IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2017 1055

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 63(1)
*Section 67 of the **Coroners Act 2008***

Inquest into the Death of Mr LY (pseudonym)

Delivered On:	22 JANUARY 2021
Delivered At:	THE CORONERS COURT OF VICTORIA 65 KAVANAGH STREET, SOUTHBANK
Hearing Dates:	9, 10 & 14 DECEMBER 2020
Findings of:	CORONER PHILLIP BYRNE
Counsel Assisting the Coroner:	MR DARREN MICHAEL MCGEE
Representation:	MR ROBERT SHEPHERD ON BEHALF OF MR LY'S FAMILY MS NAOMI HODGSON ON BEHALF OF ST VINCENT'S HOSPITAL

I, PHILLIP BYRNE, Coroner, having investigated the death of Mr LY
AND having held an inquest in relation to this death on the 9th, 10th and 14th of December 2020
at The Coroners Court of Victoria
find that the identity of the deceased was Mr LY
born on [redacted]
and the death occurred on 4 March 2017
underneath the Belford Road overpass, Eastern Freeway, Kew East

The Finding does not purport to all aspects of the evidence obtained in the course of the Investigation. The material relied upon included statements and documents tendered in evidence together with the Transcript of proceedings and submissions of legal representatives/Counsel. The absence of reference to any particular aspect of the evidence, either obtained through a witness or tendered in evidence does not infer that it has not been considered.

from:

I(a) MULTIPLE INJURIES SUSTAINED IN A FALL FROM A HEIGHT

in the following circumstances:

BACKGROUND

1. Mr LY, 42 years of age at the time of his death, was a compulsory inpatient under the Mental Health Act 2014 at St Vincent's Hospital Mental Health Acute Inpatient Service. Prior to admission to St Vincent's Hospital Mr LY had been staying with his brother Mr GY and his wife Ms OY at Balwyn North.

2. Mr LY had quite an extensive past mental health history, with periods of relative wellness, and intermittently periods of significant mental illness resulting in several inpatient admissions. Mr LY had admissions to St Vincent's Hospital on:

    - 6 December to 19 December 2016
    - 3 January to 16 January 2017
    - 10 February to 4 March 2017, the date of his death.

    It is this final admission that has been, from the outset, the focus of my coronial investigation.

BROAD CIRCUMSTANCES SURROUNDING DEATH

3. On the morning of 4 March 2017 Mr LY approached Associate Nurse Unit Manager Lucy Graham requesting unescorted leave. Mr LY told Nurse Graham he proposed to go for a walk and perhaps have lunch. Nurse Graham approved the requested leave, walked with Mr LY to the door and he left.

4. At approximately 10:40am Mr John Viney and his wife Ms Kylie Viney were travelling towards the city on the Eastern Freeway. As they approached the Belford Road overpass they observed a male person, subsequently identified as Mr LY, falling from the bridge onto the roadway. Mr and Ms Viney and a number of other motorists stopped to render assistance, including a medical practitioner who administered CPR. Shortly after ambulance paramedics, including a MICA paramedic, attended together with Metropolitan Fire Brigade members and police. In spite of full resuscitation measures Mr LY could not be revived and shortly after 11am he was formally declared deceased by an ambulance paramedic.

REPORT TO THE CORONER

5. Mr LY's death was reported to the coroner. Having considered the circumstances and having conferred with a Forensic Pathologist, I directed an external only post mortem examination and ancillary tests.

6. The directed external only post mortem examination was undertaken at the Victorian Institute of Forensic Medicine by Forensic Pathologist Dr Yeliena Baber, who in a report advised the cause of Mr LY's death was

I(a) MULTIPLE INJURIES SUSTAINED IN A FALL FROM A HEIGHT

Toxicological analysis of post mortem specimens was unremarkable.

COURSE OF THE INVESTIGATION

7. At the initial stage when the case was first presented to me on 5 March 2017, being aware that Mr LY was an involuntary/compulsory patient who had intentionally taken his life by leaping from the Belford Road overpass while on approved unescorted leave, I had my coroner's solicitor request a formal statement from St Vincent's Hospital focusing primarily upon Mr LY's treatment/management during the admission of 10 February – 4 March 2017.

8. At the Coronial Admissions and Enquiries Office second family contact on 16 March 2017 Mr RY, brother of Mr LY, who had been authorised by his mother, Mrs HY, the Senior Next of Kin, to be the nominated spokesperson for the family, advised he had "multiple concerns of care" regarding the care provided to Mr LY, in particular being given "day release" the day after a family meeting at which he claimed Mr LY "stated he was suicidal." Mr RY was invited to formalise his concerns in writing.

9. While I do not propose at this point to relate chapter and verse the various issues of concern raised by Mr RY in a statement, statutory declarations and emails, they were the bases upon which, having provided copies to St Vincent's Hospital, I sought formal statements from clinicians involved in the treatment of Mr LY addressing the concerns raised.

10. A statement dated 17 May 2017 under the hand of Consultant Psychiatrist Dr Benjamin Chia was subsequently lodged. At my direction a copy of Dr Chia's statement was provided to Mr RY.

11. Following my normal process, the statements lodged by St Vincent's Hospital were provided to Mr RY, his responses/critiques of the information provided in that material were in turn provided to St Vincent's Hospital with an invitation to respond to the criticisms, and again in turn those responses were provided to Mr RY. This process, although on occasions somewhat torturous, as was the case here, seems to be the best method to determine where the relevant contentious issues lie. Again I do not at this point in time propose to relate chapter and verse the issues raised in that exchange of material as the various statements were ultimately tendered in evidence at the subsequent inquest and consequently were extensively examined

upon in viva voce evidence, and as such form part of the formal record of the coronial investigation.

12. My investigation reached a stage where I considered it appropriate to list the matter for a Mention/Directions hearing at which I would advise the interested parties of tentative views held and advise the scope/parameters of a subsequent inquest. At a Mention/Directions hearing the issues can often be narrowed and on occasions what I call "concessions" by either party made in relation to previously disputed matters can reduce the scope of a future hearing.

13. After some difficulty setting a hearing date the matter was listed for a Mention/Direction hearing on 21 March 2020. At the hearing my coroner's solicitor Mr Darren McGee appeared to assist, Mr Robert Shepherd appeared for the Y family and Ms Katarina Bilandzic of K&L Gates appeared for St Vincent's Hospital.

14. Following the preliminary hearing of 21 March 2020 parties suggested further material should be sought.

15. At the hearing a tentative witness list was, at least to some extent, "settled". Significantly, I advised the interested parties the focus of my ongoing investigation and inquest hearing would be matters that arose during Mr LY's final admission to St Vincent's Hospital, 10 February 2017 to 4 March 2017; with my principal focus being upon what was said by Mr LY at the meeting of 3 March 2017 attended by Mr RY and Mr LY's treating clinicians, and whether Nurse Graham performed an adequate risk assessment before Mr LY's request for unescorted leave was approved the following morning.

16. Subsequently, statements were provided by Mr GY and Ms OY; Dr John Cocks, Mr LY's previous psychiatrist; and importantly Associate Unit Manager Nurse Lucy Graham. That additional material was provided to the "other side." I made it clear I was very keen to progress the matters. However, the COVID-19 pandemic greatly impacted the workings of this, and to an even greater extent, other courts. Ultimately, the matter was listed for formal inquest for Wednesday 9 December 2020 and Thursday 10 December 2020.

17. The matter proceeded over those two days with Mr Robert Shepherd, of counsel, appearing for the Y family and Ms Naomi Hodgson, of counsel, instructed by K&L Gates, representing St Vincent's Hospital. Although it was not my preference, of necessity, evidence was heard "remotely" by Webex.

18. I heard evidence from Mr RY; members of Mr LY's treating team Dr Lyndall Cowley, at the time Psychiatric Registrar; Dr Benjamin Chia, Consultant Psychiatrist and head of the treating team; Dr Andrew Chow Lin, at the time Resident Medical Practitioner of the team, and the

junior member of the team; Mr GY and Ms OY, Mr LY's brother and sister-in-law respectively; and Nurse Lucy Graham.

ASPECTS OF THE LAW – THE ROLE/FUNCTION OF THE CORONER

19. Before turning to the evidence, I feel it encumbent upon me to discuss several aspects of the law that bear on my role. The starting point is s 67 of the Coroners Act 2008 which is basically uncomplicated; the coroner must seek to establish the identity of the deceased, the cause of death and the circumstances surrounding death, that is what I seek to do. Other significant aspects of the law demand more commentary.

20. Keown v Khan,[1] a decision of the Victorian Court of Appeal, represents a landmark judgement which, in my opinion, provided much needed guidance to Victorian (and other) coroners. His Honour Mr Justice Callaway adopting a statement contained in the Brodrick Committee (UK) Report[2] said:

> *"In future the function of an inquest should be simply to seek out and record as many of the facts concerning the death as public interest required, without deducing from those facts any determination or blame."*[3]

21. Again quoting the Brodrick Committee (UK) Report, His Honour noted:

> *"In many cases, perhaps the majority, the facts themselves will demonstrate quite clearly whether anyone bears any responsibility for the death; there is a difference between a form of proceeding which affords to others the opportunity to judge an issue and one which appears to judge the issue itself."*[4]

22. So while not laying or apportioning blame a Coroner should endeavour to establish the CAUSE, or CAUSES, of a death; the distinction is fine but real. As Callaway J.A. described it in Keown v Khan[5]:

> *"In determining whether an act or omission is a cause or merely one of the background circumstances, that is to say a non-causal condition, it will sometimes be necessary to consider whether the act departed from a norm or standard or the omission was in breach of a recognised duty, but that is the only sense in which para. (e) mandates an inquiry into culpability. Adopting the principal recommendation of the Norris Report, Parliament expressly prohibited any statement that a person is or*

[1] (1999) 1 VR 69
[2] Report of the Committee on Death Certification And Coroners (1971) (UK) ("The Brodrick Report" Cmnd. 4810)
[3] (1999) 1 VR 69, 75
[4] (1999) 1 VR 69, 75
[5] (1999) 1 VR 69

may be guilty of an offence. The reasons for that prohibition apply, with even greater force, to a finding of moral responsibility or some other form of blame."

23. I have found it difficult to articulate the apparent contradiction between on one hand a conclusion that an act departed from a norm or standard, or an omission was in breach of a recognised duty representing a causal factor in the death under investigation, and, on the other hand, not laying or apportioning culpability/blame/fault. The only explanation I have found was provided by the New Zealand Court of Appeal in Coroners Court v Susan Newton & Fairfax New Zealand Ltd[6], where it is stated:

> *"It is no part of the coroner's function to apportion blame for the death. The coroner must however be able to go beyond the mere cause of death if the coroner is to serve a useful social function, and must establish so far as is possible, the circumstances of the death. The implicit attribution of blame may be unavoidable in order for the coroner to ascertain or explain how the death occurred in the wider events that were the real cause." (my emphasis)*[7]

24. It should be understood the Coroners Act does not provide a general mechanism for an open-ended enquiry into the merits or otherwise of the performance of government agencies, private institutions or individuals. In Harmsworth v The State Coroner[8], Justice Nathan broached the subject of the limits of a coroner's power and observed that the power of investigation is not "free ranging", commenting that unless restricted to pertinent issues an inquest could become wide, prolix and indeterminate. Significantly he added:

> *"Such an inquest would never end, but worse it could never arrive at the coherent, let alone concise, findings required by the Act, which are the causes of death, etc. Such an inquest could certainly provide material for such comment. Such discursive investigations are not envisaged nor empowered by the Act they are not within jurisdictional power."*[9]

25. The relevant principle was relatively recently re-stated in the Full Court of the Supreme Court of the Australian Capital Territory in R v Coroner Maria Doogan; ex-parte Peter Lucas-Smith and ors[10], and in Doomadgee and Anor v Deputy State Coroner Clements[11], Justice Muir commented that coroners are "not roving Royal Commissioners," and added:

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[6] [2006] NZAR 312
[7] [2006] NZAR 312, 320
[8] (1989) VR 989
[9] (1989) VR 989
[10] (2005) ACTSC 74 (8 August 2005)
[11] (2005) QSC 357

"The evidence relied on by the Coroner must be relevant to the matters within the scope of the coronial enquiry."

26. Standard of proof is a fundamental issue requiring comment. Not surprisingly, the starting point is Briginshaw v Briginshaw[12] where Dixon J, as he then was, provided the classic statement on the issue; he stated:

> *"...reasonable satisfaction is not a state of mind that is attained or established independently of the nature and consequence of the fact or facts to be proved. 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 issue 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."*

In Chief Commissioner of Police v Hallenstein[13] Justice Hedigan stated that the fundamentals of causation in the context of negligence were applicable to the concept of causation/contribution in the coronial context.

27. The application of the fundamental principles enumerated in Briginshaw[14] have been the subject of judicial attention on several occasions in relation to coronial matters in the Supreme Court of Victoria in Anderson v Blashki[15] and Community Services v Gurvich[16].

28. Basically, applying common sense to the facts in a particular case, for an act or omission to be a causal factor in the death under investigation the connection must be logical, proximate, readily understandable, not illogical, strained or artificial.

29. Hindsight bias requires some comment; I am required, when assessing whether Nurse Graham's approval of Mr LY's request for unescorted leave on the morning of 4 March 2017 was reasonable and appropriate to do so without the not inconsiderable benefit of hindsight. I must endeavour to put myself "in the shoes" of Nurse Graham with the knowledge she had, or should have had, at the relevant time. I think it fair to say that can on occasions present quite a challenge.

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[12] (1938) 60 CLR 336 at pp. 362-3
[13] (1996) 2 VRI
[14] (1938) 60 CLR
[15] (1993) 2 VR 89

THE EVIDENCE

30. I turn to the evidence in relation to the knowledge Nurse Graham had, or should have had on the morning of 4 March 2017. In doing so I have paid attention to several specific events that occurred during the final admission, particularly:

    - A meeting/visit (no matter how it was termed) that took place on 12 February 2017, two days after Mr LY's admission attended by a nurse Ms Lisa Harris, Mr LY, Mr GY and Ms OY and, after a period, Mr RY;
    - A consultant review of Mr LY by Professor Bosanac on 2 March 2017, also attended by Drs Cowley and Lin (Dr Chia not being there that day) and Nurse Graham; and
    - The family meeting of 3 March 2017 attended by Mr LY, Mr RY and the treating team of Drs Chia, Cowley and Lin.

    I propose to deal with these events in sequence.

Meeting/Visit of 12 February 2017

31. Prior to Mr GY leaving the arranged meeting/visit, which could fairly be described as chaotic, with Mr LY described as irritable and hostile, specific information was conveyed to Nurse Lisa Harris about concerns Mr GY and Ms OY held in relation to Mr LY:

    - Bullying his mother;
    - Threatening his mother;
    - Demanding money from his mother; and
    - Threatening to jump off a bridge.

    The evidence from Mr GY and Ms OY was heard at the behest of Mr Shepherd, counsel for the family, presumably the point being taken was that the threat of suicide by jumping from a bridge was not referenced in the progress notes and was therefore not on the record for others to see. Mr GY wanted the concerns addressed prior to Mr LY being discharged. Other than Mr LY remaining in the facility as a compulsory patient I am not sure how the treating team could persuade Mr LY to desist from such behaviours. I would have thought the family would have a better chance of success in that regard. It was claimed that a note penned by Mr GY was provided to Nurse Harris. The evidence is that when Mr RY met with Mr GY in the car park after the meeting Mr GY retained the note. It is unclear to me whether Nurse Harris saw the note during the exchange, but it did not find its way into the medical records. However the

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[16] (1995) 2 VR 69

four issues were in the context raised above so that, in my view, do not bear much weight in relation to assisting in the subsequent assessment of Mr LY's risk of self-harm. The utterances made by Mr LY at the Bosanac review and claimed to be made at the family meeting on 3 March 2017 are of more significance. Furthermore, Mr RY raised them in the family meeting of 3 March 2017.

Consultant Review of 2 March 2017

32. I turn to the consultant review of 2 March 2017. Overnight of 1 – 2 March 2017 it was reported that Mr LY was increasingly aggressive due primarily to his perception that he had been "treated like shit" and a nurse had impacted his ability to sleep. In light of his aggression and agitated presentation two code greys were called and security were involved. The situation was such that a consultant review was undertaken by Professor Bosanac on the morning of 2 March 2017. Also at the review were members of the treating team Dr Cowley and Dr Lin and Nurse Lucy Graham. The notetaker at the review was the junior doctor Dr Lin whose progress notes are noteworthy on two bases: they are comprehensive and legible, which is not always the case with doctors' progress notes. At the review Mr LY was told that if he again became aggressive requiring security being called a zero-tolerance approach would be taken and consideration would be given to intramuscular antipsychotic medication being administered and/or placement in seclusion. Mr LY stated that if injected, "I'll just commit suicide," and subsequently repeated the threat, saying, "I'm just going to kill myself." Mr LY was also advised that consideration would be given to leave being denied if he became aggressive. However, it is noted in a nursing progress note that Professor Bosanac advised that as it was therapeutic Mr LY would continue to have unescorted leave. Importantly, after the review Mr LY's request for a period of unescorted leave was approved, was taken and he returned to the unit without incident.

Family Meeting of 3 March 2017

33. I turn to the family meeting of 3 March 2017 attended by Mr RY and members of the treating team Drs Chia, Cowley and Lin, with Dr Lin again being the notetaker. The notes of this meeting are even more comprehensive and clearly legible. Prior to Mr LY joining the meeting Mr RY advised concerns the family held in relation to Mr LY's threats of suicide made to his mother and Mr GY and Ms OY. Mr RY advised that Mr LY had told him he was fearful that at the scheduled hearing before the Mental Health Tribunal, the Tribunal would put him on antipsychotic medications. After a period Mr LY joined the family meeting. The issue of where he would reside upon discharge was discussed. Mr LY stated he did not wish to reside with his mother or brother Mr GY, preferring to "go his own way." It became clear at the

meeting that residing with his mother, Mr GY and Ms OY, or indeed James were no longer options. At the conclusion of the meeting it was planned that Mr LY would remain in the unit over the weekend with a review on the following Monday with a social worker to be involved in the issue of a discharge destination. Dr Chia in evidence stated that as the final admission progressed the plan was to move towards discharge prior to the scheduled Mental Health Tribunal hearing of 10 March 2017 with a view to Mr LY being treated as a voluntary patient. He added that prior to that being achieved there was still "work to be done"; post discharge accommodation remained an unresolved issue.

The Major Issue of Contention

34. Mr RY maintains that at the meeting Mr LY stated:

> *"I might as well just top myself, end it, that's it, I'm finished, I got my priest now."*

to which James responded:

> *"What are you talking about, priest? This is a meeting about science, I believe in science."*

In viva voce evidence Mr RY was adamant that Mr LY made that precise threat to suicide. When one examines the progress note made after Mr LY joined the family meeting there is a note that he commented that he "had gone to church," but there is no reference to the claimed specific threat to suicide.

35. I have re-examined the formal statements provided by Drs Chia, Cowley and Lin and have also carefully reviewed the transcript of the viva voce evidence of those members of the treating team.

36. Dr Chia maintains his position that at the meeting Mr LY denied suicidal ideation, and that the specific claim made by Mr RY about Mr LY stating he was "finished" and "might as well just top myself" was not uttered by Mr LY. In viva vice evidence Dr Chia added that if the claimed comment was made it would be negligent, even for a "first year doctor", let alone a consultant psychiatrist, not to enquire further.

37. Dr Cowley in evidence stated she "can't recall" Mr LY making the statement attributed to him by James about "topping" himself. Dr Cowley added that if the claimed comment had been made it would have been her usual practice to "explore" the situation further. Dr Cowley further stated that if the claimed statement had been made her knowledge of Dr Chia's practice is that Dr Chia would not have "remained impassive," but would have undertaken further assessment. I think it fair to say Dr Chia's position in relation to the claimed suicide threat was somewhat different to that of the other members of the treating team in that Drs

Cowley and Lin's position was that they did not recall the comment being made, whereas towards the completion of his viva voce evidence Dr Chia was unequivocally adamant that the claimed statement was not made. Whether that should or could be viewed as a determining dichotomy I will further consider.

38. Dr Andrew Lin was the junior doctor in the treating team. As stated he was not only present at the family meeting of 3 March 2017 but also what I will call the 'scribe.' Dr Lin said that in taking notes of the meeting he would want to "capture" the relevant information. In evidence Dr Lin made an interesting comment in relation to the significance of putting comments made by a patient in quotation marks "word for word;" he said:

> *"... I think particularly in this sort of a circumstance, you want to write down what the patient has specifically said, because if you're interpreting it, these comments are always open to interpretation and you run the risk of writing down what you think the patient is meaning, rather than what the patient's actually said."*

39. In relation to the controversy surrounding the threat of suicide claimed to have been made by Mr LY at the family meeting on 3 March 2017, I am required to seek to determine where the weight of evidence lies. I have discussed what I referred to as the dichotomy between what, on one hand, Dr Chia said and on the other, what Drs Cowley and Lin said on the issue. Also, as stated earlier, Mr RY was adamant the threat was made. The first point I make is, and it makes resolution of the issue difficult, each of the witnesses that gave evidence were entirely credible, indeed for the most part impressive. In considering what weight to attach to evidence of a witness I am required to consider not only credibility, but also reliability. Quite often one can be satisfied a witness is relating what he/she believes to be the truth, but on occasions one has reservations about the reliability of those recollections. I stress that numbers do not necessarily "carry the day". While it may appear somewhat trite, in the final analysis to accept one version over the other I have to reach a comfortable satisfaction one way or the other. I have earlier referred to the Briginshaw[17] principle and the gloss placed upon it in Anderson v Blashki, Community Services v Gurvich[18] and Chief Commissioner of Police v Hallenstein[19].

40. While I am somewhat uncomfortable with my conclusion; in spite of a most assiduous examination and consideration of the evidence on the issue, I find myself not comfortably satisfied to the required level that one version is more likely than the other. Consequently I

[17] (1938) 60 CLR
[18] (1993) 2 VR 89
[19] (1996) 2 VRI

make NO formal finding on this vexed issue. I will discuss why I do not consider a finding on that particular issue determinative.

41. One of the primary reasons I do not consider determinative the issue of what Mr RY claims was said at the family meeting of 3 March 2017 is that subsequent to Professor Bosanac's psychiatric review of 2 March 2017, and post the family meeting of 3 March 2017, I am satisfied Mr LY actually took approved unescorted leave and returned to the facility without incident as he had done on a number of other occasions before and during the final admission of 10 February 2017 – 4 March 2017. Furthermore, unescorted leave was considered therapeutic in Mr LY's case and a significant management "tool," if I may call it that. It must constantly be borne in mind that the underlying philosophy upon which the Mental Health Act 2014 is founded is treatment/management in the least restrictive environment. The great majority of patients with mental health issues, even those at chronic risk of self-harm, are treated in the community.

42. The critical issue for me is whether the decision taken by Nurse Lucy Graham on the morning of 4 March 2017 to approve Mr LY's request for unescorted leave was one reasonably open to her, or whether, as argued on behalf of the family, the statements made by Mr LY at the previous events of 12 February 2017 and 2 March 2017 dictated that unescorted leave should not have been approved.

43. It was put on behalf of the family that Nurse Graham did not undertake a sufficiently meaningful assessment of Mr LY before approving his leave. Mr Shepherd put to Nurse Graham:

> *"Now you didn't perform any sort of mini-mental state examination, is that correct?"*

She responded:

> *"No, that is not correct. I did an assessment on Mr LY prior to leaving."*

44. When on duty, Nurse Graham was Mr LY's primary contact nurse throughout the admission of 10 February 2017 to 4 March 2017, and indeed on earlier admissions to the unit. I accept Nurse Graham established a certain rapport with Mr LY and knew him better than anyone else on the unit. She stated:

> *"… Mr LY was not someone that was on my radar as a suicide risk."*

She added that although with patients in an acute inpatient unit there is always a risk of suicide, Mr LY wasn't flagged as someone that she considered was at risk of suicide. Nurse Graham maintains she held that view even though she was present at the Bosanac review of 2

March 2017 at which Mr LY made what I will call the "conditional" threat of suicide in the context of the prospect of injectable anti-psychotic medication being administered.

45. While paying particular attention to what occurred at the events of 12 February 2017, 2 March 2017 and 3 March 2017, I have also considered the numerous interactions between Mr LY and Nurse Graham throughout the admission, because those personal interactions bear upon the efficacy of the judgement call made by Nurse Graham on 4 March 2017.

THE ADEQUACY OF THE RISK ASSESSMENT UNDERTAKEN BY NURSE GRAHAM ON 4 MARCH 2017

46. I cut to the chase and focus on the issue of the adequacy of Nurse Graham's assessment of Mr LY's presentation on the morning of 4 March 2017. In her formal statement (Exhibit M) Nurse Graham said Mr LY:

> *"… did not appear distressed/agitated, he seemed quite calm."*

In viva voce evidence Nurse Graham reiterated that claim, stating that in light of the plan put forward by Professor Bosanac at the review of 2 March 2017, if Mr LY was agitated or distressed she would not have approved unescorted leave. Nurse Graham made an entry in the medical records in relation to Mr LY's presentation and her assessment of him. She described Mr LY as:

> *"polite and pleasant on engagement … no evidence of perceptional disturbance"* with *"nil suicidal self-harm ideation expressed prior to leaving,"*

and stated that Mr LY said he was going for a walk and likely lunch.

47. Those notes were made in the progress notes/medical records by Nurse Graham at 1:45pm, after she became aware that Mr LY had jumped to his death from the Belford Road overpass; and therefore were not contemporaneous notes of the interaction with Mr LY prior to approving leave. In my experience it is not unheard of for retrospective notes to provide a more favourable position in relation to what really occurred. It is therefore critical I carefully consider the credibility of Nurse Graham whose performance is challenged. In his examination of Nurse Graham Mr Shepherd obliquely approached the issue surrounding non-contemporaneous notes. As I wondered whether Nurse Graham appreciated the point being made, I decided to address the issue directly, referring to it as a "$64 question." I put to Nurse Graham that in light of the fact that when she made the notes she was aware of Mr LY's death an implication could be drawn that the notes were more favourable to the adequacy and extent of her assessment. When asked if she wished to comment Nurse Graham replied:

"… Um, just to say that I do recall Mr LY on that morning and that he was calm and appropriate, or I felt he was calm and appropriate for me then I feel like as a nurse then I would not make up kind – I would not fabricate, um …"

in effect maintaining she stood by her notes as to the circumstances of Mr LY's presentation.

48. I accept Nurse Graham's evidence on the issue, she clearly, in my view, came across as a witness of truth. In the final analysis, I am comfortably satisfied, by a good margin, that Nurse Graham's approval of Mr LY's request for unescorted leave was, in spite of the tragic outcome, one reasonably open to her. It is my view that the family's contention that the risk assessment of Mr LY Nurse Graham undertook on the morning of 4 March 2017 was deficient/inadequate, is based upon a significant measure of hindsight/retrospection.

49. I add it is noteworthy that it was not only Nurse Graham who did not think Mr LY was at imminent risk of taking his own life. The evidence demonstrates Mr RY, Mr GY and Ms OY also held the same view and were understandably shocked when he did.

50. We will never know whether Mr LY had decided to intentionally take his own life before he left the facility that morning, or whether it was a decision taken on impulse after leaving. Many years ago my former colleague Deputy State Coroner Iain West made a pertinent comment with which I concur and have adopted many times over the years;

> *"This tragedy highlights the dilemma facing health professionals who manage and treat individuals with mental illness and their difficulty in predicting when a patient is at risk of crossing the suicide threshold. The patients' actions are frequently impulsive. Prior attempts and risk factors may be well documented, however, such material can rapidly go out of date and thus be less helpful as an indication of future behaviour. While the difficulties associated with fluctuating risk behaviour are well recognised; it is imperative that health professionals remain vigilant."*[20]

Risk assessment is a complex, vexed issue, the difficulty of which is often underestimated.

MENTAL HEALTH TRIBUNAL

51. In spite of Mr LY continuing to hold fears about what the Mental Health Tribunal may do at the scheduled hearing on 10 March 2017 in relation to directing intramuscular antipsychotic medication, I am satisfied he was assured the tribunal was not empowered to direct treatment. I am not persuaded by Mr Shepherd's submission that it would have been appropriate to request an "urgent hearing" at the Mental Health Tribunal to resolve that and other issues.

FORMAL FINDING

52. I formally find Mr LY on 4 March 2017 intentionally took his own life when he leapt to his death from the Belford Road overpass onto the inbound carriageway of the Eastern Freeway at Kew East.

53. Pursuant to section 73 (1) of the *Coroners Act 2008* I direct that a copy of this finding be published on the Coroners Court of Victoria website.

COMMENT

54. Pursuant to section 67 (3) of the *Coroners Act 2008*, I make the following comments in relation to the death.

55. At the conclusion of his submission on Monday 14 December 2020 (the third day of the hearing) Mr Shepherd urged me to consider a number of recommendations. I deal with each in the order they were put.

56. It was submitted where there is evidence of increasing aggravation/agitation/distress, coupled with suicidal ideation or threat, unescorted leave should not be approved without a team review meeting. I do not propose to adopt that suggested purpose primarily due to the fact that if direct threat of suicide in the context of a patient's distress/agitation did occur, a review as to the appropriateness would assuredly be undertaken, as occurred in this matter with the Bosanac review of 2 March 2017.

57. Mr Shepherd also submitted that hospital notes of arranged family meetings include details of attendees, times meeting commenced and ended, reference to documents "tendered" at the meeting and placed on the file. While on the face those suggestions seem reasonable, I do not propose to adopt the suggested recommendation as generally one would expect some, if not all, of those things would occur anyway.

58. It is further submitted that where practicable family members present be "permitted to sight the hospital's notes and to have input into the record of the meeting." It is unclear to me precisely what Mr Shephard is suggesting; however families certainly do have input into the matters discussed at a family meeting. In answer to a question I put to him Mr Shepherd confirmed that he was submitting that at the conclusion of all family meetings the family be provided with a copy of the notes. I do not know whether such a request would be acceded to, but it should be understood those notes are the hospital's notes and it is always open to family members to take their own notes.

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[20] Dennis Petran (dec'd) case 3310/01

59. One of the reasons I decline to adopt those suggested recommendations is due to the fact that in an overwhelming percentage of such meetings serious issues of contention do not arise, so that formal recommendations on those particular issues are not warranted. In my view it is not helpful to make recommendations too prescriptive.

60. Mr Shepherd also submitted that where a patient makes an application to the Mental Health Tribunal for revocation of a compulsory treatment order he/she should be provided timely information about the prospect of an early/urgent hearing. In my opinion this matter is not the appropriate vehicle for such a recommendation. Mr LY had access to legal advice, at one time reminding clinicians that his brother was a barrister. Furthermore, in this case there is no evidence to suggest the family would support discharge from the compulsory order before the scheduled hearing date; on the contrary; there were as I stated before, unresolved issues which would impact early discharge.

61. In summary, the primary reason I have not adopted the recommendations suggested by Mr Shepherd is that they are fundamentally particular to the circumstances of this case and are not replicated in the vast majority of cases dealt with at this court. They do not, in my considered view, relate sufficiently to systemic deficiencies in practice.

DISTRIBUTION OF THE FINDING

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

    - Ms Angela Torcasio, on behalf of the family of Mr LY;
    - Mr Jon Minter, K&L Gates, on behalf of St Vincent's Hospital; and
    - Dr Neil Coventry, Chief Psychiatrist, Office of Chief Psychiatrist.

Signature:

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PHILLIP BYRNE
CORONER
Date: 22 January 2021