IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: 2008 5243

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)

*Section 67 of the **Coroners Act 2008***

Inquest into the Death of: SIMON KIRWAN

Delivered On:	30 November 2012
Delivered At:	MELBOURNE
Hearing Dates:	17 and 18 July 2012
Findings of:	CORONER K.M.W. PARKINSON
Place of death/Suspected death:	186 High Street, Kew, Victoria
Counsel Assisting	Senior Constable Kelly Ramsey
Appearances:	Dr Paul Halley on behalf of St Vincent's Hospital and Eastern Health

I, KIM M. W. PARKINSON, Coroner having investigated the death of SIMON KIRWAN

AND having held an inquest in relation to this death on 17th and 18th July 2012

at MELBOURNE

find that the identity of the deceased was SIMON KIRWAN

born on 29 June 1989

and the death occurred on 24 November 2008

at 186 High Street, Kew Victoria

from:

1a. RUPTURED AORTA POST MOTOR VEHICLE INCIDENT

in the following circumstances:

1. An inquest was conducted into the death of Simon Kirwan on 17 and 18 July 2012.

2. The following witnesses gave evidence in the proceedings: Dr Peter Parker, Clinical Psychologist; Associate Professor Paul Katz, Consultant Psychiatrist; Dr Brendan Spence, Consultant Psychiatrist; Associate Professor George Mendelson, Consultant Psychiatrist; Senior Constable Caroline Sorrell, Investigating member of Victoria Police. Statements were also provided from family members and other witnesses.

<u>Background and event leading up to the 24 November 2008</u>

3. Simon was 19 years old at the time of his death. He was a student and resided with his father and his father's partner, Ms Carole Patterson and with his mother, Ms Tanya Kirwan. He is survived by his parents and his sisters and brother. His parents divorced when he was a young child and he largely resided with his father from that time. He was provided with support from his family members, however appeared to have some difficulties with his relationships. He did not have a history of illicit substance use or alcohol dependency.

Background mental health history

4. Simon first began experiencing mental health difficulties at around 16 years of age. He first attempted to take his own life in June 2006 when he was hospitalised for an intentional overdose of non- prescription analgesia. He was admitted to St Vincent's hospital and then to a private clinic, The Albert Road Clinic.

5. His psychologist, Dr Peter Parker reported that he never recovered and remained "suicidal" from that time on. Dr Parker reports that due to his mental health issues, Simon struggled to finish his schooling and attended a number of schools in an attempt to pursue his university education plans.

6. Simon's mental health issues were not complicated by poly-substance abuse issues. The evidence was uncertain as to a diagnosis. It was apparent from the evidence that even in the face of the suicide attempts in 2008, there was never any effective diagnosis of his mental health issues. This was partly because of insufficient time available to assess him, due to both his refusal to remain in the hospital and the perceived inability to detain him pursuant to the provisions of the Mental Health Act 1986 ('The Mental Health Act').

The incidents of self harm leading up to 24 November 2008

7. On 27 September 2008, Simon attempted to take his own life by slashing his wrists. He was transferred by ambulance to the Box Hill Hospital where he absconded prior to being assessed. Mr Kirwan was later returned to the hospital by Ms Patterson and admitted for assessment and surgical repair to the lacerations to his wrist. Dr Keogh who attended Simon on 29 September 2008 noted that there was an ongoing risk of self-harm and that the patient required admission to a psychiatric inpatient unit.

8. He was assessed as suffering from depressive illness at that time. During a psychiatric status review on 29 September 2008, Simon agreed that he would accept an inpatient admission at the Melbourne Clinic, a private psychiatric facility. He attended the Melbourne Clinic, however left the facility before a psychiatrist could assess him.

9. An example of the challenges faced by the family in communicating with and receiving communication from mental health services may be seen in this extract from Ms Patterson's statement relating to the events surrounding his suicide attempt on 27 September 2008 and his absconding from the Melbourne Clinic:

> *"Simon's challenge with life peaked mid September last year when his girlfriend told him she needed a break. In fact she had wanted to end the relationship. Simon cut his wrist in a suicide bid on the night of Saturday 27 September.....He was triaged to Box Hill hospital that evening but absconded during treatment and returned to his girlfriend's house. This occurred whilst hospital staff were de-briefing his father and me. Upon hearing this, his father and I pursued him to his girlfriends home and I was able to convince him to return to Box Hill Hospital. This was done without incident. Upon further assessment by Box Hill staff it was deemed that Simon required surgery for the wrist injury and should be placed in psychiatric care. The surgery occurred either late Sunday or on Monday.*
>
> *On Monday evening his father and I went to visit him at Box Hill (we had been advised by staff during the day that Simon did not want visitors). On arriving at the hospital we learned that Simon had been transferred to the Melbourne Clinic sometime that day. When we questioned the charge nurse as to why we were not informed of this she advised that she had been instructed by Simon not to do so. As Simon was an adult she was legally bound to abide by his wishes. At this point I expressed concern that Simon was not of sound mind and therefore not able to make proper decisions".*

10. The evidence is that en route to Melbourne Clinic on 29 September 2008, they ascertained that Simon had again absconded and that he was again at his former girlfriend's house in a highly agitated state. Ms Patterson arranged for police and ambulance to be called to the house and she and Simon's father attended. He was then transferred by ambulance to St Vincent's hospital where he was admitted as an involuntary patient pursuant to the Mental Health Act. The hospital did not have an inpatient psychiatric bed so Simon spent the night in the emergency department.

11. Ms Patterson reports that during the period she attended, some 3.5 hours, Simon attempted to abscond 3 times. On one attempt, he was found attempting to access the hospital car park

roof and on the last attempt she witnessed he took the opportunity of a broken wheel chair seat belt to jump out of the chair and flee. He was located by hospital security staff in the hospital car park to whom he indicated his intention had been to jump. Simon was discharged from the hospital on 3 October 2008 after 3 days as an inpatient, when after being transferred from involuntary status; he refused to remain as a voluntary inpatient.

12. Again, despite protestation of the family, Ms Patterson and Mr Kirwan, Simon was discharged into the community as clinicians had formed the view by 3 October 2008 that he no longer met the criteria for involuntary status and it was not in his interests to remain in an environment heavily exposed to seriously unwell patients. The hospital advised that they had consulted with his psychologist Dr Parker in this regard.

13. Ms Patterson described that during October things were relatively calm and that family put in place a support plan for him, which they felt, kept him focused. In November, some family tensions arose and it was necessary for him to move from his mother's where he had been staying. He also had to confront the reality of seeing his former girlfriend with another young man. The frailty of his mental health meant that he was unable to adjust easily to adverse life events, the most recent of those being the end of the relationship.

14. On 19 November 2008, he was located on the 18th floor of a shopping centre car park in a distressed state and threatening to jump from the car park ledge. Police negotiated with Simon for a number of hours and involved his psychologist. The police report that it was necessary to physically restrain Simon from jumping.

15. At the police station, the Eastern Community Mental Health Assessment Team ('CAT team') assessed him. Dr Parker also attended at the police station and it was agreed amongst the clinicians, that in view of Simon's opposition to inpatient treatment, that he would not be admitted, pursuant to the Mental Health Act to involuntary status.

16. Ms Patterson also attended at the police station. She stated that she wanted Simon returned to St Vincent's Hospital, however, the psychologist and the CAT team did not think it was in Simon's best interest. Simon was then left in the care of Ms Patterson who then drove Simon to his mother's house where he was staying. Over the next few days, he appeared to be calm; however, Ms Patterson states that he was a "master con" at portraying this.

17. He kept plans he had made with friends on Thursday and Friday nights, 20 and 21 November 2008. At approximately 1.45am on Saturday 22 November 2008, he was admitted to the Box Hill Hospital emergency department via ambulance as he had attended a friend's house unsteady of gait and slurring his speech and admitting to a drug overdose. He was released from Box Hill Hospital that morning. When speaking with clinicians Simon denied suicidal ideation and advised staff that the overdose had been unintentional as a result of trying to get into the 'zone'. No admission for a more fulsome assessment was undertaken despite this having being recommended at the September admission, by the attending doctor.

18. After his discharge that morning and at approximately 10.00am that day, Saturday 22 November 2008, he was located by his mother on the lounge room floor with a multitude of empty medication packages underneath him. He was transferred by ambulance to St Vincent's hospital and was admitted as an involuntary patient pursuant to the provisions of the Mental Health Act.

19. On this occasion after arrival at the hospital Emergency Department, he again attempted to abscond and make his way to the roof of the hospital car park from where, as he advised hospital security officers, he intended to jump.

20. Hospital staff advised his mother at the point of his admission on 22 November 2008 that Simon would be returned to the secure ward for at least the weekend. However, at 10.00am on Sunday 23 November 2008 Simon telephoned his father to advise that he was being discharged from the hospital and asked be collected.

21. Mr Kirwan spoke to staff at the hospital to express the families concern as to the discharge, in view of Simon having attempted to take his own life on three occasions in the past week. They asked to understand the criteria by which he had been moved from 'involuntary' to 'voluntary' patient status. They did not believe that this was adequately explained or sustained and were shocked and concerned at his release.

22. The evidence is that Simon was discharged on the understanding that he would consult with his psychologist for ongoing assistance. Simon did not however disclose that he had refused contact with Dr Parker over the previous days, as he was angry with him for refusing to

assist his earlier release from involuntary inpatient admission. This information did not appear to have been conveyed to the clinicians. It also appears that the detail of his history and the recent events involving self-harm was also not fully appreciated. This appears to have arisen from the attendances at various mental health facilities and upon a number of different clinicians.

23. The evidence of the treating mental health clinicians is that he was discharged from secure environment on his assurance that he was not intending to take his own life and was not suicidal and on the assumption that he would engage voluntarily with his psychologist. The assessing psychiatrist did not consider that Simon could be further detained on an involuntary basis as his symptoms had resolved and he was not actively suicidal and was not expressing suicidal ideation. Dr Spence stated:

> *"Although Mr Kirwan was likely to be at chronic risk of impulsive self harm with interpersonal discord he did not suffer with major depressive disorder nor a psychotic disorder in my opinion and on utilisation of DSM-IV TR. There was a degree of engagement, reactivity and warmth during my interview with him. He was willing to co-operate with me to gain collateral information. In my opinion and in consideration of his assessment and the collateral history, I considered that his chronic risk of impulsive self-harm had been reduced and contained. He did not meet the criteria for continued involuntary detention under the Mental Health Act."*

24. Dr Spence stated that he encouraged Simon to remain an inpatient however he was adamant that he wanted to go home. He discussed options for Simon with psychologist Dr Parker and they agreed that a psychiatric consultation was advisable and ought to be arranged with a private psychiatrist. The clinicians recognised that this would require Simon's active participation. There does not appear to have been a discussion as to his history of lack of co-operation or willingness to consult a psychiatrist.

25. Simon's history of compliance with such undertakings was poor. It was also unlikely in any event, that Simon intended to pursue any further assistance from Dr Parker in view of his refusal to take his calls. This was acknowledged in the proceedings to be a significant matter and relevant to an accurate assessment of his level of risk and mental health status and the decision to discharge.

26. The clinicians desire to maintain a good relationship with the patient, having assessed that this was in his long term best interests in terms of obtaining a commitment to treatment, defined the manner in which he was treated and the decisions about inpatient admission or otherwise. It also unfortunately defined the way in which Simon responded to clinical advice. He was conscious that if he behaved in a particular way he could not be detained.

27. Family were aware of his capacity to represent himself in this manner and to disguise his true state of mind. However they were not engaged in any meaningful way by the clinicians prior to his discharge from care, who may then have obtained a more precise appreciation of Simon's history and in particular an understanding of his capacity to mislead clinicians as to his mental health status, particularly when he was no longer willing to remain an inpatient.

28. Ms Patterson regularly intervened to advocate for Simon and family involvement in Simon's care and was actively encouraged by the mental health clinicians who assisted Simon. The family was utilised to provide a safe haven for him at times when he was discharged from the mental health inpatient services however there was little consultation or discussion with the family as to important decisions regarding Simon's treatment or discharge planning.

29. Simon did not readily accept treatment, was actively and vociferously opposed to inpatient treatment and was not accepting of anti-depressant medication. The view of the treating clinicians was that his attempts on his own life were 'event triggered responses'. However, this analysis does not account for the persistence of his disturbance and the apparent acceleration of his disturbed behaviour in the weeks before his death. It also appeared to underestimate the degree of seriousness of his mental health issue.

30. On the evening of 23 November 2008, Simon was resting at his father's home in company with his stepmother, Ms Patterson and his sister having been discharged at 10.00am from St Vincent's Hospital mental health unit in the circumstances earlier described.

31. Family report that he ate dinner and spent time talking with his sister. He had earlier in the evening been observed in his room writing in a notebook. At approximately 12.00am, he left the house and drove off in his motor vehicle. Ms Patterson became concerned after she went

into his room and located the notebook, which contained a number of notes to family members and friends indicating that he intended to harm himself.

32. A number of text message communications then occurred between Simon and Ms Patterson in which he re-assured her that he would be all right and that if she left the door open he would be over. At approximately 12.45am on 24 November 2008, she spoke to Simon where he again stated he was ok. At 1.20am, however he sent a further text message to Ms Patterson, which said "thank you", that he loved her and that he was "so scared".

33. At 12.45am, Simon had been located sitting in his green Subaru Impreza motor vehicle by police officers attending a reported burglary in Walpole Street Kew. They approached the vehicle and Simon who was sitting in the vehicle with headphones on. They made inquiries of Simon's welfare. He advised that he was sitting in his car listening to music and that he was ok. They searched the car in relation to the burglary with Simon's permission and located letters and emails, which related to his relationship. Simon requested that they not continue to read the documents as they were private and police complied. He explained that he was having relationship problems and that he had parked his car so that he could think. Constable Sorrell states that Simon was not drug or substance affected and that whilst he appeared anxious, which he explained was because of a relationship problem, he gave no indication that he was suicidal or that he was contemplating self-harm. Police allowed him to return to the car and when he did so he put on his seatbelt and police left to return to their criminal investigations.

34. At approximately 1.32am, they received a notification through police communications to attend at the Kirwan home in relation to a report of suicide notes having been located at the home. Constable Sorrell recognised the name and the address as being related to the young man to whom they had earlier spoken. Shortly afterwards the police radio notified a motor vehicle collision at Walpole Street, Kew. Constable Sorrell arrived at the scene of the collision at 1.39am. She recognised the vehicle as that which had been driven by Simon.

35. Police report that the green Subaru Impreza vehicle was located on the footpath of the southern side of the intersection of Walpole and High Streets, Kew. Police report that the vehicle had apparently been driven at an extremely high rate of speed along Walpole Street, crossing the T-intersection with High Street and colliding into the wall of a cafe premises

situated at 186 High Street, Kew. The vehicle sustained extensive damage. Simon sustained catastrophic injuries and was deceased at the scene.

36. Dr Paul Bedford, Forensic Pathologist reported that examination identified the cause of death as ruptured aorta post motor vehicle incident. He summarised the anatomical findings as left hemothorax and ruptured aorta. Toxicological analysis of post mortem samples revealed therapeutic levels of diazepam, which were not contributory to the collision. No alcohol was identified.

37. Simon's mental health issues were not complicated by poly-substance abuse issues. The evidence was uncertain as to a diagnosis. It was apparent from the evidence that even in the face of the suicide attempts in 2008, there was never any effective diagnosis of his mental health issues. This was partly because of insufficient time available to assess him, due to both his refusal to remain in the hospital and the perceived inability to detain him pursuant to the provisions of the Mental Health Act.

38. As at the date of the hearing of the inquest, there was still expressed uncertainty about diagnosis of Simon's mental health issues and as to whether he was appropriately diagnosed as suffering with depression or with some other diagnosis including personality disorder. This was significant because the diagnosis of 'mental illness' influences upon the application of the involuntary status provisions of the Mental Health Act. It was however conceded by Prof. Katz, Dr Spence and by Prof. Mendelson, that a more extensive inpatient admission, which enabled a fulsome assessment of Simon's mental health issues and a more accurate diagnosis, should have taken place and may have resulted in a better outcome.

39. Prof. Mendelson discussed that ideally there would be facilities available for long-term stays involving months, not days. This would enable an opportunity to diagnose identify if there were pharmaceutical options available to stabilise the patient's condition.

40. Simon had made serious attempts to take his own life, a recent one of which involved inflicting significant lacerations, which involved not merely cutting his arm, but lacerating his tendons, such that he required surgical intervention for repair. Immediately prior to his surgery, he asked the surgeon for his advice on the best way to make sure he succeeded in killing himself in the future.

41. The evidence is that Simon had on a number of occasions prior to his death attempted to by various means to take his own life. These involved his threat to jump from height and involving police in preventing the event and inflicting serious injury upon himself requiring surgical intervention. He had absconded from mental health treatment or assessment on a number of occasions and required recovery even to emergency departments whilst under assessment.

42. These behaviours are not 'normal' behaviours by any standard. They may not fit into a diagnostic tool range as conclusive evidence of a 'mental illness' however they are what the community would describe as unbalanced behaviour and what appears to be contemplated by the Mental Health Act when it describes ' suicidal' and 'abnormal thought'.

43. I do not accept that this pattern of behaviour in a young man, who does not use illicit substances and whose behaviour is not therefore influenced by such drugs, is normal or able to be characterised as anything less than compelling evidence of a 'disturbance of thought or mood', as contemplated by S8(1A) of the Mental Health Act.

44. This is not a person who is making a decision to take their own life on arguably rational grounds, such as in circumstances where they have a terminal illness or physical incapacity. Simon was a young male, 19 years old, with no diagnosed physical illness or ailment, well educated and supported by family members, who, despite all of these favourable factors, persistently and violently attempted to take his own life.

45. These recent attempts to take life warranted a more extensive analysis than acceptance of the patient's word that he is no longer suicidal, particularly in face of vociferous objection and concern from the family members who knew him best. Simon's circumstances warranted a more incisive and comprehensive analysis by clinicians prior to his being released from involuntary and inpatient status.

46. The evidence satisfies me that this young man was in effect able to direct the clinicians as to the type of care he was prepared to accept and they were largely accepting of this approach to provision of care. That is, if he was not accepting of certain types of care they did not press the issue, out of concern for losing his confidence and perceived co-operation.

Relevant Legislative Provisions - Mental Health Act and its application to Simon

47. 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. S9 provides that the patient is assessed for involuntary treatment by reference to the criteria in S8 of that Act.

48. 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 principal's 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.

49. 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.

50. The evidence of the clinicians is that Simon did not meet the criteria for involuntary detention under the provisions of the Mental Health Act at the time of the assessments in November 2008 and in particular on 22 November 2008. This was the reason he was discharged from inpatient involuntary care, despite the clinicians being of the opinion that he remained at high risk for self-harm after discharge.

51. The application of the Mental Health Act appears to be that if the patient is not floridly symptomatic of mental illness, then even if there is a diagnosed and abiding mental illness or disorder, that person does not meet the definition for involuntary status. Once Simon's active suicidal ideation had appeared to resolve, despite an acknowledged likelihood of relapse, the opinion of the clinicians was, he could not involuntarily be detained in a mental health facility pursuant to the provisions of the Mental Health Act. This was the evidence of Prof. Mendelson and of Prof. Katz and Dr Spence.

52. Dr Mendelson's evidence was that ideally, Simon would be detained for a long period of treatment and stabilisation; however, there is no facility to undertake such treatment and the current provisions of the Mental Health Act did not accommodate the circumstances of one such as Simon.

Findings as to cause and contribution

53. I find that Simon Kirwan died on 24 November 2008 due to injuries he sustained in a motor vehicle collision in which he was the driver.

54. I find that Simon Kirwan took his own life on 24 November 2008 and that no other vehicle or driver caused or contributed to his death.

55. I find that Simon's mental illness or mental disorder, however characterised, was a contributing factor to his death.

56. I find that Simon's failure to accept voluntary inpatient admission was a contributing factor to his death.

57. Whilst the prognosis for a patient such as Simon is described by clinicians as often poor, had Simon been detained on an involuntary basis for longer term involuntary inpatient treatment of his mental health issues, in September 2008 and at any time in the period 19 November to 23 November 2008 his death may have been prevented.

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

58. The decision to remove Simon from involuntary status and to discharge him from inpatient care on 23 November 2008 was made by the clinician in the context of prevailing clinical understanding of the appropriate application of the provisions of the Mental Health Act.

59. This is a case where there was too great a willingness in clinicians, in the face of Simon's well practiced veneer of normality, to accept Simon on his word that he did not intend any further attempts at self harm. This acceptance resulted in decisions as to discharge being made absent complete knowledge or inquiry of past medical history or family information.

60. In view of his history of attempts at self-harm it would have been prudent to make much broader inquiry and to involve his family in the information and decision making process.

61. I am satisfied that had there been a more complete assessment and analysis undertaken including of his history, it is likely that a different decision would have been made about his appropriateness for discharge.

62. The lack of availability of longer-term involuntary inpatient facilities for persons suffering with mental illness or disorder, results in early and inappropriate discharge of patients into the community.

63. In applying the Act, it is apparent that there is a tendency in clinicians to attribute a requirement that the patient be floridly symptomatic, before they can be subject to involuntary orders. If this is the correct interpretation of the Act then the legislation is inadequate to deal with the circumstances of someone in Simon's position and ought to be amended to include express provision for detention for assessment, diagnosis and treatment. It is apparent that in Simon's case the mental illness whilst perhaps not clinically florid was still in existence, placing him at risk and requiring of treatment.

64. It would be of great concern if that approach to the application of the Mental Health Act were a practical response by mental health clinicians to a lack of resources and in particular the limited number of inpatient mental health beds available in the public hospital system.

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

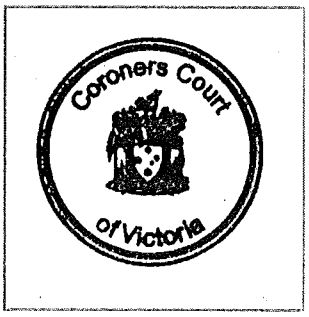
65. That the operation of the provisions of the Mental Health Act be enhanced by the provision of additional long term inpatient voluntary and involuntary public treatment beds to enable effective assessment, diagnosis and care to be provided to mentally ill patients in Victoria.

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

67. I direct that a copy of these findings be provided to the Family of Simon Kirwan; the Interested Parties; Associate Professor Mendelson; The Honourable Mr David Davis MLC,

Minister for Health (Victoria); The Office of the Chief Psychiatrist; The Secretary, Department of Health (Victoria); The Chief Commissioner Victoria Police.

Signature:



CORONER K.M.W. PARKINSON

Date: 30 November 2012