IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: 5605/08

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of SIMON RHYS MACQUEEN

Delivered On:	23 March 2012
Delivered At:	Coroner's Court of Victoria Level 11, 222 Exhibition Street Melbourne Victoria
Hearing Dates:	25 January 2012
Findings of:	JOHN OLLE, CORONER
Representation:	Dr P B Halley on behalf of the family. Mr R G McCloskey on behalf of North Western Mental Health
Police Coronial Support Unit (PCSU):	Senior Sergeant D Dimsey

I, JOHN OLLE, Coroner having investigated the death of SIMON MACQUEEN

AND having held an inquest in relation to this death on 25 January 2012
at Melbourne

find that the identity of the deceased was SIMON RHYS MACQUEEN

born on 22 January 1974

and the death occurred on 15 December 2008

at Upfield Railway Line, Coburg, Victoria 3058

from:

1a. HEAD AND NECK TRAUMA (TRAIN IMPACT)

in the following circumstances:

Purposes of a coronial investigation

1. The primary purpose of the coronial investigation of a reportable death[1] is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which the death occurred.[2] The practice is to refer to the medical cause of death incorporating where appropriate the mode or mechanism of death, and to limit the investigation to circumstances sufficiently proximate and causally relevant to the death.

2. Coroners are also empowered to report to the Attorney General on a death they have investigated; the power to comment on any matter connected with the death, including matters relating to public health and safety, or the administration of justice; and the power to make recommendations to any Minister, public statutory or entity on any matter connected with the death, including recommendations relating to public health and safety or the administration of justice.[3]

3. The focus for a coronial investigation is to determine what happened, not to ascribe guilt, attribute blame or apportion liability and, by ascertaining the circumstances of the death, a Coroner can identify opportunities to help reduce the likelihood of similar occurrences in future.

Background

4. Simon MacQueen was aged 34 years at the time of his death. He lived at 4/16 The Grove, Coburg.

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[1] Section 4 of the Act requires certain deaths to be reported to the Coroner for investigation. Apart from the jurisdiction nexus with the State of Victoria, a definition of a reportable death includes all deaths that appear *"to have been unexpected, unnatural or violet, or to have resulted, directly or indirectly, from accident of injury."*

[2] Section 67 of the Act.

[3] Section 72(1), 72(2) and 67(3) of the Act regarding reports, recommendations and comments respectively.

5. A comprehensive coronial brief has fully addressed the circumstances of Simon's death.

6. At Inquest I heard evidence from Dr Fariba Kavianpour, Psychologist, and Dr Achira Kiriella, Psychiatric Registrar, each of whom were involved in the management of Simon in the period prior to his death. In addition, Dr Gaurav Deva, Consulting Psychiatrist, provided an overview of Simon's management.

7. I say at the outset the evidence of all witnesses was impressive. My investigation has been greatly assisted by each of them.

The Investigation

8. The tragic circumstances of Simon's death are detailed in the Inquest Brief. Further recitation within this finding is unnecessary. Save to say, Simon died on 15 December 2008, having stepped in front of an oncoming train on tracks between Coburg and Moreland Railway Stations.

9. The train driver bears no responsibility for the sad circumstances of Simon's death.

Focus of my investigation

10. Simon had a lengthy history of mental health illness. He suffered multiple self-harm incidents, serious suicide attempts and was considered a chronic suicide risk. He had a history of auditory hallucinations, which were derogatory. According to Simon, they were "from hell".

11. Some clinicians considered Simon's self-harm to be as a result of these voices. On other occasions, the self-harm was considered a behavioural factor.

12. Most types and combinations of medication had been tried, without adequate and sustained effect. Simon showed greatest improvement in an in-patient unit receiving supervised medication. Sadly, once well, Simon would initiate disengagement from services.

13. Following his seven day admission in the Broadmeadows In-patient Unit, Simon was discharged on 12 November 2008. Simon was discharged from the in-patient unit directly from overnight leave after he had refused to return to the unit.

14. Following a lengthy telephone assessment on 12 November, Dr Negibe Mankir assessed Simon as being appropriate for discharge. Simon was a voluntary patient. Following his assessment, Dr Mankir called Simon's mother, Mary. He advised her of the discharge and follow up arrangements with Moreland Community Treatment Team ("MCTT").

15. Follow up arrangements were made with MCCT for a brief period of case management. The impetus for this engagement appears to have been a request from the Office of the Chief Psychiatrist, directly to Dr Mankir and Mr Dermanakis (Program Manager, Moreland Continuing Care Program). The request was in response to a complaint made by Mary, prior to Simon's November 2008 admission to the Broadmeadows In-Patient Unit.

28 November 2008

16. Simon's first consultation with MCTT was an appointment with Dr Fariba Kavianpour and Dr Achira Kiriella on 28 November 2008.

17. At Inquest I heard from both Dr Kavianpour and Dr Kiriella. Simon reported ongoing suicidal ideation he could not control. He heard persistent derogatory voices. Dr. Kiriella diagnosed persistent schizophrenia. Simon agreed to commence cognitive behavioural therapy with Dr Kavianpour, to increase the dose of Risperidone to 6mg nocte, maintain the Mirtazapine 90mg daily. A second appointment was made for 23 December 2008.

18. Simon liked his General Practitioner, Dr Marcus Weyland. He considered Dr Weyland's approach, holistic. He consulted Dr Weyland for prescriptions repeats and general health issues. MCCT planned to co-share Simon's management with Dr Weyland.[4]

Complexity of Simon's mental illness

19. Simon's psychiatric diagnosis was complex. Throughout the file, including the final in-patient admission, clinicians were unsure of his primary illness.

The treatment dilemma - disengagement from services

20. Simon's reluctance to engage provided a challenge to mental health services. In crisis, Simon's parents invariably secured engagement, resulting in Simon's voluntary admission. At times Simon would voluntarily engage with a case manager, a private psychiatrist and Dr Weyland, but in all but Dr Weyland's case, he did not sustain the engagement.

21. Simon had a history of disengagement from private psychiatrists and from MCCT as recently as 10 June 2008. At this time, MCCT discharge summary in the North Western Mental Health Clinical file did not record the rationale for discharge from case management. The decision to discharge appears to be made based on Simon not engaging rather than on a clinical decision. MCCT appears to have been reassured by their perception that Simon was engaged with Dr Weyland.

[4] Simon's last consultation with Dr Weyland was 27 November, 2008

Critical Issues

22. I endorse the submissions of Dr Halley for the family - the critical issues raised by this investigation are communication and documentation.

i. Breakdown of communication between the Ward of Moreland Health and MCCT
   a. The discharge summary should have included Dr Muirhead's opinion that the anti-psychotic medication should be reduced over time.
   b. The circumstances of Simon's refusal to return to the unit precipitating his discharge should have been clarified.
   c. The discharge plan should have been forwarded to Dr Weyland.[5]
   d. That the family complained to the Office of Chief Psychiatrist, in respect to the lack of communication with them and additional concerns raised by the family.[6]

ii. There was a communication breakdown between MCCT and Dr Weyland.

iii. Dr Weyland should have been telephoned on 28 November 2008 by Dr Kiriella. In the telephone call Dr Weyland would have been informed of the circumstances of Simon's discharge from the ward, together with the decision of Dr Kiriella to increase the anti-psychotic medication. In return Dr Kiriella would have received first hand knowledge of the nature and extent of the consultations between Simon and Dr Weyland.

Discharge summaries

23. It is essential that discharge summaries are carefully considered and contain all relevant information. The discharge summary should be provided to the general practitioner and MCCT. The discharge summary in respect to Simon should have included the concerns the family had raised with the Chief Psychiatrist, the proposed anti-psychotic reduction regime (Dr Muirhead) and the nature and extent of Simon's discharge in circumstances where he refused to return to the unit.

Telephone call

24. When co-sharing care and/or in circumstances where a general practitioner is expected to perform an important role, a telephone call at the time of initial consultation is essential. There are no circumstances in which a telephone call should not be made. A telephone call will ensure a two-way discussion is held, and the best interests of the patient assured. A follow up confirmation letter should be provided, in particular when variation in medication is undertaken.

[5] There is no evidence in Dr Weyland's file that he ever received a discharge summary from Moreland Health.
[6] All witnesses, notably the Case Manager, Psychologist, Dr Kavianpour, acknowledge that the family often knows more than the professionals in terms of the wellbeing of the individual.

Lack of notation

25. Irrespective of work pressure, it is patently unsatisfactory for a clinician to conclude a consultation without having made notes of important issues. Notably, follow up steps required such as telephone calls to general practitioner. It is unacceptable for clinician's to rely solely on memory, after other consultations have been conducted and several hours elapsed. Such practice is fraught and the wellbeing of the patient potentially jeopardised.

26. Every professional person experiences work pressure. Pressure of work can never excuse a failure to achieve best practice.

27. North Western Mental Health Services must provide clinicians a reasonable opportunity to make important notes at the conclusion of consultation prior to the commencement of the following consultation.

Crisis/Emergency Plan

28. Save for providing Simon a card with the name of the unit and triage telephone numbers, there was no current care plan or current crisis or emergency plan for Simon on 28 November 2008. There was no attempt to engage Simon's family and no record of discussion whether Simon wanted them involved.

29. A crisis emergency plan or pathway developed at the first consultation, is essential, albeit of an interim nature. A more comprehensive plan can be created at a subsequent consultation. The lack of information about a patient is the most powerful reason for creating an interim crisis/emergency plan/pathway.

30. Dr Deva spoke of the tension between maintaining therapeutic rapport on the one hand and involving supportive family on the other. However, the conversation must be held. It is essential that full and frank dialogue is held, highlighting the need to keep the patient safe. A patient's refusal to permit contact with family, heightens, not minimises the need to create a crisis management plan.

31. Mary had attempted to contact relevant medical professionals when she became alarmed that Simon was in critical danger. Because there was no crisis pathway, she could not obtain help for her son. Regrettably, the clinicians entrusted with Simon's care, were unaware of her concerns for Simon's wellbeing.

32. At times, Simon did not want his family involved. At other times, he relied heavily upon them. This situation is not uncommon with persons who suffer from mental health illness. The nature of his text messages and telephone calls to his sister and mother, reflect his reliance upon his family. A crisis/emergency plan could only assist.

33. Families are a fertile source of valuable information for clinicians. Safety and well being of patients can only be enhanced by transparent communication between clinicians and family members. I am saddened to hear Dr Deva's response to family's' frustration not being heard by other services to simply knock harder. Surely a clinician should consider a family member offering input a welcome guest, not an interloper.

34. I acknowledge the enormous time pressures faced by professionals who work in the public mental health system. It is difficult to imagine a more complex and challenging work environment.

35. I do not criticise the role of the clinicians who gave evidence before me. I am satisfied that every decision made by them was made in Simon's best interests, despite the fact there were systemic issues identified and failings made by way of communication.

Post mortem medical examination

36. On 18 December 2008, Dr Malcolm Dodd, Forensic Pathologist with the Victorian Institute of Forensic Medicine, performed an autopsy on the body of Simon Rhys MacQueen. Dr Dodd found the cause of death to be head and neck trauma (train impact).

RECOMMENDATIONS

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

That North Western Mental Health Service ensure:

1. At every first contact with MCCT there must be a telephone call with the general practitioner or service with whom care is shared.

2. Clinicians must be provided an opportunity to make important notes prior to commencing subsequent consultation.

3. Discharge summaries contain all relevant information in respect to treatment and medication plans, provision of medication to the patient and circumstances of discharge and confirmation with co-sharing professionals in the community are contacted by telephone and with follow up discharge plan.

4. MCCT creates a Crisis/Emergency plan at the first consultation. Ideally to encompass a crisis pathway for families.

Finding

I find the cause of death of Simon Rhys MacQueen to be head and neck trauma (train impact).

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

The family of Simon MacQueen;
Investigating Member, Victoria Police;
North Western Mental Health;
Dr Weyland;
Broadmeadows In-patient Unit;
Interested Parties.

Signature:

JOHN OLLE
CORONER

23 March 2012