IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2012 3776

FINDING INTO DEATH WITHOUT INQUEST

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

I, JUDGE IAN LESLIE GRAY, State Coroner having investigated the death of RJA

without holding an inquest:
find that the identity of the deceased was RJA
born [removed]
and the death occurred 26 April 2011
at Metford Railway line, New South Wales
from:

1 (a) MULTIPLE INJURIES

Pursuant to section 67(2) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances**:

1. RJA aged 30 lived at . RJA was a roofing plumber by trade.

2. On 26 April 2011, at about 3.05pm a train driven by Mark Stephenson and assistant driver Paul Remington departed Kooragang terminal heading to Pelton terminal at Cessnock. At about 3.30pm, the train passed Metford Station and neither driver observed any persons near or on the track. Prior to arriving at Metford Station, Mr Stephenson conducted a brake test.

3. At 3.35pm, RJA arrived at Metford station. He parked his vehicle and headed towards an erected fence line, which he climbed over. RJA walked a short distance to the railway line and remained stationary before jumping under the train driven by Mr Stephenson causing fatal

injuries. The sequence of events was confirmed by CCTV footage, which police had obtained from Rail Corp.

4. Witnesses contacted emergency services, however, none of the witnesses observed RJA whilst alive. Police and paramedics attended the scene shortly thereafter and confirmed RJA sustained fatal injuries. Mr Stephenson and Mr Remington confirmed with police they did not observe any person(s) on the track. Both drivers were breath tested with a nil blood alcohol concentration recorded.

5. In the weeks preceding his death, RJA visited his parent's residence and he was observed to be unsettled and they were concerned about his mental wellbeing. About three years earlier, RJA had a conversion and became religious.

6. On 23 April 2011, RJA visited his parents. The following morning his parents located a note. On 24 April 2011, [Father] attended RJA's unit but RJA was not home. Neither RJA's family nor his friends saw or spoke to RJA between 24 and 26 April 2011.

7. Dr Rohan Samarasinghe from the Newcastle Department of Forensic Medicine performed an external examination and reviewed the police report of death to the coroner and an x-ray scan. On the basis of this information and in the absence of an autopsy, Dr Samarasinghe considered a reasonable cause of death in the circumstances could be ascribed as 'multiple injuries'. Toxicological analysis did not detect alcohol or any other common drugs or poisons.

Medical History

8. A review of the medical records from Frankston Hospital (Peninsula Health) indicate the following:

    i) On 17 March 2011, RJA presented to the Frankston Hospital Emergency Department and was admitted to the ward as a voluntary patient. RJA indicated that he did not inform anyone of his whereabouts and did not have his phone and could not recall numbers. It was recorded that a nurse attempted to call his phone in the hope that his housemate would answer.

    ii) On 18 March 2011, it is noted that RJA requested a social worker to contact his sister. A message was left for his sister to contact the hospital.

iii) On 19 March 2011, RJA was visited by his housemate, who indicated that he would contact RJA's family.

iv) On 20 March 2011, RJA was visited by [Father]. [Father] indicated to the nurse that he would like to meet RJA's treating doctors to discuss RJA's condition.

v) On 22 March 2011, a family meeting took place. During that meeting, the family were advised of the "R_x" (treatment) and "$\triangle$" (diagnosis). There is, however no reference to what RJA's diagnosis was. It appears RJA was not present at this meeting, however the notes indicate that "RJA was happy with plan."

vi) On 24 March 2011, RJA was visited by his brother. On 27 March 2011, RJA had day leave with his sister. The following day, the notes referred to Frankston Hospital contacting the family about concerns. It appears that there were no issues raised by the family or incidents during RJA's day leave.

vii) On 30 March 2011, [Mother] was informed about a further planned day leave and the family indicated they would be in touch with RJA. [Mother] indicated they were happy with this plan and had no concerns.

viii) Between 1 April and 4 April 2011, further discussion took place with [Mother] about RJA's progress and his visit to Bendigo upon his discharge. The family indicated that they had seen some improvement with RJA.

ix) On 4 April 2011, RJA was discharged from the ward and his ongoing treatment transferred to Peninsula Health Mental Health Service (PHMHS). The notes do not indicate whether the family were advised of the discharge plan.

9. From 17 March 2011 up until RJA's discharge on 4 April, 2011, the notes indicate RJA's clinical course. It appears that his mental condition and his compliance with medication was variable.

Family Concerns

10. In a letter dated 25 July 2012, the family raised a number of concerns to the coroner in Maitland, New South Wales. The family's concern surrounded RJA's admission at and discharge from Frankston Hospital and the need for greater security around rail networks.

***Coroners Act 2008* - Jurisdiction**

11. Deaths required to be reported to the Victorian coroner are set out in the *Coroners Act* 2008[1]. It is clear from the circumstances that RJA's death occurred under reportable circumstances in Victoria and therefore it fits within the statutory definition of a reportable death.

12. RJA's death was originally reported to the New South Wales coroner, however given that RJA ordinarily resided in Victoria and the issues raised by the family related to his treatment at Frankston Hospital, the investigation into RJA's death more appropriately rests with the Victorian coroner.

Statement from Peninsula Health

13. A statement was obtained from Dr Sean Ording-Jespersen, Clinical Director of PHMHS to address the concerns raised by the family. Dr Ording-Jespersen has been Clinical Director of PHMHS since 31 August 2009 and had no direct involvement in RJA's care.

Delay in notification

14. Dr Ording-Jespersen indicates that there appears to have been a delay in notifying RJA's parents of his admission and that staff also had some difficulty confirming the relevant contact details, as those listed on his medical records were out of date.

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[1] See section 4; **Reportable Death**

"reportable death" means a death—

(a) where the body is in Victoria; or

(b) that occurred in Victoria; or

(c) the cause of which occurred in Victoria; or

(d) of a person who ordinarily resided in Victoria at the time of death—

being a death—

(e) that appears to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from accident or injury; or

....

15. I note, however, under paragraph 7(ii) above, the medical records do refer to a social worker attempting to contact RJA's sister on 18 March, 2011 as requested by RJA.

Treatment

16. Dr Ording-Jespersen accepts that the medical records do not clearly reflect whether a diagnosis of schizophrenia and corresponding treatment was specifically discussed. He indicates that it was "unusual" for this not to have been discussed.

17. I accept that the medical notes indicate that a discussion did take place regarding diagnosis and treatment. However, there is no accurate recording of whether a diagnosis or, at the very least, a provisional diagnosis of schizophrenia was raised with the family. I note, in particular, Dr Ording-Jespersen's statement that "this is contrary to the PHMHS Clinical Practice Guideline *Family Sensitive Practice"*.

Family conference

18. Dr Ording-Jespersen states that there is no reason provided in the clinical records as to whether or not RJA attended the family conference. Even though, it can be assumed from the notes that the outcomes of the meeting was discussed with RJA[2], given the general position (as indicated by Dr Ording-Jespersen) is to include patients in family meetings, any discussion not to include them, therefore, should be noted on the file. This clearly was not done.

Release & follow up

19. According to Dr Ording-Jespersen, RJA was discharged to the PHMHS Community Mental Health Team as per the PHMHS Clinical Practice Guideline *Transfer/Referral Form.* However, he acknowledges that the failure to include RJA's parents in the discharge planning was contrary to the PHMHS Clinical Guideline *Family Sensitive Practice.*

20. Dr Ording-Jespersen confirmed that a formal risk assessment was completed in accordance with PHMHS Clinical Practice Guideline *Risk Assessment.* The assessment rated RJA as a low risk prior to discharge.

21. Whilst I accept that RJA's risk assessment was suitably completed prior to discharge and, given RJA was a voluntary patient, it would have been inappropriate to detain him had he

[2] See paragraph 7(v) above under 'Medical History'

wanted to leave; however, the family was not properly informed nor involved in RJA's discharge plan. Given that they were on record as the next of kin this should have been followed up.

22. Whilst, I consider that the note taking and involvement of RJA's parents by Frankston Hospital was somewhat poor and contrary to the PHMHS Clinical Practice Guidelines, I am satisfied that medical care given to RJA whilst he was admitted was appropriate. The heartache for the JA family in the wake of the loss of RJA is palpable in their communications and, whilst I appreciate that they wish they could have done more, it is evident that RJA struggled with his mental state. I also note that at the time of the report of RJA's death, his brother indicated that RJA had made a number of previous attempts of self-harm and attended local mental health services.

Accessibility on rail networks

23. Despite the presence of fencing at the Metford Station, RJA scaled the fence in order to gain access to the railway line. I note that the Victorian Department of Transport in conjunction with rail authorities have undertaken significant research into the best countermeasures to help prevent suicides on the rail network. Of significance is the Ringwood Rail Fencing Project which commenced in June 2012 and is expected to be completed in April 2013.[3] The fencing of railway reserves is no doubt an important initiative and one that will require monitoring as to its benefits locally, statewide and nationally. Unfortunately, however, there may be limited capability of mitigating rail suicides due to continued access through other parts of a railway reserve.

RECOMMENDATIONS

[3] Response from Mr Michael Averkiou, Senior Manager, Legal and Insurance Branch, Department of Transport dated 13 June 2012 and 27 March 2013

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

1. That Peninsula Health should ensure all medical, nursing and allied health personnel are adequately trained in, informed of and adhere to the PHMHS Clinical Practice Guidelines.

2. That patient's notes are the official record of the patient's care. They are the medico-legal record of the interaction between the patient (including family) and the heath service. In this respect, I note that the Progress Notes Report Documentation lists a number of guidelines that should be followed in completing the Progress Notes, however, formal consideration should be given to include in the guidelines the types of information that should be documented including reasons for decisions to be set out on the patient's file.

FINDING

On all the available evidence, I **find** RJA died as result of multiple injuries sustained from impact by a train. I find that RJA intentionally put himself in the path of the train. There do not appear to be any suspicious circumstances surrounding his death.

Pursuant to rule 64(3) of the Coroners Court Rules 2009, I order that the finding be published on the internet.

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

- [Father] and [Mother] (senior next of kin)

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

- Mr David Goldberg, General Counsel, Peninsula Health

- Hon David Davis, MP, Minister for Health

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

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

- Hon Terry Mulder, MP, Minister for Roads and Public Transport

- Mr Michael Averkiou, Senior Manager, Legal & Insurance Branch, Department of Transport

- Magistrate Mary Jerram, State Coroner, Coroners Court NSW

Signature:

JUDGE IAN LESLIE GRAY
State Coroner
Date: 10 April 2013