it is nonetheless apparent that better flow of pertinent information would have optimised clinical decision-making and may have changed the outcome in this case.

COMMENTS

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

1. Several individuals – clinicians, non-clinicians and family members – were involved in the management of Mr Connell's mental health proximate to his death. Each had opportunities to observe his behaviour and make judgments, not necessarily clinical ones, on the basis of their observations at particular points in time. Ultimately, each individual had only a partial picture of Mr Connell's mental state. Had a more complete and richly drawn clinical picture been available, particularly to the clinical decision-makers, Mr Connell's death may have been prevented.

2. While it is acknowledged that clinicians, particularly in the mental health setting, must often reach decisions on the basis of imperfect, incomplete or "best available" information, it is reasonable to infer that better information will produce better clinical decisions.

3. This case highlights both how opportunities to obtain – or provide – information relevant to clinical decision-making can be missed, and how such information can be lost.

4. Mr Connell's presentation and disclosures to police highlighted his impaired and disordered mental state. However, the determination that his reason for attending the police station was irrelevant to the medical issue for which paramedics were called resulted in the loss of information about his strange behaviour, delusional beliefs and confused mental state from the information handed over to Sunshine Hospital staff.

5. Similarly, it appears that both Melton Police and the Sunshine Hospital had a contact telephone number for Mr Connell's partner. Notwithstanding the antisocial hour of Mr Connell's presentations to these institutions (and his instruction to police that she should not be notified at that late hour), no-one tried to call her until several hours after Mr Connell's departure from the hospital, by which time his whereabouts were unknown. Ms Matthews could have provided a collateral account: of Mr Connell's recent behaviour and mood; the extent to which recent behaviour differed from his usual behaviour; likely stressors; confirmation that he was not taking medications as directed and had not seen his psychiatrist for two months. Collateral information was missing from Mr Connell's clinical picture so that Dr Loh had little against which to evaluate Mr Connell's assertion that he was not experiencing psychotic phenomena.

6. Mr Connell had a chronic mental health condition requiring regular medication and was known to be non-compliant. Irrespective of whether Mr Connell had disengaged from treatment with Dr Wijesinghe, or had merely neglected to reschedule an appointment, the reality was that he had not seen (or spoken to) his psychiatrist for two months. The impacts of disengaging from mental health treatment obviously vary according to the severity of mental illness, the patient's level of insight, independent compliance with treatment recommendations, access to social supports and risk to self or others when unwell.

7. Nonetheless, research suggests that while there is little agreement about the reasons for disengagement, there is ample evidence that patients who have dropped out or who are not followed up face a range of adverse outcomes such as poorer mental health outcomes (including hospital admissions and involuntary treatment) and greater social impairment.[55] Clinicians and patients would benefit from better guidance from the relevant professional society about patient follow up, especially in the voluntary psychiatric outpatient setting.

RECOMMENDATION

Pursuant to section 62(2) of the *Coroners Act* 2008, I make the following recommendation:

1. I recommend that the Royal Australian and New Zealand College of Psychiatrists develop specific practice advice or guidelines regarding patient "dropouts" or "disengagement" (including defining these terms) to assist private psychiatrists to make an appropriate decision regarding the need to follow-up of patients who unexpectedly disengage from treatment.

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

Ann Matthews

Luke Connell

Dr Patra, c/o Mr Mariadason of Avant Law

Dr Wijesinghe, c/o Ms Larking of TressCox Lawyers

Western Health, Ms Frydenlund

NorthWestern Mental Health, c/- Ms Moffatt of Donaldson Whiting + Grindal

Director Operations, Melbourne Heath

Office of the Chief Psychiatrist

Royal Australian and New Zealand College of Psychiatrists

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[55] See for example, A. Briend, R. Fahmy and S. Singh (2009), 'Disengagement from Mental health Services', *Social Psychiatry Psychiatric Epidemiology*, 44: 558-568.

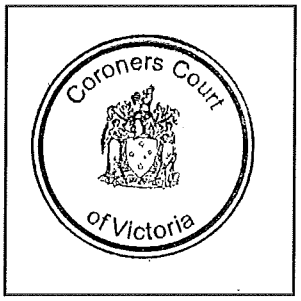
Ambulance Victoria, c/- Ms Samaan

Chief Commissioner of Police, c/o Mr Lloyd of Russell Kennedy

Trauma Program Manager, Royal Melbourne Hospital

A/Sgt. Brett Butterworth, Footscray Police Station

Signature:



PARESA ANTONIADIS SPANOS
CORONER
Date: 2 December 2015

Cc: Manager, Coroners Prevention Unit