IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2014 002874

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

Section 67 of the Coroners Act 2008

Findings of:	**ROSEMARY CARLIN, CORONER**
Deceased:	**KP**[1]
Date of birth:	8 January 1999
Date of death:	7 June 2014
Cause of death:	1(a) [redacted]
Place of death:	[redacted][3] Victoria

[1] The names of the deceased, the deceased's family and the deceased's most recent treating psychologist are substituted with initials throughout this finding to protect the identities of the persons involved.
[2] This finding is partially redacted in order to protect the identities and privacy of the persons involved.
[3] The place of death has been amended from [redacted] to [redacted] pursuant to the slip rule in s 76 of the *Coroners Act 2008* (Vic).

HER HONOUR:

Background

1. K was born on 8 January 1999. He was 15 years old when he died from [redacted]

2. K lived in [redacted] with his mother A, father B, 19 year old brother Y and 17 year old sister Z. He was in Year Ten at [redacted]

3. K suffered from depression. From a young age, K was a challenging child who was difficult to manage.

The coronial investigation

4. K's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**).

5. The role of a coroner is to independently investigate reportable deaths to find, if possible, identity, medical cause of death and with some exceptions, surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. Coroners make findings on the balance of probabilities, not proof beyond reasonable doubt.[5]

6. The law is clear that coroners establish facts; they do not cast blame, or determine criminal or civil liability.

7. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

8. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation into K's death. The Coroner's Investigator conducted inquiries on my behalf, including taking

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[5] In the coronial jurisdiction facts must be established on the balance of probabilities subject to the principles enunciated in *Briginshaw* v *Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

statements from witnesses, and submitted a coronial brief of evidence. I also obtained reports from the Coroners Prevention Unit ('CPU') as to the appropriateness of medical and psychological treatment provided to K. The CPU is comprised of independent doctors and nurses, including mental health care professionals. It provides advice to coroners in relation to deaths that occur in a health care setting or where there has been prior medical attendance with particular emphasis on prevention opportunities.

9. After considering all the material obtained during the coronial investigation I determined that I had sufficient information to complete my task as coroner and that further investigation was not required.

10. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity.

Circumstances proximate to the death

11. On the night of 6 June 2014, K's sister Z was watching television in the lounge room. K was sitting at the dining room table with his mobile phone. At about 11:00pm K went over to the couch, took the doona Z had been using and went to his room. They did not have any conversation at this stage. At 11:00pm and 12:50am respectively, Z sent K two messages on Facebook asking if he was ok. He did not respond.

12. [redacted]

13. [redacted]

14. Inspection of K's bedroom revealed information sheets about depression scattered on the floor. There was no suicide note, however his personal diary contained numerous undated passages about wanting to die, such as: *'Every night I wish to die just to kill myself people say [there] is so much to live for yet I can't find anything I might have full hands but I have an empty heart' … 'I just want to fall asleep and never wake up'*. K also sent a number of text messages to various acquaintances on 6 June 2014 and just after midnight on 7 June 2014, saying *'sorry'*, and *'goodbye'*.

15. [redacted]

Identity of the deceased

16. K was visually identified by his mother A on 7 June 2014. Identity was not in issue and required no further investigation.

Medical cause of death

17. On 8 June 2014, Dr Matthew Lynch, Forensic Pathologist at the Victorian Institute of Forensic Medicine, conducted an external examination of the body of K.

18. Toxicological analysis of post mortem specimens taken from K was negative for common drugs and poisons.

19. After reviewing toxicology results, Dr Lynch completed a report, dated 12 June 2014, in which he formulated the cause of death as [redacted] I accept Dr Lynch's opinion as to the medical cause of death.

K's psychological background

20. [redacted]

[redacted]

22. From the time K was about 8 years old, his family took him to see three psychologists and one psychiatrist. K mostly refused to attend sessions. Sometimes the family would attend

sessions and K would remain in the car. This behaviour continued on and off until K was about 14 years old.

23. [redacted]

[redacted]

25. In 2012, K was diagnosed with Glandular Fever, and subsequently Chronic Fatigue Syndrome. This caused him to miss some school but he continued basketball training, which was a big part of his life at that time. He recovered slowly from these illnesses.

26. [redacted]

27. In February or March 2014 K and his girlfriend of 9 months broke up. He started seeing more of his friends and partying more after this occurred.

28. In March 2014 K's attendance at school dropped, and he found it hard to get out of bed. His mother took him back to the doctor, but K was uncommunicative making it difficult to assess him.

29. On the long weekend in March 2014, K got extremely drunk with friends. An ambulance was called, and the ambulance officers ultimately called his parents to collect him. He had been vomiting for some hours before his parents were notified. His parents took him home, put him to bed and kept an eye on him. A noticed that things went downhill for K after this weekend.

30. On 3 April 2014, A rang the Eastern Child & Adolescent Mental Health Services (**CAMHS**) Box Hill seeking assistance for K. She told them he was suicidal. He was losing interest in

basketball training, which was usually very important to him. CAMHS told A they would contact K and get back to her. They tried to contact K that day but he did not answer. Some two weeks after their original call, CAMHS contacted A. She said it was too late and she was not interested as she had already arranged other services.

Sessions with Dr B

31. On 9 April 2014 A took K to see clinical psychologist Dr B. A sat in on that first session. Dr B saw K again two days later without his mother. Her records reveal that this was a 'rapport building' session.

32. On 15 April 2014, A took K to his General Practitioner (**GP**), [redacted] to obtain a referral for Dr B. [redacted] prepared a mental health care plan for K and provided a referral to see Dr B.

33. On 23 April 2014, K signed a consent form in relation to psychological treatment. This appears to have been a standard consent form utilised by Dr B's practice for adult patients in that it covered issues such as fees and expectations for payment and did not address the ability of patients under 18 years of age to consent to treatment[6]. Under the heading 'Communication with GP, specialist or allied health professional' the form advised 'at times it may be useful for your psychologist to talk with other health professionals involved in your treatment'. However, it did not cover issues of confidentiality for a minor such as when communication with parents would occur.

34. On 8 May 2014 K saw Dr B for the third time. A Depression Anxiety Stress Scale ('DASS')[7] was completed by Dr B which indicated that K had stress and depression in the 'Severe' range and anxiety in the 'Normal' range. Dr B later acknowledged the DASS is not a valid tool for use in patients under 17 years of age, but said it was only used as a guide. Suicide was discussed during this session, but K said to Dr B he would not do it as it would hurt his family too much. Dr B noted that he was oriented to the future. When asked, K told Dr B if he were going to commit suicide, it would be by [redacted] Dr B assessed K's suicide risk as 'Low-Moderate'. She provided him with protective strategies and relevant contact

[6] In Victoria, the legal age for maturity is 18 years. People under this age may be able to consent for treatment providing the clinician is satisfied that the young person has reached sufficient maturity and is competent to give valid consent. K was only 15 years of age and there was no documentation to indicate that K had ever been assessed as fulfilling the 'mature minor' criteria in relation to this requirement.

[7] An assessment scale that isolates and identifies aspects of emotional disturbance.

numbers and made a follow up appointment the next week, on 15 May 2014 (rather than the next fortnight as would be the usual practice) based on her assessment of K's suicide risk.

35. Dr B did not involve K's parents at this point. The difficult relationship between K and his parents meant that involving them pre-emptively on the basis of his Low-Moderate suicide risk would, in Dr B's assessment, have likely resulted in K refusing to attend further sessions. Dr B decided against involving them by balancing the concern to keep K safe against the likelihood of breaking the emerging therapeutic alliance. She explained that K was very reluctant to attend treatment and was often silent during therapy sessions, so she focussed on building rapport with him.

36. On 9 May 2014 Dr B wrote to K's GP [redacted] thanking him for forwarding K for psychological assessment and opinion. She stated that she had undertaken three appointments with K since 11 April 2014 and believed he could benefit from cognitive behavioural therapy and a mindfulness approach. She was happy to manage his care and said in her letter that she would forward a progress report detailing her assessment, treatment summary and recommendations after the sixth session. The letter did not mention that she had assessed K to be at Low to Moderate risk of suicide, nor did she request collateral information regarding any previous psychiatry clinical input or clarification about K's medications.

37. K did not attend the session scheduled with Dr B on 15 May 2014. Dr B followed up his non-attendance by telephoning the P's home number twice, then calling A's mobile phone. A did not answer and Dr B left a voicemail. A returned Dr B's phone call and confirmed that K had been home when she called, but chose not to answer the phone. Without going into detail, Dr B told A she had some concerns about K. A asked for an appointment with Dr B that day, however her schedule was full. An appointment was made for K the following week instead. For reasons that are not entirely clear, but may have related to K re-commencing school, K did not see Dr B again until 3 June 2014, his last session with her.

38. At the session on 3 June 2014, Dr B assessed K's suicide risk as 'Low'. She specifically asked him whether he had any thoughts or plans of taking his life in the past few days, to which he replied, *'no'*. They arranged a further session a fortnight later, however K took his life in the meantime.

[8] Records forwarded by the [redacted]

Findings

39. Pursuant to section 67(1) of the *Coroners Act 2008*, I make the following findings connected with the death:

(a) I find that:

(i) the identity of the deceased was KP, born 8 January 1999;

(ii) K died on or about 7 June 2014 in [redacted],[9] Victoria, from [redacted]

(iii) K intended to end his life; and

(iv) his death occurred in the circumstances described above.

Comments

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

1. This case illustrates the difficulty mental health practitioners face in balancing the imperative of forming a trusting relationship with a patient who is a minor against the rights and/or desires of parents to be informed about their children.

2. There is no clear legal position on a therapist's duty of confidentiality in relation to a young patient. Clearly a minor who is assessed as mature enough to consent to treatment should have their wishes regarding the sharing of information respected. However, that child's parents would still have a key role in monitoring their child's safety between professional visits and may have a legitimate expectation of being advised of important issues affecting their child.

3. It is understandable that Dr B did not wish to jeopardise K's trust in her by reporting anything he said, particularly given his problematic relationship with his parents. On the other hand there is no documentation indicating he did not wish to have information shared with his mother and he was only 15. Something as serious as a 'severe' stress and depression rating on a DASS assessment ought usually trigger a discussion between a

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treating psychologist and a minor's parents (or other significant adult) and GP as to whether there was a need for referral for psychiatric consultation in addition to psychological therapy.

4. Further, where a psychologist contacts a referring GP following a session with a minor with a suicide risk, it is desirable that the suicide risk is mentioned to the referring GP and that the psychologist makes enquiries of the GP regarding any previous or current psychiatric clinical input or medication.

5. Dr B's predicament might not have occurred had she established clear ground rules at the commencement of therapy with K in relation to her communication with his parents and GP.

6. The circumstances of this case demonstrate the need to improve the process of ensuring that consent, confidentiality and information-sharing with parents or carers, or other health professionals, is appropriately managed for minors who have been referred for mental health support or treatment, particularly in cases where the minor has been identified as being at risk of serious self-harm or suicide, and at risk of not fully engaging with their mental health clinician. I therefore distribute this finding to relevant agencies and make a recommendation in relation to this issue.

Recommendation

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

1. To improve the safety of minors, the Australian Health Practitioner Regulation Agency (Psychology Board) develop advice for clinical psychologists regarding the establishment of 'mature minor' status and subsequent information sharing, confidentiality and clarification of boundaries, relating to attendance and any emerging risks for adolescents.

Publication

Given that I have made a recommendation I direct that this finding be published on the internet pursuant to section 73(1A) of the *Coroners Act 2008*. As the purpose of the recommendation and publication is to improve public safety and in order to avoid any perception of casting blame, I direct that the published finding be redacted so as to remove any identifying information of the deceased's family or affected treating health professionals.

I convey my sincere condolences to K's family.

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

A, Senior Next of Kin

Dr B, Clinical Psychologist

Dr Jenny Babb, Eastern Health

Australian Health Practitioner Regulation Agency

The Australian Psychological Society

Office of the Chief Psychiatrist

The Australian Government Department of Health

Leading Senior Constable Leah Michelle Thowless, Coroner's Investigator, Victoria Police

Signature:

ROSEMARY CARLIN
CORONER
Date: 5 April 2017