IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2008 005634

FINDING INTO DEATH WITH INQUEST

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

Inquest into the death of TRAVIS JOSEPH HARTSKEERL

Delivered on:	25 August 2014
Delivered at:	Coroners Court of Victoria 65 Kavanagh Street Southbank Victoria 3006
Hearing dates:	15 and 16 October 2012
Findings of:	Coroner Paresa Antoniadis SPANOS
Representation:	Mr David GOLDBERG of Counsel, instructed by Ms Kate McCULLOUGH of Peninsula Health Corporate Counsel, represented Peninsula Health. Ms Deborah FOY of Counsel, instructed by Ms Vanessa NICHOLSON of Avant Law, represented Dr George MARAGOUDAKIS.
Police Coronial Support Unit Assisting the Coroner:	Senior Constable Kelly RAMSEY.

I, PARESA ANTONIADIS SPANOS, Coroner,
having investigated the death of TRAVIS JOSEPH HARTSKEERL
and having held an inquest in relation to this death on 15 and 16 October 2012 at MELBOURNE

find that the identity of the deceased was TRAVIS JOSEPH HARTSKEERL
born on 22 June 1976, aged 32
and that the death occurred on 16 December 2008
about 200 metres north of Kananook Railway Station, Seaford, Victoria 3198
from:

1 (a) HEAD AND NECK TRAUMA (TRAIN IMPACT)

in the following circumstances:

BACKGROUND AND PERSONAL CIRCUMSTANCES

1. Travis Hartskeerl (Travis) was a 32-year-old man who resided with his father, Bernard Hartskeerl (Mr Hartskeerl) in Frankston North. In the eight years preceding his death, Travis had resided with his father from time to time, most recently from September 2008 until his death.
2. Travis had a significant and complex mental health history including a long history of polysubstance abuse, psychosis, thought disorder, depression and schizophrenia and several serious suicide attempts. He was treated by Peninsula Health on a number of occasions between September 2006 and his death, including admission to the acute mental health inpatient unit, treatment by the community mental health team, referrals to a drug and alcohol program and the Consultant Liaison Inpatient Service (CLIPS)[1] in the Frankston Hospital Emergency Department (ED).
3. Mr Hartskeerl stated that his son went 'in and out of difficulties in handling of his medical condition', and would arrive at his home looking for a place to stay when he was unwell. These times were particularly difficult, as his son's mood would change very quickly. According to Mr Hartskeerl, during their most recent period of living together, his son's mood seemed to be well, but changed in the weeks immediately preceding his death when he became more depressed.[2]

[1] Transcript page 122.

[2] Statement of Bernard Johannes Hartskeerl, page 6 of the inquest brief, Exhibit K.

DETERIORATING MENTAL HEALTH

4. On Tuesday 9 December 2008, Mr Hartskeerl arrived home in the evening to find Travis sleeping on the concrete outside at the back of the house. He brought him inside and put him to bed. The following morning, Travis told his father that he had taken an overdose of paracetamol and temazepam. Mr Hartskeerl contacted Frankston Hospital, told them what had happened and was advised that his son should see his general practitioner (GP) for blood tests. According to Mr Hartskeerl, Travis refused to do so.[3]
5. Over the following week, Mr Hartskeerl noticed a deterioration in Travis' condition. He encouraged his son to seek help, and Travis said that he was seeing his doctor. Mr Hartskeerl had no reason to doubt his son, as he did regularly attended his GP, always returned with a prescription which was filled, but at times would refuse to take his prescribed medications.[4]
6. On 16 December 2008, Mr Hartskeerl became concerned for his son's welfare when he left home early to go for a walk, and did not return. Mr Hartskeerl contacted Frankston Hospital Mental Health Triage team to seek advice about treatment for Travis, including the possibility of a hospital admission.
7. At about midday, Travis returned home. His father told him that he thought they should go to the hospital together to get help for him, but Travis said that he had just returned from the Frankston Hospital where he was advised to see his own GP.
8. Mr Hartskeerl telephoned the hospital again to confirm this, and was told that Travis had attended and had been assessed as not requiring admission, but an appointment had been made for him to see his GP, Dr George Maragoudakis, the following morning at 10.30am. The nurse informed him that relevant documents would be faxed to Dr Maragoudakis. Mr Hartskeerl then telephoned Dr Maragoudakis' clinic but was unable to speak to him.[5] At about 1.00pm, while his father was on the phone, Travis left the house again.
9. After looking for him and contacting friends with whom he might have stayed overnight, Mr Hartskeerl reported his son missing to police the next day, Wednesday 17 December 2008.[6]

16 DECEMBER 2008 - TRAIN INCIDENT

10. On 16 December 2008, at about 1.40pm, a Frankston to Flinders Street train departed Kananook station. At a left curve in the track, the driver[7] saw something on the tracks in front

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[3] Statement of Bernard Johannes Hartskeerl, page 6 of the inquest brief, Exhibit K.

[4] Ibid pages 6-7 of the inquest brief, Exhibit K.

[5] Ibid page 7 of the inquest brief, Exhibit K.

[6] Ibid.

of him, and applied the emergency brake. He was unable to stop the train in time to avoid impact with Travis who was lying on the tracks.[8]

11. Police and Metro Trains Control Centre staff were contacted and arrived at the scene a short time later. Paramedics also attended and confirmed that Travis was deceased. As part of their initial investigations, the police performed a preliminary breath test on the driver which was negative for the presence of alcohol.

PURPOSE OF A CORONIAL INVESTIGATION

12. Travis' death falls within the definition of a reportable death in section 4 of the ***Coroners Act 2008***, as it was *unexpected* and *appears to have resulted indirectly from accident or injury.*[9]

13. The purpose of a coronial investigation of any reportable death is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[10] The *cause* of death refers to the *medical* cause of death, incorporating where possible the *mode* or *mechanism* of death. For coronial purposes, the *circumstances* in which death occurred refers to the context or background and surrounding circumstances, but is confined to those circumstances sufficiently proximate and causally relevant to the death, and not merely all circumstances which might form part of a narrative culminating in death.[11]

14. The broader purpose of any coronial investigations is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of recommendations by coroners, generally referred to as the prevention role.[12]

15. Coroners are also empowered to report to the Attorney-General in relation to a death; to comment (at large) on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and to make recommendations to any Minister or public statutory authority on any matter connected with

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[7] Coincidentally, there was another driver in the cabin who was travelling to prepare another train, who played no active role in controlling the train/brakes.

[8] Statement of the train driver, pages 117-118 of the inquest brief, Exhibit K.

[9] The ***Coroners Act 2008,*** like its predecessor the ***Coroners Act 1985***, requires certain deaths to be reported to the coroner for investigation. Apart from a jurisdictional nexus with the State of Victoria, generally, a reportable death is one that appears *"to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from accident or injury"* – see section 4 of the Act.

[10] Section 67(1) of the ***Coroners Act 2008***. All references to legislation which follow are to the provisions of this Act, unless otherwise stipulated.

[11] This is the effect of the authorities – see for example *Harmsworth v The State Coroner* [1989] VR 989; *Clancy* v *West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J).

[12] The 'prevention' role is now explicitly articulated in the Preamble and purposes of the Act, cf the *Coroners Act 1985* where this role was generally accepted as 'implicit'.

the death, including public health or safety or the administration of justice.[13] These are effectively the vehicles by which the prevention role is advanced.[14]

SOURCES OF EVIDENCE/INVESTIGATION

16. This finding draws on the totality of the material the product of the coronial investigation of Travis' death. That is, the investigation and inquest brief compiled by then Constable David McAuliffe of the Frankston Police Station, and the statements, reports and testimony of those witnesses who testified at inquest, and any documents tendered through them. All this material, together with the inquest transcript, will remain on the coronial file. In writing this finding, I do not purport to summarise all evidence, but refer to it only in such detail as appears warranted by its forensic significance and the interests of narrative clarity.

FINDINGS AS TO UNCONTENTIOUS MATTERS

17. In relation to Travis' death, most of the matters I am required to ascertain, if possible, were uncontentious from the outset. His identity, the date and place were never at issue. I find, as a matter of formality that Travis Joseph Hartskeerl born on 22 June 1976, late of 42 King Close, Frankston North, died about 200 metres north of Kananook Railway Station, Seaford, at about 1.40om on 16 December 2008.

18. The medical cause of death was also uncontentious. No autopsy was performed. However, Senior Forensic Pathologist Dr Malcolm Dodd from the Victorian Institute of Forensic Medicine (VIFM) performed an external examination of Travis' body, and reviewed the medical records provided by Peninsula Health and post-mortem CT scanning of the whole body (PMCT) undertaken at VIFM. Having done so, he provided a detailed report of his findings and concluded by advising that it would be reasonable to attribute Travis' death to *head and neck trauma (train impact)*, without the need for autopsy.

19. Significantly, routine post-mortem toxicological analysis did not reveal ethanol (alcohol) or any other common drugs or poisons, indicating that Travis had not been taking any prescription medications in the period immediately preceding his death, nor any illicit substances.

20. I find that Travis died as a result of head and neck trauma sustained in impact with a train, and that he intentionally took his own life.

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[13] See sections 72(1), 67(3) and 72(2) regarding reports, comments and recommendations respectively.

[14] See also sections 73(1) and 72(5) which requires publication of coronial findings, comments and recommendations and responses respectively; section 72(3) and (4) which oblige the recipient of a coronial recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation.

FOCUS OF THE CORONIAL INVESTIGATION

21. The focus of the coronial investigation of Travis' death, including the inquest, was on the clinical management and care provided by both Peninsula Health and his GP Dr Maragoudakis. In particular, the investigation focused on the management of his discharge from Peninsula Health to his GP, and the interface between the public health system and primary care/GPs. A preliminary consideration of the circumstances surrounding Travis' death suggested scope for improvement in this interface.

22. Of particular significance were the events around the time of his discharge in April 2008, the extent of communication between Dr Maragoudakis and the hospital in the ensuing period, and the events of November 2008 when Travis presented to Frankston Hospital ED asking for a depot injection, and was refused and referred back to Dr Maragoudakis.

HOSPITAL ENGAGEMENT AND DISCHARGE TO GP

23. Travis' first recorded hospital contact regarding his psychiatric history was in 2006 when he was admitted to the Peninsula Health inpatient psychiatric unit 2West, following serious suicide attempts, including stabbing himself and overdosing on prescription medications.

24. Thereafter, Travis was case managed by the Peninsula Health Mental Health Community Team until April 2008, when he was considered stable enough for discharge to the care of his GP, Dr Maragoudakis, at the Parkside Clinic in Frankston. His treatment plan on discharge included a fortnightly intramuscular depot injection of the antipsychotic zuclopenthixol decanoate ('depot injection'), a 20mg dose of the antidepressant fluoxetine each morning in tablet form and a 2mg dose of benztropine[15] twice per day.

25. A draft Mental Health Care Plan was prepared for Travis by Peninsula Health and a copy provided to Dr Maragoudakis.[16] An appointment was made for Travis to see Dr Maragoudakis on 23 April 2008, but he did not attend. Another appointment was made on 18 August 2008 and a third on 12 December 2008. In the 11 months between his discharge and death, Travis did not receive any depot injections from Dr Maragoudakis, but did attend his clinic on these two dates. It also appears from the doctor's notes that Travis ceased taking fluoxetine at some point during this time.

26. On 21 November 2008, Travis presented to the CLIPS at Frankston Hospital ED and saw psychiatric nurse Vahitha Koshy. Ms Koshy stated that before seeing Travis she was told by one of the triage nurses that he had indicated that he wanted to leave, so she responded

[15] Benztropine (or benzatropine) is used in patients to reduce the side effects of antipsychotic treatment, such as parkinsonism and akathisia (restlessness).

[16] Exhibit C.

straight away.[17] Travis told Ms Koshy that he had ceased his depot injections, and asked to be administered his medication in the ED. Ms Koshy stated that she informed him that EDs do not usually administer depot injections, and he said that he had not attended his GP for the depot injection as he was too busy. She recalled that Travis told her that he could make an appointment to see his GP straight away.

27. Ms Koshy conducted a mental state examination during which Travis denied psychotic symptoms, suicidal or self-harm ideation, and she did not observe any signs of depression. She discharged Travis home to the care of his father with a plan for GP follow-up, given that he told her that he was planning to see his GP for his depot injection.[18]

28. At inquest, Ms Koshy was asked whether it would be normal practice to contact a patient's GP in such a situation. She replied that if Travis had not demonstrated good insight, for example by stating that he did not need his depot injections, then she might have considered this. However, she did not contact the GP because he told her the reason that he had not attended his GP was because he had been busy and "couldn't make up the GP appointment".[19]

29. At about 11.00am on 16 December 2008, Travis was again seen by Ms Koshy in her capacity as CLIPS clinician in the Frankston Hospital ED. She was informed that Travis asked to see CLIPS as he was felt confused and was experiencing paranoid delusions.[20] Ms Koshy accessed Travis' clinical assessment summary (CAS) on the hospital system to familiarise herself and noted that it was last updated in April 2008. She noted a history of schizophrenia, polysubstance abuse and self-harming behaviour, with a previous admission to Peninsula Health following an amitriptyline overdose. Ms Koshy recalled seeing Travis in November 2008. Significantly, there was no record on the CAS of Mr Hartskeerl's telephone call to the hospital following Travis' overdose on 9 December 2008.

CARE PROVIDED BY PENINSULA HEALTH

30. Psychiatric Nurse Catherine Malone-Kearney was Travis' case manager at Peninsula Health from October 2007 to April 2008.[21] She stated that a clinical review meeting was held on 4 February 2008 to review Travis' care, which included herself, a consultant psychiatrist, a team leader and other staff. A decision was made at this meeting to prepare Travis for discharge

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[17] Statement of Vahitha Koshy dated 19 July 2012, page 14 of the inquest brief, Exhibit F.

[18] Statement of Vahitha Koshy dated 19 July 2012, pages 14-15 of the inquest brief, Exhibit F.

[19] Transcript page 41.

[20] Statement of Vahitha Koshy dated 13 November 2009, page 16 of the inquest brief, Exhibit E.

[21] Statement of Catherine Malone-Kearney, page 12 of the inquest brief, Exhibit A.

from the Peninsula Health service to his GP for administration of his depot injections in the future.[22]

31. At inquest, Ms Malone-Kearney stated that, after the decision to plan for discharge, a letter was sent to Dr Maragoudakis that provided a history of Travis' treatment. She advised that Travis chose Dr Maragoudakis as his clinic was in a convenient location.[23] Ms Malone-Kearney advised that discharge planning also included ensuring that Travis had stable housing, and assisting him to obtain a health care card[24] as Travis was experiencing difficulty affording his medications.[25]

32. With respect to Travis' attendance for depot injections from its initiation in September 2007, Ms Malone-Kearney stated that he was compliant overall but did not always attend his appointments on the day. Sometimes he would attend early, and sometimes he would be late, but he would inevitably present twice a month as required. On occasions, hospital staff would attend Travis' home to administer the depot injection.[26]

33. When discharging Travis, Ms Malone-Kearney did not speak to Dr Maragoudakis directly, but mostly communicated through his receptionist. She could not recall what steps she put in place to ensure that Travis attended his GP appointment, but stated that in such situations she might have asked clinic staff by telephone to advise the hospital whether Travis attended his first appointment.[27]

34. In response to the suggestion from Counsel for Dr Maragoudakis that he did not receive a discharge letter from the hospital, and that it was not clear that a letter was ever sent, Ms Malone-Kearney testified that she did send a letter, relying on her notes and the CAS to this effect. She could not explain why there was no copy of the letter on the hospital file, but stated that she would not have made the above notes if she had not sent a discharge letter.[28]

35. As part of the discharge process, an appointment was made for Travis to see Dr Maragoudakis on 23 April 2008. Ms Malone-Kearney also personally delivered a supply of depot medication to his clinic.[29] Travis did not attend this appointment. When cross-examined about

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[22] Statement of Catherine Malone-Kearney, page 12 of the inquest brief, Exhibit A.

[23] Transcript pages 3-4.

[24] Transcript page 5.

[25] Transcript page 7.

[26] Transcript pages 6-7.

[27] Transcript page 8.

[28] Transcript page 14 and statement of Catherine Malone-Kearney, page 13 of the inquest brief, Exhibit A.

[29] Transcript page 15 and statement of Catherine Malone-Kearney, page 13 of the inquest brief, Exhibit A.

a note in the GP's records that reads 'message left for Cathy',[30] Ms Malone-Kearney testified that she did not recall receiving a message, and that if she had received a message, she would have documented it in Travis medical record, and would have sought advice from her team leader. In such circumstances, Ms Malone-Kearney anticipated that her team leader would have likely advised her to contact either Travis or Dr Maragoudakis, or both, in order to ensure that Travis attended the GP.[31] At inquest, she stated that she would also have advised Travis to attend CLIPS in order to be reassessed as to the need for further case management.[32]

36. When seeing Travis on 21 November 2008, Ms Koshy referred to his history on the hospital's CAS. At inquest, she testified that she did not refer to his medical records, and that the CAS documented that he was discharged from a community treatment order in April 2008. The CAS information was available to her again on 16 December 2008, but did not include information about a mental health care plan prepared for Travis earlier in 2008.[33] Ms Koshy explained that she did not add notes or updates to the CAS after seeing a patient, that it was not part of her role and that she did not know who was responsible for updating the CAS.[34]

37. At inquest, Ms Koshy was asked whether, as a psychiatric nurse, she had considered Travis' previous mental health history with the same hospital at his second presentation to her, and whether this, together with his reported failure to take prescribed medications, might indicate that he was relapsing. Ms Koshy testified that in her role as a CLIPS clinician in the ED, she only assessed the situation at hand, was not particularly concerned about Travis' paranoia, attributed his reported difficulty sleeping as arising from conflict with his father, and understood he was compliant with his medications.[35]

38. Ms Koshy stated that later that day, she received a telephone call from another nurse advising that Mr Hartskeerl had called CLIPS with concerns for his son's deteriorating mental health, and advised that Travis had taken a paracetamol overdose. Ms Koshy testified that she discussed the matter with the triage nurse, reported her assessment of him in the ED that day, and faxed a copy of her assessment to the nurse. Ms Koshy stated that the nurse then

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[30] Transcript page 17.

[31] Statement of Catherine Malone-Kearney, page 13 of the inquest brief, Exhibit A.

[32] Transcript page 31.

[33] Transcript page 42.

[34] Ibid.

[35] Transcript page 44 "*at that time I only - when I'm in ED I only assess the situation and, um, at that time when I assessed him there wasn't much concern about the paranoia and the, um - regarding his sleep he said that because he is often - often he argues with - the father's argument between him and the father, that's because of that he is not able to sleep, that's the reason he told me. And with his compliance the last visit he said that he has seen his GP and he is compliant - he is compliant with his medication, so. And he talked to me quite openly also, so.*"

undertook to make an appointment with Travis' GP straight away.[36] Ms Koshy was aware of the diagnosis of schizophrenia[37] and testified that if she had thought Travis needed his depot injection, it would not have been administered by ED staff, but the Crisis Assessment and Treatment Team (CATT) would have been called.[38]

39. Ms Koshy emphasised that at his visit, Travis reported an inability to sleep and that she did not have concerns about any paranoid or delusional thoughts. Early warning signs of relapse recorded on the CAS included 'insomnia, suicidal ideation, bizarre behaviour and thoughts, suspicious, paranoid, elevated mood and pressured speech'. When asked whether she had made the connection between Travis' reported difficulty sleeping and his early warning signs, Ms Koshy testified that she asked him why he was unable to sleep and he referred to an argument with his father that he kept thinking about. This led Ms Koshy to the conclusion that he was experiencing a situational crisis.[39]

CARE PROVIDED BY DR MARAGOUDAKIS

40. Dr Maragoudakis gave evidence that Travis had been a patient since August 2006 and he knew that he had prior alcohol and drug issues, depression and schizophrenia.[40] Dr Maragoudakis agreed that he had received a draft mental health care plan from Peninsula Health in March 2008, and that a case conference was arranged to discuss the draft plan with Travis and his case manager Ms Malone-Kearney on 23 April 2008, but Travis did not attend.[41]

41. Dr Maragoudakis asked his receptionist to telephone Peninsula Health to advise that Travis had not attended. The receptionist made a note in a diary, and a copy was provided to the Court. The note reads '[d]idn't keep appointment. Message left for Kathy to please phone me. Haven't heard from Travis either'.[42] Dr Maragoudakis understood at this time that all aspects of Travis' care had been formally transferred entirely to him, and that Peninsula Health would cease to have any regular contact with him.[43]

42. Dr Maragoudakis next saw Travis on 18 August 2008. He reported having 'had a stormy course and had lost his job', and using drugs again. Dr Maragoudakis noted his poor

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[36] Transcript page 45.

[37] Transcript page 52.

[38] Ibid.

[39] Transcript page 58.

[40] Transcript page 80.

[41] Statement of Dr George Maragoudakis, page 11.1 ff of the inquest brief, Exhibit H.

[42] Copy of handwritten receptionist diary note, page 11.9 of the inquest brief.

[43] Transcript page 74.

medication compliance.[44] At inquest, Dr Maragoudakis did not recall any discussion of Travis' medication regime at this appointment. As he assessed his mental health as stable, Dr Maragoudakis felt no need to contact Peninsula Health.[45]

43. He saw Travis again on 12 December 2008 when he told him that he had not had his depot injections for 11 months, that he was not working, was still using drugs, and reported being depressed but stable. Dr Maragoudakis testified that Travis denied any risk of harm to himself or others, and was keen to try a new antidepressant. Dr Maragoudakis did not consider him to be suffering any psychotic symptoms.[46] At inquest, Dr Maragoudakis stated there was nothing in his records to suggest that Travis had presented to the Frankston Hospital ED on 21 November 2008.[47]

44. Like Ms Koshy, Dr Maragoudakis stated that he understood Travis' early warning signs of relapse, including insomnia, but explained that the report of one symptom did not, in his view, indicate that he was at risk of self-harm and that Travis did not display any other early warning signs.[48]

45. Dr Maragoudakis' office received a fax from Peninsula Health on the afternoon of 16 December 2008, advising that Travis had presented to Frankston Hospital ED that day and was discharged, and confirming an appointment with Dr Maragoudakis for the following day.[49]

46. At inquest, Dr Maragoudakis emphasised his concern that Travis had not been taking his depot injections, and that this was against his advice, as was Travis' decision not to see a psychologist for counselling. However, he noted that Travis was a voluntary patient and that despite urging him to comply with his medication regime and seek psychological counselling, as he was of sound mind, there was nothing in his presentation to suggest to Dr Maragoudakis that he should be made an involuntary patient.[50]

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[44] Statement of Dr George Maragoudakis, page 11.5 of the inquest brief, Exhibit H.

[45] Transcript pages 62-3.

[46] Statement of Dr George Maragoudakis, page 11.5 of the inquest brief, Exhibit H.

[47] Transcript page 64.

[48] Transcript pages 65-6.

[49] Statement of Dr George Maragoudakis, page 11.5 of the inquest brief, Exhibit H.

[50] Transcript page 81.

PENINSULA HEALTH PRACTICE AND PROCEDURE

47. Consultant Psychiatrist Associate Professor Sean Jespersen was the clinical director of Peninsula Health Mental Health Service from 31 August 2009, and was not working at Peninsula Health at the time of Travis' death.

48. A/Professor Jespersen outlined expected discharge processes and improvements made since Travis' death. He testified that current ED practice on discharge to a GP is that the CLIPS clinician faxes a discharge summary to the GP, and the clinician is expected to contact the GP's clinic by telephone to ensure that the discharge summary has been received. This is to be documented in the patient's records, and if the patient presents out of hours, the telephone call is to be made the following working day by a triage nurse.[51]

49. A/Professor Jespersen did not think that accessing information contained in the CAS, without access to the patient's clinical record, was adequate for the CLIPS clinicians assessing Travis in both November and December 2008.[52] In his second statement, A/Professor Jespersen explained that communication problems that arose from a lack of complete clinical records being readily accessible to ED mental health clinicians, have been addressed by the introduction of electronic discharge summaries in September 2011 and digitised medical records in February 2012. He also anticipated improvement in the availability of medication information following introduction of electronic prescribing from August 2012.[53]

50. With respect to Travis' presentation on 21 November 2008, A/Professor Jespersen stated that such communication practices had changed since 2008. Where Ms Koshy testified that she did not consider contacting Dr Maragoudakis, A/Professor Jespersen's expectation was that a CLIPS clinician would confirm the patient's history, would speak to their family or carer and to someone involved in their care, such as a GP, mental healthcare worker or other healthcare professional as appropriate.[54]

51. A/Professor Jespersen described a new practice of contacting or engaging with a GP as early as possible when a person attends Peninsula Health community mental health care services, and including that GP in the person's care as early as possible, rather than waiting until discharge planning as in this case, to have the GP commence administering the depot injections.[55] He acknowledged that follow up of patients who had been discharged to their GP

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[51] Statement of A/Professor Sean Jespersen dated 28 August 2012, page 20 of the inquest brief, Exhibit J.

[52] Transcript page 101.

[53] Ibid.

[54] Transcript pages 85-6.

[55] Transcript page 87.

but do not then attend is a significant issue, as was acknowledged in the relevant Chief Psychiatrist's guideline.[56] He expressed the view that the focus should therefore be on planning for discharge and communicating clearly with all parties involved, and accepted that the discharge process involving Travis did not align with the Chief Psychiatrist's guideline.[57]

52. A/Professor Jespersen also explained that if Travis had been a patient at the time of inquest, depot injections would have been administered several times by his GP as part of a transition, prior to formal discharge, in the hope of developing a habit of attending his GP for such appointments. In circumstances where a GP notifies the hospital that a patient has not attended as planned, A/Professor Jespersen expected a degree of follow up by hospital staff who would contact the patient to encourage them to attend their GP.[58] A/Professor Jespersen also referred to a template letter to facilitate communication with general practitioners when a patient is discharged, which included information about the patient's medication regimen, reasons for any changes to treatment and follow up treatment plans.[59]

53. A/Professor Jespersen conceded that when Travis presented to the ED in December 2008, there were a number of features suggestive of a relapse of his psychotic illness, which were not present at the November presentation. In his view, it was unclear that, had Ms Koshy or another clinician contacted Dr Maragoudakis, he would have been any the wiser about Travis' deterioration, but he would have been aware that he was not taking his antipsychotic medication. A/Professor Jespersen also expected that, in such a situation at the time of the inquest, clinicians would also contact the person with whom a patient was living.[60]

54. A/Professor Jespersen acknowledged that it was a failing that Dr Maragoudakis contacted CLIPS after Travis' non-attendance on 23 April 2008 and received no response, but stated that it was difficult to know where that failing arose.[61]

FAMILY CONCERNS

55. Shortly after Travis' death, his father wrote to the Court expressing concerns about the clinical management and care provided to his son. Mr Hartskeerl stated a belief that Peninsula Health

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[56] Transcript page 88.

[57] Transcript pages 96-7.

[58] Transcript page 90.

[59] Appendix 1 to Peninsula Health Mental Health Service Clinical Practice Guideline – Youth, Adult and Aged Persons Service Discharge, page 70 of the inquest brief.

[60] Transcript page 92-3.

[61] Transcript 97.

had failed Travis when he attended the ED on 16 December 2008 shortly before taking his own life.[62]

56. Mr Hartskeerl was not legally represented at inquest. However, he was afforded the opportunity to make submissions or raise any concerns through my assistant, Senior Constable Ramsey, and through her was kept appraised of developments with the coronial investigation. Mr Hartskeerl welcomed the evidence of A/Professor Jespersen and advised S/C Ramsey that he was pleased to hear of the improvements made at Peninsula Health, especially in relation to the improvements in family contact when a patient presents to the ED.[63]

57. Mr Hartskeerl also told S/C Ramsey that he was unaware that Dr Maragoudakis had contacted Peninsula Health when Travis did not attend his April appointment, and S/C Ramsey reported that clarification of this issue at inquest appeared to assist him.[64]

SUBMISSIONS OF COUNSEL

Counsel for Dr Maragoudakis

58. Ms Foy, Counsel for Dr Maragoudakis, submitted that his management accorded with his obligations as a GP treating a voluntary patient with a mental illness who had been discharged to his care by Peninsula Health Mental Health Services, and that, immediately on becoming aware that Travis had received a diagnosis of schizophrenia and was receiving medication, Dr Maragoudakis promptly sought advice and information from Peninsula Health.[65]

59. Counsel noted that Peninsula Health did not obtain his prior consent to accepting Travis, or advise him explicitly of the need to ensure compliance with the depot injections. Such an absence of direct communication did not accord with the Chief Psychiatrist's guidelines on discharge, and also breached a protocol between Peninsula Health and the Mornington division of General Practitioners. Nonetheless, Dr Maragoudakis acted on the basis that Travis had been discharged into his care, and appropriately notified Peninsula Health of his non-attendance on 23 April 2008.[66]

60. Ms Foy submitted that at no time did Dr Maragoudakis receive any clear advice that he should advise Peninsula Health if Travis had not received his depot injection, but only that he was required to monitor his mental health. Furthermore, at inquest, Dr Maragoudakis displayed a clear understanding of his role as Travis' GP, and there was no evidence that his clinical

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[62] Letter to the Court from Mr Bernard Hartskeerl received by facsimile on 18 December 2008.

[63] Transcript page 109.

[64] Ibid.

[65] Transcript pages 109-10.

[66] Transcript pages 110-11.

management fell below the standard of a GP in those circumstances. Counsel highlighted that Peninsula Health staff made no attempt to contact Dr Maragoudakis after Travis' presentations to the Frankston Hospital ED in November and December 2008, even despite his self-reported non-compliance with the depot injections in November.[67]

61. Counsel concluded by submitting that:
    - there was no clear evidence about what would have happened if Dr Maragoudakis had notified Peninsula Health in August 2008 of Travis' attendance and failure to have his depot injections that would have changed the outcome in any way
    - in November 2008, when Peninsula Health staff did become aware that Travis had not received his depot injections, no action was taken other than referral back to his GP
    - Dr Maragoudakis was diligent in his contact with Peninsula Health in that he sought notes in October 2007, notified the hospital of Travis' failure to attend in April 2008, and recognised that his role was to monitor his mental health and alert Peninsula Health if there was any change to his mental state.[68]

Counsel for Peninsula Health

62. Mr Goldberg, Counsel for Peninsula Health acknowledged that the investigation and inquest into Travis' death highlighted opportunities to improve care, but submitted that whilst Travis' death was tragic, there was no evidence that it was preventable.[69]

63. Peninsula Health submitted that Travis' treatment up to and including his discharge in April 2008 constituted appropriate care, that Travis had a history of seeking assistance when required, and that treating staff were therefore comforted that he would do so again, notwithstanding his known history of non-compliance with medication. Counsel noted that Dr Maragoudakis accepted responsibility for all aspects of Travis' physical and mental health when he accepted transfer.[70]

64. Regarding post-discharge communication, Counsel submitted that there was no evidence as to the content of the message left by Dr Maragoudakis' receptionist following Travis' non-attendance on 23 April 2008, nor as to the person with whom the message was left or the time at which it was left. Peninsula Health conceded that, if a message was left with an appropriate

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[67] Transcript pages 112-13. I note Ms Koshy's evidence with respect to the *December* attendance that Mr Hartskeerl reported that he had seen his GP and was compliant with his medications, see transcript page 44.

[68] Transcript pages 120-1.

[69] Transcript page 122.

[70] Transcript pages 123-5.

person, it should have been communicated to Ms Malone-Kearney in order for her to contact Travis to encourage him to attend his GP.[71]

65. In this regard, Counsel submitted that it was appropriate for Dr Maragoudakis' practice to make further attempts to contact Travis directly following his non-attendance, and that further follow-up with Peninsula Health after the initial message was unanswered, would have been appropriate.[72]

66. Counsel submitted that the failure of the discharge plan could not be said to have caused or contributed to Travis' death, as he was a voluntary patient whose compliance with medication was variable and who was, effectively, at liberty to comply with the discharge plan. Peninsula Health accepted that it did not contact Travis after discharge to check on his progress. He drew attention to A/Professor Jespersen's evidence that follow-up of patients after discharge to their GP is an ongoing issue, and that once a patient is discharged, the hospital's ability to influence a patient's clinical course was greatly diminished.[73]

67. Counsel noted that compliance with medications was a key issue for Travis and submitted that it was, as it should have been, in the minds of all those who treated him. Counsel commended A/Professor Jespersen's evidence, that the most effective time for Peninsula Health to influence a patient's ability to engage with community supports post-discharge is during an admission, and in particular, during a structured transition period.[74] Counsel submitted that Peninsula Health made substantial efforts to ensure compliance with the discharge plan, including personal delivery of depot medication to Dr Maragoudakis' practice and letters to both Travis and his father. Counsel submitted that no adverse finding should be made against Peninsula Health in relation to its actions in following up with Travis post-discharge, but conceded that if the telephone message of 23 April 2008 was received by the hospital, it should have been communicated to the appropriate person and actioned by them.[75]

68. With respect to the Peninsula Health CLIPS assessments by Ms Koshy, Counsel submitted that her assessment and plan at the November visit was reasonable in the circumstances, and that she had reason to believe Travis to be sincere in his intention to recommence his depot injections. Counsel submitted that no adverse finding should be made against Ms Koshy with

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[71] Transcript pages 126-7.

[72] Transcript page 128.

[73] Transcript page 129.

[74] Transcript page 132.

[75] Transcript page 133.

respect to the 21 November 2008 visit, nor with respect to the 16 December visit, in the context of her assessment of a situational crisis.[76]

69. In relation to the 16 December visit, Counsel noted that Ms Koshy conceded that she did not contact Mr Hartskeerl after his son's presentation. Counsel noted that he contacted Peninsula Health with concerns for his son's welfare shortly after Travis was discharged, and that the nurse he spoke to arranged an urgent appointment with Dr Maragoudakis for the following day, and faxed a letter to the GP in advance of that appointment.[77] Counsel referred to A/Professor Jespersen's evidence that if the same situation had arisen at the time of inquest, he expected that the CLIPS clinician would have contacted the patient's primary carer. This, it was submitted, reflected improvements in the hospital's model of care in mental health, which was only recently implemented at the time of Travis' death.[78]

70. Peninsula Health accepted that Travis had some of the early warning signs/clinical features in his relapse profile on presentation to the ED, but that it was only with the benefit of hindsight that the significance of these features could be linked to his relapse profile.[79] In noting improvements in practice at Peninsula Health, Counsel submitted that the evidence did not suggest that such improvements would have altered the outcome for Travis.[80]

CONCLUSIONS

71. 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.[81] The effect of the authorities is that coroners should not make adverse findings against or comments about individuals or institutions involved in the clinical management or care of the deceased, unless the evidence provides a comfortable level of satisfaction that their negligence and/or departure from the generally accepted standards of their profession, caused or contributed to the death.[82]

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[76] Transcript pages 134-5.

[77] Transcript pages 135-6.

[78] Transcript pages 136-7.

[79] Transcript pages 137-8.

[80] Transcript page 138.

[81] *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…"

[82] *Anderson v Blashki [1993] 2 VR 89 at 95; Secretary to the Department of Health & Community Service v Gurvich [1995] 2 VR 69 at 73-74; Re State Coroner; ex parte Minister for Health (2009) 261 ALR 152 at [21].*

72. Applying that standard to the evidence before me, it is clear that Travis had a significant mental health history that was known to Peninsula Health and CLIPS, as well as Dr Maragoudakis.

73. Questions of causation in suicide are always complex, rarely amenable to definitive answer, and, in any event, are not central to this investigation.

74. The available evidence does not support a finding of a clear causal connection between the clinical management and care provided to Travis and his death. That is, it does not support a finding that there was any want of clinical management and care on the part of the medical and nursing staff of Peninsula Health, or on the part of Dr Maragoudakis that caused or contributed to his death.

75. However, the available evidence does support a finding that optimal care of such a patient required more thorough discharge planning and improved communication and information-sharing between Peninsula Health and Travis' GP, Dr Maragoudakis. This was required both at the time of his discharge from the Peninsula Health Mental Health Community Team in April 2008, and when he was referred back to his GP after presenting to CLIPS on both occasions in late 2008.

76. Whilst I accept Dr Maragoudakis' evidence, and Peninsula Health's submission, that he took responsibility for all aspects of Travis' physical and mental health when he accepted transfer of the patient, optimal discharge planning does not rely on communication by the patient's GP back to the hospital. What is required is ongoing appropriate communication with the patient, their carer and the patient's treating GP during a transitional period, before it can be said with any accuracy that the patient has been *discharged to the care of the GP.*

77. I am unable to find that earlier intervention or proactive and improved communication between Peninsula Health and Dr Maradougakis *would* have saved Travis' life, but the *potential* for a different outcome remains. In that sense, Travis' death was potentially *preventable.*

78. I make no adverse findings or comments against Ms Koshy. Inherent is an acceptance that, in her role as CLIPS clinician in the ED, she was focussed on assessing Travis for signs of an acute deterioration requiring immediate attention, and without the benefit of hindsight, these were not apparent.

79. I make no adverse findings against Dr Maragoudakis, accepting Counsel's submissions that the evidence indicates that he was diligent in his contact with Peninsula Health when Travis failed to attend his April 2008 appointment, and that he recognised that his role was to monitor Travis' mental health and alert Peninsula Health if his condition changed.

COMMENTS[83]

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

1. It is appropriate to acknowledge that Peninsula Health has implemented a number of changes in the Mental Health Community Team and CLIPS since Travis' death. Discharge planning, communication, education and risk assessments have been significantly reviewed in order to improve the functioning of the mental health service.[84]
2. Preparing a patient for transfer to their GP is, without a doubt, an important part of discharge planning. This case highlights that it is also important to prepare and inform the practitioner who is assuming care of the patient. It is vital to the provision of mental health services that each party's roles and responsibilities are clearly articulated and agreed. It is also important that patients are able to easily 'return' to the public mental health system when appropriate, and that primary care practitioners can facilitate a return for their patients as needed. Since Travis' death, Peninsula Health has made improvements in this regard in implementing a 'recovery' model of care.
3. One of the aims of discharge to a patient's GP (and back again) is to maintain a consistent level of care and good management of the patient's mental health, while avoiding periods of no treatment or engagement, followed by episodic engagement when the patient's condition is deteriorating, as occurred here. Travis' compliance with medication fluctuated throughout his entire treatment period, and clinicians could have reasonably predicted that it would continue to fluctuate.
4. Rather, improved outcomes for patients would be for discharge planning to explicitly provide for contingencies, such as periods of non-compliance with medication, so that all parties,

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[83] I requested that a Mental Health Investigator (MHI) from the Coroners Prevention Unit conduct a review of the health care provided to Travis in the lead-up to his death, specifically, the discharge from Peninsula Health to Dr Maragoudakis and the CLIPS and GP responses to Travis' mental health crisis in December 2008.

The MHI concluded that prevention of Travis' death may have resulted from more proactive intervention by all the health professionals involved in his care, particularly via a transitional approach to discharge planning in the year prior to his death, acting on crisis plans when early warning signs of relapse were evident, and engaging a CATT response when Mr Hartskeerl provided information regarding Travis' deterioration after the initial assessment by Ms Koshy. The MHI proposed that I consider recommendations to Peninsula Health regarding:

- review of its discharge policies and procedures that apply to patients who have received case management for a sustained period and are being discharged to providers such as GPs
- review of its policies and procedures to ensure that clinical staff consider the presence of early warning signs when conducting patient risk assessments
- providing CLIPS and psychiatric triage staff with training in risk assessment for clients with a known mental health history and documented early warning signs, in order to improve patient safety through better identification of potential risks.

[84] I therefore do not make recommendations to the effect suggested to me by the MHI at footnote 83 above.

including the primary carer/treating GP, can implement an agreed 'action plan'. More comprehensive discharge planning or a more reciprocal understanding of their respective roles, might avoid the situation where in transferring clinical management and care to a treating GP, the public mental health service effectively ceased involvement, relying on a chronically ill patient to remain well and stable by remaining engaged in treatment.

5. Travis had been relatively well-engaged with clinicians for the period prior to his discharge from Peninsula Health, and appeared to have a good rapport with Dr Maragoudakis when he did attend. Therefore, and I can only speculate, a simple telephone call or other prompting by Ms Malone-Kearney or any other person involved in the service, might have changed his clinical course and the tragic outcome here. Even given his status as a voluntary patient, the potential beneficial effect of a simple telephone contact, should not be underestimated.

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

The family of Mr Travis Hartskeerl

Mr David Goldberg, Peninsula Health

Dr Maragoudakis, c/o Ms Vanessa Nicholson, Avant Law

Dr Mark Oakley Browne, Chief Psychiatrist

Ms Emily Jordan-Baird, Veolia Transport Australasia Pty Ltd

Mr Michael Averkiou, Department of Transport, Planning and Local Infrastructure

Senior Constable David McAuliffe, Frankston Police Station.

Signature:

PARESA ANTONIADIS SPANOS
CORONER
Date: **25 August 2014**

cc: Manager, Coroners Prevention Unit.